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ONE HUNDRED FIFTH LEGISLATURE

SECOND SESSION

LEGISLATIVE RESOLUTION 296

Introduced by Walz, 15.

WHEREAS, an individual residing at Life Quest at the Coolidge Center, a state-licensed care facility in Palmer, died on September 3, 2017, after three days of life-threatening symptoms; and

WHEREAS, the Department of Health and Human Services produced an eighty-one page report of violations found during inspections in June and July of 2017 and another six-page report after a visit in September of 2017. These reports were not released until officials revoked the facility's mental health care license on October 5, 2017, a month after the incident occurred. The revocation took effect fifteen days later; and

WHEREAS, the report indicates that the Department of Health and Human Services knew of multiple violations in the months preceding the closure of this facility. If more immediate action had been taken to remedy these violations or draw attention to the inequities in quality of care standards, a life could have been saved; and

WHEREAS, the circumstances surrounding this event have garnered media attention throughout Nebraska, along with scrutiny from the public. This care facility, as well as multiple others in the past few years, including Hotel Pawnee in North Platte and Park View Villa in Gothenburg, have been shut down due to violations regarding maintenance, cleanliness, and personnel issues; and

WHEREAS, the individuals affected by these policies are some of the most vulnerable in our community. The citizens of Nebraska have a right to know the standard of care to which our governmental organizations are held, including, but not limited to, policies, procedures, and regulations regarding oversight of assisted living facilities and mental health centers; and

WHEREAS, under Title II of the Americans with Disabilities Act (ADA) it is

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illegal for public entities, namely state and local governments, to deny the benefits of programs, services, or activities to qualified individuals with disabilities; and

WHEREAS, the regulations which implement Title II mandate that state governments administer services "in the most integrated settings appropriate to the needs of qualified individuals with disabilities"; and

WHEREAS, the integration mandate in the ADA is implicated when a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities; and

WHEREAS, a public entity may violate the integration mandate in the ADA when it: (1) Directly or indirectly operates facilities or programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; or (3) through planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.

NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE ONE HUNDRED FIFTH LEGISLATURE OF NEBRASKA, SECOND SESSION:

1. That the Legislature hereby calls for the Executive Board of the Legislative Council to meet forthwith and appoint a special committee of the Legislature to be known as the State-Licensed Care Facilities Oversight Committee of the Legislature. The committee shall consist of seven members of the Legislature appointed by the Executive Board. The committee shall elect a chairperson and vice-chairperson from the membership of the committee. The Executive Board is hereby authorized to provide the committee with a legal counsel, committee clerk, and other staff as required by the committee from existing legislative staff.

2. The State-Licensed Care Facilities Oversight Committee shall limit the scope of its inquiry to assisted living facilities where many of the residents are diagnosed with a mental illness. The oversight committee shall also examine the recent closures of the mental health centers known as Life Quest, located

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in Palmer and Blue Hill.

3. The State-Licensed Care Facilities Oversight Committee of the Legislature is hereby authorized to study the lack of adequate conditions of state-licensed care facilities, the treatment of individuals residing in such facilities, the effectiveness of regulation and licensure by the Division of Public Health in providing oversight, and how the Department of Health and Human Services implements and administers its behavioral health services through the behavioral health regions to address the needs of this vulnerable population. The committee shall also investigate what steps the department has taken to advance the recommendations proposed by the Technical Assistance Collaborative as a consultant to the department, namely, the reasons that assisted living facilities are the primary residential options for individuals with severe and persistent mental illness and alternatives such as permanent supportive housing and services do not exist. The committee shall also investigate whether the department is taking adequate steps to ensure behavioral health services are administered in the most integrated setting pursuant to the ADA. The committee shall utilize existing studies, reports, and legislation developed to address the current conditions. The committee shall not be limited to such studies, reports, or legislation.

4. The State-Licensed Care Facilities Oversight Committee of the Legislature shall issue a report with its findings and recommendations to the Legislature on or before December 15, 2018.