AM1884
LR104
JDL - 05/16/2019

AMENDMENTS TO LR104

Introduced by Executive Board.

1 1. Strike the original provisions and insert the following new
2 provisions:
3 WHEREAS, an individual residing at Life Quest at the Coolidge
4 Center, a state-licensed care facility in Palmer, died on September 3,
5 2017, after three days of life-threatening symptoms; and
6 WHEREAS, the Department of Health and Human Services produced an
7 eighty-one page report of violations found during inspections in June and
8 July of 2017 and another six-page report after a visit in September of
9 2017. These reports were not released until officials revoked the
10 facility’s mental health care license on October 5, 2017, a month after
11 the incident occurred. The revocation took effect fifteen days later; and
12 WHEREAS, the report indicates that the Department of Health and
13 Human Services knew of multiple violations in the months preceding the
14 closure of this facility. If more immediate action had been taken to
15 remedy these violations or draw attention to the inequities in quality of
16 care standards, a life could have been saved; and
17 WHEREAS, the circumstances surrounding this event have garnered
18 media attention throughout Nebraska, along with scrutiny from the public.
19 This care facility, as well as multiple others in the past few years,
20 including Hotel Pawnee in North Platte and Park View Villa in Gothenburg,
21 have been shut down due to violations regarding maintenance, cleanliness,
22 and personnel issues; and
23 WHEREAS, the individuals affected by these policies are some of the
24 most vulnerable in our community. The citizens of Nebraska have a right
25 to know the standard of care to which our governmental organizations are
26 held, including, but not limited to, policies, procedures, and
27 regulations regarding oversight of assisted-living facilities and mental

1 health centers; and
2 WHEREAS, under Title II of the Americans with Disabilities Act (ADA)
3 it is illegal for public entities, namely state and local governments, to
4 deny the benefits of programs, services, or activities to qualified
5 individuals with disabilities; and
6 WHEREAS, the regulations which implement Title II mandate that state
7 governments administer services "in the most integrated settings
8 appropriate to the needs of qualified individuals with disabilities"; and
9 WHEREAS, the integration mandate in the ADA is implicated when a
10 public entity administers its programs in a manner that results in
11 unjustified segregation of persons with disabilities; and
12 WHEREAS, a public entity may violate the integration mandate in the
13 ADA when it: (1) Directly or indirectly operates facilities or programs
14 that segregate individuals with disabilities; (2) finances the
15 segregation of individuals with disabilities in private facilities; or
16 (3) through planning, service system design, funding choices, or service
17 implementation practices, promotes or relies upon the segregation of
18 individuals with disabilities in private facilities or programs.
19 NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE ONE HUNDRED
20 SIXTH LEGISLATURE OF NEBRASKA, FIRST SESSION:
21 1. That the Legislature hereby calls for the Executive Board of the
22 Legislative Council to meet forthwith and appoint a special committee of
23 the Legislature to be known as the State-Licensed Care Facilities
24 Oversight Committee of the Legislature. The committee shall consist of
25 seven members of the Legislature appointed by the Executive Board. The
26 committee shall elect a chairperson and vice-chairperson from the
27 membership of the committee. The Executive Board is hereby authorized to
28 provide the committee with a legal counsel, committee clerk, and other
29 staff as required by the committee from existing legislative staff.
30 2. The State-Licensed Care Facilities Oversight Committee shall
31 limit the scope of its inquiry to assisted-living facilities where many

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1 of the residents are diagnosed with a mental illness. The oversight
2 committee shall also examine the recent closures of the mental health
3 centers known as Life Quest, located in Palmer and Blue Hill.

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

24 4. The State-Licensed Care Facilities Oversight Committee of the
25 Legislature shall issue a report with its findings and recommendations to
26 the Legislature on or before December 15, 2019.