Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

PEOPLE FIRST OF TENNESSEE, on behalf of its members,

BONNIE CHAFFEE, by her next friend, Crystal Goodman,

DOWELL HARRIS, by his next friend, Rocky Akin,

EFFIE ESTELLE PIPPIN, by her next friend, Frances Hamblen,

SANDRA JO PROCTOR, by her next friend, Evelyn McCormack,

CYNTHIA DAWN SOMMERVILLE, a minor, by her parents and natural guardians, Jeff and Kathy Sommerville,

KEVIN TROUPE, by his next friend, Charles Hall,

JUANITA WRIGHT, by her next friend, William A. Goodman, Jr.,

MARY ANN AVERY, by her next friend, Jason Elam,

AUDRINIECE HOLLISTER, by her next friend, Ethyl Ervie,

KENNETH LEE, by his parent and natural guardian, Diane Lee,

EDDIE JONES, by his next friend, John Kennington,

LARRY WAYNE VAUGHN, by his next

FIRST AMENDED COMPLAINT
CLASS ACTION--
No. 3:95-1227
Judge Echols
Magistrate Haynes

friend, Andy Devoti,

CHARLES WILHOITE, by his next friend, James Turner,

CAROLYN BRITT, by her next friend, Jane Humphrey,

REBECCA WORKMAN, by her next friend, Rebecca Smith,

JENNY BELLE GREENWOOD, by her next friend, Patricia Hornick,

DAVID BALTHROP, by his next friend, Rex Stephens,

TERRY BEATY, by his next friend, Edward Sewell, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

THE CLOVER BOTTOM DEVELOPMENTAL CENTER,

THE GREENE VALLEY DEVELOPMENTAL CENTER

THE NAT T. WINSTON DEVELOPMENTAL CENTER

DON SUNDQUIST, in his official capacity as Governor of the State of Tennessee,

O. STEVEN ROTH,in his official capacity as Superintendent of the Clover Bottom Developmental Center,

ROBERT ERB, in his official capacity as Superintendent of the Greene Valley Developmental Center,

PETE DAVIDSON, in his official capacity as Superintendent of the Nat T. Winston Developmental Center,

THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION,

BEN DISHMAN, in his official capacity as Acting Commissioner of Mental Health and Mental Retardation,

THOMAS SULLIVAN in his official capacity as Assistant Commissioner for Mental Retardation,

THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

JOHN FERGUSON, in his official capacity as Commissioner of Finance and Administration,

THE TENNESSEE DEPARTMENT OF HEALTH,

FREDIA WADLEY, in her official capacity as Commissioner of Health,

RUSTY SEIBERT, in his official capacity as Assistant

of the severity of their disabilities, and because the defendants have failed to meet their federal statutory and regulatory obligations with regard to placing, monitoring and discharging plaintiffs to alternative non-institutional services.

Jurisdiction and Venue

5. This court has subject-matter jurisdiction over this action pursuant to 28 U.S.C. §§1331 and 1343. Plaintiffs' cause of action arises under 29 U.S.C. §§ 720 and 794, 42 U.S.C. §§1396, 1396a, 1396d and 1983 and the First, Fifth and Fourteenth Amendments to the United States Constitution. Venue in this district is proper under 28 U.S.C. § 1391(b).

Plaintiffs

6. PEOPLE FIRST OF TENNESSEE is a state wide advocacy organization governed entirely by people with disabilities. It was founded in 1981 and was incorporated in 1984 as a non-profit corporation under the laws of the State of Tennessee. People First of Tennessee has more than 1000 members, all of them persons with disabilities, in 40 chapters and support groups in 31 counties across the state.

7. The purposes of People First of Tennessee, for which it expends its resources, are as follows:

(a) To promote the philosophy that everyone, no matter what disability he or she has or its severity, has the same basic civil rights and responsibilities;

(b) To advocate and defend the rights of persons with disabilities in the areas of employment, education, housing and transportation;

(c) To provide a way for persons with disabilities to express and remedy their concerns and enhance their well-being.

8. To advance those goals, People First of Tennessee and its members advocate for legislation to enable Tennesseeans with disabilities to live more independently. Members travel around the state to teach people with disabilities about their legal rights and responsibilities. They provide leadership development training and foster community awareness through community volunteer service. They represent Tennesseeans with disabilities by serving on regional, state and national committees including the State Advisory Planning Council for the Department of Mental Retardation. They conduct local, regional and state-wide conferences, meetings and training programs.

9. In 1989, Governor Ned McWherter issued a proclamation recognizing People First for Outstanding Service to Tennessee. In 1990, People First of Tennessee received the Nashville Mayor's Award for Outstanding Organization Serving People With Disabilities; in 1994, the organization received the Nashville Mayor's Advisory Committee Award. In 1995, People First received the J.C. Penney Golden Rule Award.

10. In 1991, People First of Tennessee organized and hosted a nation-wide conference of self-advocacy organizations; at this conference, a national organization of self-advocacy or "People First" organizations was founded named Self-Advocates Becoming Empowered. Since that time, members of People First have been appointed to the President's Committee on Mental Retardation and the board of directors of the American Association on Mental Retardation, one of the leading professional organizations in the field of developmental disabilities. A Tennessee member served as a regional representative on the National Committee of Self-Advocates Becoming Empowered; a member of People First of Tennessee was chosen to honor Senator Frist upon his appointment to the chairmanship of the Senate Sub-committee on Disability Issues,

and members were invited by President Clinton to the 5th anniversary celebration of the anniversary of the Americans with Disabilities Act. Twenty-four delegates from People First of Tennessee attended the 3rd International People First Conference in Toronto, Canada. Finally, People First's training program on self-determination was published in 1995 by the James Stanfield Publishing Co., a nationally recognized distributor of special education training programs.

11. The name "People First" was conceived by the members of People First International, which was founded in 1974 by residents of the Fairview Training Center, a state institution for persons with retardation in Oregon. In discussing the selection of a name, one of the members said, "Why not call ourselves People First, because we want to be known as people before we're known for our handicap?" After that, People First organizations were formed in many other states, including Tennessee. All share the common purpose of supporting their members' right to speak for themselves, to make their own decisions, and to know and exercise their rights as citizens, including their right to live in the community.

12. People First has many members who live at all three defendant developmental centers. Beginning in 1984, members of the local Nashville chapter decided to conduct outreach to individuals residing at Clover Bottom. Since that time many individuals from Clover Bottom, Greene Valley and Nat T. Winston have become People First members and have attended local meetings. Members who reside at Clover Bottom Developmental Center have attended public hearings on efforts to limit the size of residential programs. They have been elected to local chapter leadership positions and one individual has served on the organization's board of directors in the past.

13. BONNIE CHAFFEE is a woman in her late 30's who has lived at Clover Bottom for approximately fifteen years. She lives in Magnolia, a large building with two residential units for men and women respectively, on either end. She and the other women in her unit have little or no choice about when to wake up and go to bed, or what to eat. She was institutionalized at Clover Bottom because she had challenging behavior, and because defendants served people with her disabilities only at institutions like Clover Bottom.

14. Ms. Chaffee is a capable woman with good communication skills. She has been labelled moderately retarded. She attends People First meetings regularly. She has stated at every recent People First meeting that she wants to leave Clover Bottom and live in a normal home in the community. In the past, she was placed in a group home but the placement failed because the home was, in effect, a mini-institution with many residents, was not staffed to meet her needs, and was funded far below the level of Clover Bottom. Defendants' "cookie-cutter" approach to community services denied Ms. Chaffee the individualized services she needed.

15.Ms. Chaffee has been recommended for community placement; however, she remains at the institution because the community service system operated by defendants poses many barriers to her successful placement. Those barriers include the defendants' failure to develop supported employment and other daytime services for persons living in the community; their failure to develop residential support services for people with significant disabilities and need for behavioral support; and their failure to make training and technical assistance available to people who work in the community service system.

16. Ms. Chaffee lacks meaningful employment training opportunities at Clover Bottom. She attends a sheltered workshop on campus, where she spends about six hours a day, much of

it dead time with nothing to do, the rest of it repetitive assembly work for minimal wages. This is the only employment training opportunity available to the vast majority of Clover Bottom residents.

17. Bonnie Chaffee experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, she has been unnecessarily confined at Clover Bottom.

18. DOWELL HARRIS is a man of middle age who has been institutionalized at Clover Bottom for many years. He lives in the Spruce building, in a "behavior unit" where he is congregated together with other men who are considered "lower functioning ambulatory" residents with behavior problems. He has little opportunity to model appropriate behavior or to learn how to act in the community; instead, he is exposed without respite to persons whose behavior is at least at problematic as his own. He and the other men in his unit have little or no choice about when to wake up and go to bed, or what to eat. He has no family who are involved in his life and has not received a Christmas card from a friend in at least twenty years.

19. Mr. Harris has multiple disabilities. He does not say many words clearly, and he has visual difficulties. He walks with a hunched-over gait. He has difficulty with activities of daily living. He engages in stereotypical, perseverative behavior that is the result of his long institutionalization. The irony is that because of the disabilities that were created in part by institutionalization, he is now considered to be completely inappropriate for community placement. Defendants refuse to consider him for the community on the ground that he requires too much support--support they have chosen to provide only at Clover Bottom.

20. Mr. Harris rarely leaves his residential unit--he is in the Spruce building 24 hours

a day for weeks at a time. He has little or no opportunity to practice vocational skills, recreational skills or community living skills. His environment is barren, monotonous and unpleasant; he is condemned to live without hope or companionship.

21. Dowell Harris experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because defendants limit their community services to persons who do not have his behavioral disabilities, he has no alternative to Clover Bottom.

22. EFFIE ESTELLE PIPPIN will be 44 years old on December 23, 1995. She has lived at Clover Bottom for nearly twenty years. She lives in Magnolia. Her parents are deceased. She has a brother who does not visit or send cards or letters, and a sister who has only limited contact with her. She attended public school for a time but left while she was still in elementary school.

23. Ms. Pippin is capable and articulate and states that she would like to leave Clover Bottom and move to her own apartment. She is an active member of People First of Tennessee. With training and support she could easily work at a real job and use public transportation. She has been labelled mildly or moderately retarded. She has hemiplegia and has some difficulty walking, which places her at risk of falling and injuring herself. In the last year she has had a broken foot and a sprained ankle. She has been denied adequate dental care at Clover Bottom.

24. Ms. Pippin has been hit frequently by other Clover Bottom residents. At People First meetings, she has been observed to have bruises that Clover Bottom staff could not adequately explain. She has also been the recipient of forced sexual attention at Clover Bottom.

25. In the past, Ms. Pippin has been placed in group homes in the community, but defendants' one-size-fits-all approach to community services did not meet her individual needs.

As a result, she was returned to Clover Bottom.

26. Effie Pippin experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, she has been unnecessarily confined at Clover Bottom.

27. SANDRA JO PROCTOR is 46 years old and has lived at Clover Bottom for more than twenty years. She lives in Harrison Hall, a large building composed of several wards in which twelve to fifteen people share living space and bathroom facilities. Until recently Ms. Proctor hardly ever left her building; even now, she spends most of her time on the unit.

28. 28. Ms. Proctor does not speak but understands others when they speak to her. She can walk, feed herself and make known her choices and preferences. She has been labelled severely and profoundly retarded.

29. Ms. Proctor is not receiving adequate habilitation at Clover Bottom. She does not have access to meaningful activities, vocational training, or the opportunity to learn real-life skills in the natural environments where those skills are practiced. She lives in a barren ward with stark, institutional furniture, a television blaring for most of the day, and little else to do.

30. Ms. Proctor has been denied community placement because of challenging behavior. With proper support and training, however, she could learn how to act appropriately in the community, where she could also receive much richer and more meaningful habilitative services. However, the staff support she needs would cost more than the defendants' cost ceiling under the home and community based waiver. That ceiling--$107 per day--is significantly less than the $180 per diem cost of care at Clover Bottom.

31. Sandra Jo Proctor experiences, on a daily basis, the harmful and unlawful conditions

described in paragraphs 128-249 below. Because defendants limit their community services to persons who do not have her behavioral disabilities, she has no alternative to Clover Bottom.

32. CYNTHIA DAWN SOMMERVILLE is the adopted daughter of Jeff and Kathy Sommerville of Portland, Tennessee. She is sixteen years old and has lived at Clover Bottom Developmental Center from September 12, 1986, until going into a community program in June, 1996. She is diagnosed as having autism, profound retardation and cerebral palsy.

33. At Clover Bottom, Ms. Sommerville experienced many health and behavior problems requiring hospital treatment, including hyperactive behavior, loss of sleep, agitation, self-mutilation, dehydration, aspiration pneumonia, gastroesophageal reflux, neurogenic bladder, otitis, tonsillitis and severe constipation. She has received many psycho-active and other medications at the institution, including Valium, Haldol, Thorazine, Mellaril, Loxitane, chloral hydrate, diphenhydramine, Trilafon, Benadryl, Ditropan, Ativan, Tegretol, Zantac, and Senokot. Some of these medications have caused serious side-effects; for example, she has experienced involuntary muscular movements due to repeated doses of Loxitane, and has suffered rapid weight loss as a reaction to medication.

34. In 1987, Ms. Sommerville was admitted to Vanderbilt Hospital for phenobarbital ingestion. At the time, she was not supposed to be taking any barbiturates. When Clover Bottom staff queried the hospital whether the test result that showed phenobarbital in her blood could have been a false positive, further specialized assays were done and the drug was identified as phenobarbital.

35. Cynthia Sommerville has experienced sexual abuse and injury at Clover Bottom. In 1991, a psychologist at the institution called Cynthia's mother and informed her that her

daughter had bruising on her upper inner thighs near the genitals and recommended that she be checked by a gynecologist. Subsequently, she was seen by a doctor about bruises on her back and hand prints on her ribs. The institution explained that these bruises were a result of having been lifted and moved by a direct care staff.

36. On March 10, 1992, Ms. Sommerville was taken to Nashville General Hospital with two sets of bruises to be evaluated for possible abuse. She was referred to the Department of Human Services and "Our Kids," a program for children who may have been sexually abused. The hospital was unable to confirm or deny physical abuse. However, she was found to have "significant bruising of at least two ages consistent with recent falls and/or blunt trauma." Her mother had found bruises on her lower back and dried blood on her inner thighs when visiting to check on her.

37. On March 25, 1992, Ms. Sommerville was again seen at General Hospital for assessment of possible sexual abuse. At that time, a report was made to the Department of Human Services.

38. On August 21, 1993, Ms. Sommerville was the victim of an assault and battery by an unknown person or persons at Clover Bottom. She was found with severe bruises and swelling of her arms and knees. The injury was not reported to Ms. Sommerville's mother in a timely fashion.

39. On December 8, 1993, some time between 8 and 10 PM, Cynthia Sommerville was sexually assaulted. When she was bathed at 8 PM, staff noticed no bruises. At 10 PM, a staff person checked Ms. Sommerville's bed, noticed that the covers needed adjusting, and found Cynthia with bruising on the left inner thigh close to the vaginal area and a heavy vaginal

discharge on the buttocks, vaginal area and sheets. A nurse was summoned and Ms. Sommerville was taken to the infirmary and from there she was transported to Nashville General Hospital. The nurse called Kathy Sommerville and told her that she could not rule out the possibility that "something had happened to [Cynthia]." Clover Bottom staff reported to General Hospital staff that Cynthia had a copious white and yellow vaginal discharge, a strong body odor despite having been bathed only a few hours before, and fresh bruising. However, between the time the injuries were discovered and the time Cynthia arrived at the infirmary, staff must have cleaned her up to eliminate signs of sexual abuse because the physician on duty found no discharge. The institution found that several violations of procedure had occurred uring the time the injuries would have to have occurred and that staff were not working in their assigned places. Clover Bottom staff concluded that the injuries were either "self-inflicted" or caused by someone else. General Hospital expressed concern that there was no explanation for the bruises or discharge.

40. Cynthia Sommerville has experienced, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because defendants limited their community services to persons who do not have her significant and multiple disabilities, she had no alternative to Clover Bottom until after this case was filed.

41. KEVIN TROUPE is a young man in his 20s who came to Clover Bottom at the age of twelve. He lives in the Spruce building, where he is inappropriately congregated with "lower-functioning" men with challenging behavior. He was initially admitted to Clover Bottom for short-term respite and was institutionalized there permanently because of defendants' failure to make services available in the community for persons with his behavioral disabilities.

42. Mr. Troupe is a capable young man who, although he does not speak, understands the speech of others and is able to follow directions. His abilities belie defendants' classification of him as profoundly retarded. He joined People First of Tennessee in 1991, but has not been to meetings recently, probably because staff in his building rarely accompany the men who live there outside the unit. With support Mr. Troupe could live in his own home with a companion, work at a job and learn community living skills.

43. Mr. Troupe badly needs dental care which he not receiving at Clover Bottom. His appearance is often dishevelled, his clothes dirty and ill-fitting. He is not receiving adequate habilitation, meaningful vocational training, or realistic opportunities to learn social skills or skills of daily living.

44. Kevin Troupe experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, he has been unnecessarily confined at Clover Bottom.

45. JUANITA WRIGHT is 71 years old and has lived at Clover Bottom for at least ten years. She lives in a building for "higher-functioning" older women. Her living unit has few meaningful or functional activities that would be appropriate for persons of retirement age. The women in her building get up and go to bed at the same time and eat their meals at prescribed times. Although she could learn to assist in meal preparation, she must eat food that is trucked in on plastic trays.

46. Ms. Wright is quiet, soft-spoken and polite. She has good social skills. She could enjoy an active retirement in the community. She is an active member of People First of Tennessee and served on a team of People First members that met with Tennessee legislators

in 1989. She has been labelled severely retarded, but her abilities are at least in the moderate range. She has some hearing and visual losses.

47. Ms. Wright has repeatedly and consistently expressed her desire to move to a normal home in the community. Her need for support is modest and could easily be met in the community.

48. Juanita Wright experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, she has been unnecessarily confined at Clover Bottom.

49. MARYANN AVERY is a 26 year old woman who has been at Nat. T. Winston for approximately 8 years. She lives in the Mississippi unit, where she is inappropriately congregated with "lower-functioning" women with challenging behavior. Mary Ann has been abused by other residents while staff members stood and watched but failed to intervene.

50. Mary Ann is a capable young woman who is ambulatory, verbal and understands the speech of others. She is able to follow directions and is able to communicate her needs and desires to others. With minimal support Mary Ann could live in the community and learn the functional skills necessary for her to succeed in society as a working adult.

51. Currently, Mary Ann spends her days in a workshop where she puts tiny automotive parts together. While she does her job quite well, she does not know what the parts are used for and has no opportunity to view the final product. She has little opportunity to go into the community and has no interaction with non-disabled peers.

52. Mary Ann is not receiving adequate habilitation, meaningful vocational training, or realistic opportunities to learn social skills or skills of daily living.

53. Mary Ann Avery experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, she has been unnecessarily confined at Nat T. Winston.

54. AUDRINIECE HOLLISTER is a woman in her 30's who has lived at Nat T. Winston for many years. She lives in the Mississippi Unit, a unit for women with behavioral disabilities. Audriniece has been hit by other residents and receives no protection or intervention by staff.

55. Audriniece spends her days in a workshop where she puts greeting cards in piles for packaging. Audriniece lacks meaningful employment training opportunities at Nat T. Winston.

56. Audriniece is a very capable woman who can read and is both ambulatory and verbal. She is very unhappy at Nat T. Winston and has clearly expressed her desire to move into the community. She would like to work as a waitress and thinks she would be good at it.

57. Audriniece has not seen her mother for many years. Her mother has been in a coma for nine years and has been unable to visit. Likewise, Audriniece is unable to leave the institution to go visit her mother. Audriniece misses her mother very much.

58. Audriniece experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, she has been unnecessarily confined at Nat T. Winston.

59. KENNETH LEE is a 24 year old man who has been institutionalized at Nat T. Winston for approximately 3 years. He lives in the Hatchy building, in a "behavior unit" where he is congregated together with other men who lead him into trouble. Ken has been convinced several times to break out of Nat T. Winston by one of the other men in his unit. While staff

recognize the problem of housing Ken with this other resident, they continue to do so despite requests by his mother at IDT meetings to separate the two men.

60. Kenneth enjoys and is good at housekeeping and would like to work in the community. While his mother has requested that Ken be allowed to do housekeeping, he is not permitted to get a housecleaning job because he has not met the institutions standards for his work in an assembly-line type workshop. Kenneth is denied the transitional services and vocational rehabilitation necessary for him to become a productive member of society.

61. Kenneth has been forcefully restrained by staff members despite the facility policy and a statement in Ken's behavior plan that only "time out" will be used if physical aggression occurs or appears imminent.

62. Kenneth experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, he has been unnecessarily confined at Nat T. Winston.

63. EDDIE JONES is a 51 year old man who has been institutionalized at Greene Valley for approximately 34 years. He lives in the Newel Building with other men who are considered residents with behavior problems. Eddie's IDT considers that Eddie is a good candidate for a group home placement.

64. Eddie was placed in Greene Valley by a juvenile court because of hyperactivity and behavior problems. His parents are both mildly mentally retarded and are not involved with Eddie. Due to Eddie's behavior problems he has been forced to spend most of his life in an institution taking psychotropic medication for depression.

65. In the past year, Eddie has been treated for pneumonia 3 times, bronchitis 2 times,

upper respiratory infection one time, fecal impactions 2 times, ear wax removal two times, foot fungus and dry skin.

66. Eddie works in downtown Greeneville but has little or no exposure to non-disabled peers. He does not have any opportunity to go into the community for activities other than work in a sheltered workshop.

67. Eddie experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, he has been unnecessarily confined at Greene Valley.

68. LARRY WAYNE VAUGHN is a 26 year old man who has been institutionalized at Greene Valley for 6 years. He lives in the Alder building, in a "behavior unit" where he is congregated together with other men who are considered "lower functioning" residents with behavior problems. Larry is diagnosed as having mild retardation, congenital spina bifida with hydrocephalus, generalized tonic-clonic seizures and paraplegia.

69. Larry is a warm, capable, personable and articulate man who has clearly expressed his desire to live in the community. His communication is clear and he communicates using complex sentences relating to past and future events including reasoning and abstract concepts

70. Larry is an active member of People First and is president of the Greene Valley chapter.

71. Larry spends his time working downtown putting boxes together. He also enjoys listening to music and doing crossword puzzles. Larry has been denied the right to have his hair cut the way he would like, very short, because staff feel that the scar on his head should be hidden. Larry is also denied the right to own his own television. He is very unhappy at Greene

Valley and complains that his civil rights are violated on a daily basis. Larry would like to learn how to cook so that he could make his own meals and cook for friends.

72. 72. Larry experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because defendants limit their community services to persons who do not have his behavioral disabilities, and because Larry has intense medical needs, he has no alternative to Greene Valley.

73. CHARLES WILHOITE is a 48 year old man who has been institutionalized at Greene Valley for 21 of the past 23 years. He lives in the Newel building.

74. Charles is ambulatory, he communicates quite well verbally and he is a highly capable man. He works doing laundry day after day for $4.00 per day. Charles is denied the transitional services and vocational rehabilitation necessary for him to become a productive member of society.

75. Charles has no contact with his mother or father. He has no opportunity for interaction with non-disabled peers and spends all of his time either at work or on Greene Valley grounds. Charles is taking two psychotropic medications, Mellaril and Pamelor to control his behavior.

76. Charles could live in the community and become a productive member of society with minimal support. Charles experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below. Because of defendants' failure to provide individualized services in the community, he has been unnecessarily confined at Greene Valley.

77. CAROLYN BRITT is a 43 year old woman who has been institutionalized at Greene Valley for 15 years. She lives in the Laurel building, a behavioral unit. Carolyn has been

diagnosed as having moderate mental retardation and schizophrenia. She is currently medicated with Buspar, Paxil, Haldol, and Nortriptyline to control her schizophrenia.

78. Carolyn is ambulatory and verbal and works cleaning classrooms at Greene Valley. She is able to initiate conversation and she bathes, dresses, toilets, grooms and eats independently. She is unhappy at Greene Valley and has expressed her desire to live in a group home in the community. Carolyn is a member of People First.

79. Carolyn is denied the transitional services and vocational rehabilitation necessary for her to become a productive member of society.

80. Carolyn has no contact with her mother or father and lost contact with her brother several years ago. All attempts to locate her brother have not been successful. Carolyn has no opportunity for interaction with non-disabled peers and spends all of her time on Greene Valley grounds.

81. Carolyn experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below.

82. REBECCA WORKMAN is a 22 year old woman who has been institutionalized at Greene Valley for nearly 6 years. She lives in the Laurel building. Rebecca has been diagnosed as having moderate mental retardation, disorder of impulse control and depression. She is currently medicated with Paxil to control her depression.

83. Rebecca is a member of People First. She is ambulatory and verbal and attends the special education program ABC at Doak School in Tusculum. She will be graduating this year and is currently deciding whether or not she will attend the graduation party. Rebecca does not attend any regular education classes.

84. Rebecca is denied appropriate transitional services and vocational rehabilitation necessary for her to become a productive adult member of society.

85. Rebecca has limited contact with her mother or father. She is permitted to call her parents once per month with staff assistance in order to maintain contact. Rebecca has had no home visits during the past year. Rebecca has little opportunity for interaction with non-disabled peers and spends most of her time on Greene Valley grounds.

86. Rebecca's IDT considers Rebecca appropriate for placement in a level one community group home as long as she had access to psychiatric services to meet her needs.

87. Rebecca experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below.

88. JENNY BELLE GREENWOOD (Belle) is a 39 year old woman who has been institutionalized at Greene Valley for nearly 30 years. She lives in the Laurel building. Belle has been diagnosed as having severe mental retardation, degenerative arthritis and schizo-affective disorder.

89. Belle is currently medicated with Buspar and Mellaril to control her behavior. The known side effects of Mellaril are drowsiness, dizziness or blurred vision; stomach upset, loss of appetite, headache, drooling, dry mouth, sleep disturbances, restlessness, increased photosensitivity, chest pains, involuntary movements. Buspar also has the following side effects: stomach upset, headache, change in appetite, vomiting, gas, lightheadedness, fatigue, weakness, vivid dreams, sleeplessness, dry skin, blurred vision, altered sense of taste and smell, weight gain and muscle aches.

90. Belle is a member of People First. She is ambulatory, verbal and independent in

skills of daily living. Belle is denied appropriate transitional services and vocational rehabilitation necessary for her to become a productive member of society.

91. Belle is missing several of her upper front teeth. Her IDT discussed the replacement of these missing teeth but recommended that the teeth go unreplaced. They concluded that Belle's lack of front teeth does not hinder her appearance or ability to eat, talk, etc., and that replacement would not benefit Belle. This is a decision Belle could and should make for herself.

92. Belle's mother does not visit her at Greene Valley nor does Belle visit her mother at home. Belle maintains limited contact with one of her sisters by telephone. Belle has little opportunity for interaction with non-disabled peers and spends most of her time on Greene Valley grounds.

93. Belle experiences, on a daily basis, the harmful and unlawful conditions described in paragraphs 128-249 below.

94. DAVID BALTHROP and TERRY BEATY are former residents of Nat T. Winston who now live together in their own apartment in Crossville, Tennessee in a supportive living arrangement. Terry is a 34 year old male who lived at Nat T. Winston from 1990-1995. Terry is diagnosed as having mild mental retardation and manic depression. David is a 36 year old male who spent approximately one and one half years at Nat T. Winston. David is diagnosed as having moderate mental retardation, schizophrenia and adjustment disorder with disturbance of conduct.

95. While at Nat T. Winston David and Terry both experienced physical and mental abuse by staff members. David reported that staff members often pushed him and also took various personal possessions such as clothing and lighters. Terry was assaulted and almost

strangled by a staff member at Nat T. Winston when he failed to comply with the staff members orders. Terry was also forced to where diapers that did not fit properly because staff refused to order the appropriate size. This was both humiliating and painful for Terry.

96. Terry and David have much more autonomy now than they did at Nat. T. Winston. They make their own decisions regarding what to eat, what to do with their free time, and who their home care providers will be. David and Terry are both happy with their current living arrangement and cringe at the thought of returning to Nat T. Winston or any other similar institution.

97. David and Terry both work five days a week at Hilltoppers, Inc., a community workshop designed for people with disabilities located in Crossville, Tennessee. While they have limited interaction with non-disabled peers, they have the option to pursue such interactions when they are not working at Hilltoppers

98. David and Terry have both experienced in the past the harmful and unlawful conditions described in paragraphs 128-249 below.

Class Action Allegations

99. The class consists of all persons who presently reside or will reside at the Clover Bottom Developmental Center, including the Harold Jordan Center, Greene Valley Developmental Center or Nat T. Winston Developmental Center and all persons who have resided there since December 22, 1992.

100. The members of the class have all been denied rights under federal law as a result of the actions, inactions, policies, and practices of defendants. Plaintiffs seek for themselves and for all members of the class declaratory and injunctive relief to eliminate those actions,

policies and practices and to require defendants to establish standards and procedures that do not arbitrarily deny to plaintiffs and the class their rights guaranteed by federal law.

101. There are substantial questions of law and fact common to the entire class, including the following questions:

(a) Are the conditions at the defendant developmental centers as alleged herein?

(b) Does plaintiffs' segregation at the defendant developmental centers violate, among other rights, plaintiffs' right to: the equal protection of the laws; habilitation in the least separate, most integrated community setting; freedom of association; freedom of expression; the right to participate in public services and programs and activities receiving federal assistance regardless of the severity of plaintiffs' disabilities?

(c) Do the defendants have an obligation under the Constitution and the laws of the United States to provide necessary services to plaintiffs and the class in the least separate, most integrated community setting?

(b) Have defendants subjected residents of the defendant developmental centers to abuse and neglect and unnecessary physical and chemical restraint, and deprived the residents of adequate food, clothing, shelter, medical care, and habilitation?

(c) Have the defendants failed to develop and deliver a professionally designed, consistently and aggressively implemented program of training, treatment, and other services to each developmental center resident to enable him or her to function with the greatest self-determination and independence possible?

102. The claims of the plaintiffs are typical of the class. The named plaintiffs will adequately and fairly represent the interests of the class. Defendants have acted on grounds

generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole. The plaintiffs' attorneys have the resources and experience adequately to represent all members of the class.

Defendants

103. THE CLOVER BOTTOM DEVELOPMENTAL CENTER is a state-operated and state-owned institution for persons with mental retardation located in Nashville, Tennessee. It includes the Harold Jordan Center. It is classified as an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under Title XIX of the Social Security Act, and receives federal funds under that Act.

104. The GREENE VALLEY DEVELOPMENTAL CENTER is a state-operated and state-owned institution for persons with mental retardation located in Greeneville, Tennessee. It is classified as an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under Title XIX of the Social Security Act, and receives federal funds under that Act.

105. The NAT T. WINSTON DEVELOPMENTAL CENTER is a state-operated and state-owned institution for persons with mental retardation located in Bolivar, Tennessee. It is classified as an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under Title XIX of the Social Security Act, and receives federal funds under that Act.

106. Defendant DON SUNDQUIST is the governor of the State of Tennessee. He is responsible for faithfully executing the laws of the State of Tennessee and of the United States of America. He is responsible for appointing the officers of the various departments of the executive branch, including the Departments of Mental Health and Mental Retardation, Health and Human Services, and those officers serve at his pleasure. He is responsible for preparing

the budgets of the various departments and for determining the budget of the Department of Finance and Administration for the Developmental Centers and for mental retardation services in the community. He has the authority to approve and disapprove grants and cooperative programs for the operation of community mental retardation services.

107. On June 23, 1994, Governor Sundquist's predecessor in office, Governor Ned McWherter, was informed by the United States Department of Justice that it was commencing an investigation into conditions at the Clover Bottom Developmental Center pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq. Thereafter, the Department of Justice conducted several comprehensive tours of Clover Bottom, Greene Valley and Nat T. Winston with independent experts who observed conditions in all the residential units at each institution at various times of the day, interviewed administrators, staff and residents, examined records, and analyzed documents pertaining to staffing, injury, abuse, mortality, medications, and institutional policies and procedures. Based on that extensive investigation, the Department of Justice concluded that conditions at Clover Bottom, Greene Valley and Nat T. Winston deprive their residents of their constitutional rights to adequate medical care, reasonable safety, and the training required by professional judgment. The Department of Justice found conditions at the defendant institutions that seriously threaten the residents' health and safety, including:

(a) A pattern of unacceptable injury, abuse and neglect.

(b) Dangerously deficient medical care.

(c) An almost total lack of unit activities or stimulation of any kind.

(d) Failure to provide a free appropriate public education for school-age residents as required by the Individuals with Disabilities Education Act, 20 U.S.C. § 1401 et seq.

(e) The harm of unnecessary institutionalization to residents who should be supported in the community.

108. The Department of Justice notified Governor Sundquist of these findings, and of the remedial measures necessary to eliminate the violations at each institution of residents' rights, in a detailed letters dated January 10, 1995, March 10, 1995, and May 12, 1995.

109. Defendant O. STEVEN ROTH is the Superintendent of the Clover Bottom Developmental Center. He is responsible for the operation, administration, and supervision of all aspects of the Clover Bottom Developmental Center, including the custody, care and treatment of all persons admitted there. He is responsible for insuring compliance by the staff with the rules, regulations and procedures of the facility and of the Department of Finance and Administration and with applicable state and federal law and regulations. He is further responsible for insuring that incidents of alleged abuse of residents are reported to the appropriate local or state authorities. He has oversight responsibility for the process by which residents are discharged to community-based placements, nursing homes, or other placements.

110. Defendant ROBERT ERB is the Superintendent of the Greene Valley Developmental Center. He is responsible for the operation, administration, and supervision of all aspects of the Greene Valley Developmental Center, including the custody, care and treatment of all persons admitted there. He is responsible for insuring compliance by the staff with the rules, regulations and procedures of the facility and of the Department of Finance and Administration and with applicable state and federal law and regulations. He is further responsible for insuring that incidents of alleged abuse of residents are reported to the appropriate local or state authorities. He has oversight responsibility for the process by which residents are discharged to community-

based placements, nursing homes, or other placements.

111. Defendant PETE DAVIDSON is the Superintendent of the Nat T. Winston Developmental Center. He is responsible for the operation, administration, and supervision of all aspects of the Nat T. Winston Developmental Center, including the custody, care and treatment of all persons admitted there. He is responsible for insuring compliance by the staff with the rules, regulations and procedures of the facility and of the Department of Finance and Administration and with applicable state and federal law and regulations. He is further responsible for insuring that incidents of alleged abuse of residents are reported to the appropriate local or state authorities. He has oversight responsibility for the process by which residents are discharged to community-based placements, nursing homes, or other placements.

112. The Tennessee DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (DMHMR) is charged by law with executing the primary functions of the State of Tennessee pertaining to persons with retardation and developmental disabilities. Those duties which are comprised in the Division of Mental Retardation have been transferred to the Department of Finance and Administration by Executive Orders Nos. 9 and 10 of Governor Sundquist. The department executed its functions through the administration, operation, and oversight of the state-operated Developmental Centers, including Clover Bottom, Greene Valley and Nat T. Winston, and by contracting with private agencies to provide residential and other services to persons with developmental disabilities in community-based settings. The department had the duty to insure that all residents of Clover Bottom, Greene Valley and Nat T. Winston receive services in accordance with the provisions and protections of Tennessee and federal law. The department had the statutory authority, with the approval of the Governor, to

make grants to counties and nonprofit corporations for the construction, maintenance and operation of mental retardation facilities, programs and services, or to operate such services directly. It had the duty and authority to make and enforce rules for the efficient and lawful operation of such services. It was responsible to ensure that each client of a mental retardation program licensed and funded by the department has an opportunity for a fair hearing before an impartial decision-maker before that person can be discharged from a program.

113. Defendant BEN DISHMAN is the Acting Commissioner of the Department of Mental Health and Mental Retardation. As the chief executive and administrative officer of the department, he was responsible for the proper and efficient operation of the department, its institutions and programs and for insuring that those programs are operated in compliance with federal law. He was responsible for selecting, with the approval of the Governor, the superintendents of the institutions and other personnel required for the operation of the department. He was responsible for making and adopting rules and regulations for the government, management and supervision of each and all state mental health and mental retardation facilities. He was responsible to regulate the admission and transfer of residents of state facilities, including the Clover Bottom, Greene Valley and Nat T. Winston Developmental Centers, and to provide for the care, maintenance and treatment of the persons who reside in those facilities. He was responsible for making alterations at the facilities as required for the proper treatment and well-being of the residents. He was responsible to ensure that institutional residents were placed in employment and other activities of therapeutic and rehabilitative benefit to the resident, and that residents have appropriate opportunities for physical exercise and recreation. These duties have been shifted by Executive Order Nos. 9 and 10 to the Department

of Finance and Administration.

114. Defendant THOMAS SULLIVAN is the Assistant Commissioner for Mental Retardation of the Department of Mental Health and Mental Retardation which division has been transferred to the Department of Finance and Administration. He is responsible for supervising and administering all mental retardation programs and services in the state of Tennessee that were formerly subject to the jurisdiction of the Department of Mental Health and Mental Retardation prior to the issuance of Executive Order No. 10 on October 19, 1996 and No. 9 on February 7, 1996.

114.The Tennessee DEPARTMENT OF HEALTH (DH) is the single state agency in Tennessee authorized to administer the Medicaid program under Title XIX of the Social Security Act. DH is responsible to review the needs and level of care required by all persons in intermediate care facilities for the mentally retarded (ICFs/MR) in order to insure that appropriate placements are made and to identify persons inappropriately placed in such facilities instead of in the community. DH also is responsible for ensuring that Medicaid-certified facilities in Tennessee, including Clover Bottom, Greene Valley, Nat T. Winston and other ICFs/MR, meet minimum standards for certification for the receipt of Medicaid funds pursuant to Title XIX of the Social Security Act.

115. Defendant FREDIA WADLEY is the Commissioner of the Department of Health. She is the chief executive and administrative officer of the department, and is responsible for ensuring that Clover Bottom, Greene Valley, Nat T. Winston and other ICFs/MR meet the minimum standards for state licensure and certification for the receipt of Medicaid funds pursuant to Title XIX of the Social Security Act.

116. The TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION is responsible for financial planning, budgeting and oversight of expenditures by departments and officers of the State of Tennessee. The Division of Mental Retardation has been reassigned by Executive Order Nos. 9 and 10 to the Department of Finance and Administration. Therefore, all of the functions of the Division of MR are now the resposibility of the Department of Finance and Administration. The Department of Finance and Administration assists the Department of Health in the planning and establishment of Medical Assistance programs in the State of Tennessee and is responsible for all financial matters related to Medical Assistance.

117. Defendant JOHN FERGUSON is the Commissioner of the Department of Finance and Administration. He is the chief executive and administrative officer of the department. He is responsible for preparing the governor's annual budget request to the state legislature, for financial planning of Medical Assistance programs in Tennessee, for review and audit of the expenditure of funds by state agencies, for determining the amount of reserve allotments, and for ensuring that program expenditures are maintained within legislative appropriations. Before other departments and officers of state government are allowed to enter into contracts, the Commissioner must certify that there is a balance in the appropriation from which the contract obligation is to be paid. The Commissioner is authorized to use the general reserve account in the state treasury to offset revenue shortfalls for which other funds are not available. He is responsible, pursuant to Executive Order Nos. 9 and 10 for all operations and responsibilities of the Department of Mental Health and Mental Retardation relative to Greene Valley, Clover Bottom, Nat T. Winston, and their respective offices of community services.

118. Defendant RUSTY SEIBERT is the Assistant Commissioner for Tenncare. He is

responsible, in cooperation with the Division of Mental Retardation, for developing, supervising and administering Medical Assistance programs under which services to persons with developmental disabilities are provided. These programs include the Tennessee Home and Community-Based Waiver program, which enables the state to use Title XIX funds to serve former institutional residents and those at risk of institutionalization in normal home and community settings.

119. 120. The Clover Bottom Development Center, the Greene Valley Developmental Center, the Nat T. Wilson Developmental Center, the Tennessee Department of Mental Health and Mental Retardation, the Tennessee Department of Health, and the Tennessee Department of Finance and Administration are recipients of federal financial assistance .

How Plaintiffs Came To Be At The State Institutions

120. Clover Bottom was established in 1919 by an act of the state legislature as the Tennessee Home and Training School for Feeble-Minded Persons. 1919 Tenn. Pub. Acts 561, ch. 150. In the Act, the legislature actively inculcated fear of retarded people as dangerous. The Act required county health officers and county superintendents of education to "file application for the commitment of feeble-minded persons whose parents or guardians neglect such duty ... whenever such officer shall have reasonable cause to believe that such commitment is necessary to secure the welfare of such feeble-minded persons or of the persons with whom they come in contact." Id. § 5 (emphasis added). The Act applied to "any person with such a degree of mental defectiveness" as to be "a menace to the community." Id. § 2 (emphasis added). State officials supported the legislation and echoed the conviction that persons with retardation were a threat to "normal" people, stating that "there are very many feeble-minded in the State of

Tennessee who have never gotten into one of the State institutions and are more or less a menace and burden to their respective communities." 1 Q. REP. ST. INSTITUTIONS 30-31 (1919) (emphasis added).

121. The Nat T. Winston Developmental Center was established in July, 1979 through the Department of Mental Health and Mental Retardation in order to serve persons with retardation inappropriately served in mental health facilities. There are currently 99 residents at Nat T. Winston, down from 150 at the beginning of this fiscal year.

122. The Greene Valley Developmental Center was established in 1960. There are currently 484 residents at Greene Valley.

123. Class members are or have been institutionalized at state developmental centers because of defendants' failure to serve persons with severe and profound retardation, physical disabilities, challenging behavior and other severe disabilities in community-integrated services and settings. Many class members were admitted to these developmental centers after their families sought services in community-based programs, but were denied because the person had severe and profound retardation or a physical or behavioral disability.

124. Other class members came to the developmental centers after being discharged from a group home. Defendants' contractors, the community providers, routinely discharge group home residents when they begin to present behavioral difficulties. Defendants fail to prevent this practice or to ensure that group home residents are not discharged without adequate procedural due process.

125. Many class members were placed at developmental centers because they are classified, in accordance with defendants' system for ranking people with disabilities by their

level of functioning, at "Level One"--the lowest level. Defendants disproportionately consign persons classified "Level One" to institutions rather than normal, family-scale homes, although persons with the most significant disabilities have the greatest need for the individualized services and close personal attention that is possible only in small settings.

126. Prior to their placement at the defendant institutions, class members are not informed of any feasible alternatives available under the Medicaid Waiver Program and neither are they given the choice of either institutional or home and community-based services.

127. Prejudice and stereotype continue to support the segregation of people with severe disabilities in state institutions, away from the rest of us.

The Harmful Conditions Imposed Upon Residents

128. Clover Bottom, Greene Valley and Nat T. Wilson are "total institutions," where recreational activities, social activities, and medical care are provided in the same facility where residents sleep and eat. The institutions' self-contained character inhibits meaningful community involvement; many residents never leave the facilities or their respective living units at all.

129. At the defendant state institutions, plaintiffs spend their days waiting out the hours. They sprawl in ill-fitting wheelchairs or carts. They are parked in dayrooms or hallways unattended, or are left alone in their rooms. Many plaintiffs languish in hospital beds or cribs, with no stimulation except when they are changed or fed. Others are left in wheelchairs, unattended for hours, with no stimulation or human contact available to them. Interaction between staff and residents is minimal.

130. The physical environment at the developmental centers was designed for mass management and custodial care. Their architecture cannot be adapted to the habilitative needs

of persons with developmental disabilities. Activity space is limited to classrooms that are locked except during the limited "program hours," and to the dayrooms attached to the residents' living units; they are inadequate for habilitation and active treatment.

131. The living and activity space at these institutions is dehumanizing. The facilitys' physical layout encourages passivity and dependence rather than activity and growth. The environments are bare, uncarpeted, devoid of warmth, individuality, or dignity. Living and sleeping areas are sparsely furnished and do not contain age appropriate furnishings associated with normal active living. Plaintiffs are denied the developmental opportunities, the sensory and intellectual stimulation, the comfort and pleasure that community residents obtain from the usual surroundings and conveniences in homes, schools, restaurants, work places and recreational facilities.

132. At best, staff at the developmental centers provide bare custodial care. More often, they fail to provide the attention necessary to safeguard residents from deterioration, atrophy, physical injury and abuse.

Lack of Adequate Basic Care

133. Plaintiffs' basic care needs are ignored; they are left alone for hours. Clover Bottom residents in diapers are often wet, their clothes soaked through with urine. In some units, the smell of urine is pervasive.

135. In many units at Clover Bottom and Greene Valley staff ratios are inadequate to meet residents' basic care needs. Despite the inadequate staffing, the staff who are on duty commonly ignore their clients and leave the residents unattended.

134. Because of staff shortages, staff often "float" to areas of the institution to which they

are not typically assigned and care for a large number of residents whom they do not know. This practice creates an unacceptably high risk of harm.

135. Direct care staff at all three developmental centers lack the skills to provide adequate basic care to class members with complex disabilities and serious health needs.

Lack of Adequate Medical Care

136. Many class members do not receive adequate and timely medical care or dental care. Their health problems often go unrecognized and untreated.

137. Medical staffing at all three defendant developmental centers is grossly inadequate to provide medical care that is consistent with professional standards.

138. Further, medical personnel have inadequate experience and training. They are hired without significant experience caring for persons with developmental disabilities and have virtually no in-service training or continuing education after they begin.

139. The number of adequately trained nurses at Clover Bottom and Greene Valley is insufficient to meet residents' health care needs.

140. Because of the lack of trained and experienced medical staff, residents at all three institutions receive grossly inadequate preventive and ongoing care. Instead, medical care is characterized by "crisis management." The result is that class members suffer unnecessary pain, fractures, injuries, aspiration, pneumonia, decubitus ulcers and swallowing dysfunction which in turn inevitably cause decline in health status and, in many cases, a direct threat to life. These problems could be avoided with adequate medical management plans to treat residents' ongoing health care needs.

141. Seizure management is deficient. Many Clover Bottom residents with seizure

disorders have not been seen by a neurologist for years. Some residents continue to receive anticonvulsant medications long after they have stopped having seizures, while others receive grossly subtherapeutic doses of the anticonvulsant medications they need. The inconsistent recording of seizures by staff seriously compromises the rationale for, and the efficacy of, prescribed medications and treatment.

142. In a representative case, a 44-year old woman died in October, 1993 at Clover Bottom as a result of aspiration during a prolonged seizure. Lab tests repeatedly showed substantially therapeutic levels of anti-seizure medication in her blood although her seizures were increasing. Despite numerous seizures, including one lasting ten minutes and described as uncontrolled, this woman's physician failed to pursue therapeutic levels of anti-seizure medication.

143. Emergency medical care is inadequate. The institutions have no written guidelines prescribing when 911 should be called. Residents who need immediate emergency medical care are transported from their living units to the medical building by non-medical personnel such as security officers when they should be taken by emergency medical technicians directly to the hospital.

144. Quality control, peer review and coordination of medical care are virtually non-existent at all three institutions. Medical recordkeeping and data collection also are inadequate. Individual medical records are in disarray: Important information is missing, progress notes and plans are cursory, documents are misfiled and physician notes are illegible. Data concerning the chronic medical needs of residents is lacking. This absence of organized information is a serious impediment to the ability of staff to meet the critical health care needs of the residents. The

disorganization of medical care means that planning for managing the care of persons with chronic medical conditions is practically impossible.

145. Psychiatric services are seriously deficient at all three developmental centers. The psychiatric consultation currently available to the institution by psychiatrists under contract is completely inadequate to supervise and monitor the care of residents who are receiving psycho-active medications. Failure adequately to monitor the effects of medications is dangerous to residents. It greatly enhances the risk that psycho-active medications may be used as chemical restraints.

146. Staff members often present conflicting data about residents to the psychiatrist which, in turn, may lead to inappropriate prescription of psycho-active medications.

147. No formal process exists for approval of medications that may be used for behavioral control. The institutions' procedures for tracking medication side-effects is similarly deficient. This absence compounds the risk of harmful side-effects and jeopardizes the rights and liberty of class members who are unnecessarily medicated. For example, 119 of the 150 residents of the Nat T. Wilson Developmental Center at the time of the Department of Justice tour in early 1995 were on neuroleptic medications for behavior control and there is no evidence that the staff is attempting to integrate behavioral and psychopharmacological treatments.

148.The significant lapses in the medical services being provided to residents are unacceptable. They compromise plaintiffs' long-range outlook and create an undue risk of physical harm and loss of life.

Frequent Injury and Abuse

151. Safety conditions at all three developmental centers are seriously deficient. The rate

of injury is alarmingly high. Many of the injuries are of unknown cause and were unobserved at the time they occurred.

149. In congregate care settings such as these developmental centers, residents with maladaptive behavior will hurt other residents. This risk is severe at all three institutions in Tennessee, where residents suffer injuries and assaults on a regular basis and are at serious risk of harm in their own living units and throughout the institutions. For instance, at the Greene Valley Developmental Center over 1/3 of the injuries reported in incidence reports resulted from residents' behaviors, including self-injury and aggression.

150. Reasonable professional attempts to prevent injury are not made at any of the three developmental centers. Staff fail to intervene when residents injure themselves or others. Residents push, hit and bite one another, often causing injury serious enough to require stitches or loss of teeth, in plain view of staff yet without staff intervention.

151. Two representative cases involve residents of the Nat T. Wilson Developmental Center. One individual was injured 25 times in an eight month period, receiving 11 lacerations, including one that was six inches in length. The other individual was also injured 25 times in an eight month period. Sixteen of those injuries were self-inflicted and the remainder resulted from fights with other resident. In a another representative case at the Greene Valley Developmental Center an 11 year old boy lost his sight in one eye due to repeated headslapping which resulted in a detached retina.

152. Lack of trained staff, nonimplementation of programs and the almost complete lack of activity or stimulation in the units contribute significantly to the high rate of injury.

153. These institutions do not conduct the analysis needed to prevent re-occurrence of

avoidable injuries. Without adequate reporting of data on causes and patterns of injuries, it is impossible to know how to prevent them.

154. Defendants have failed to protect residents of the institutions from physical abuse and neglect.

155. Verbal abuse is widespread. Staff at Clover Bottom use abrupt, verbal commands to communicate with residents; often, they scream at them.

156. Staff are not encouraged to report abuse or neglect; some staff use intimidation to prevent other staff from reporting such incidents. Out of a sample of ten residents at the Greene Valley Developmental Center, the Department of Justice investigation revealed that 60% of the residents had injuries for which no report could be located.

157. Abuse investigations are cursory, and many potential incidents of abuse are never investigated. Those investigations that are carried out typically conclude with a finding that the allegation is not substantiated, even in cases in which the evidence suggests that abuse did occur.

158. Neglect of residents is common. Residents are left for extended periods of time in soiled clothes or engaging in self-injurious behavior unattended.

159. Numerous environmental health and fire safety deficiencies were found at Nat. T. Winston which greatly increase the risk of injury to class members. The kitchen area was found to be unsanitary and in poor repair, subjecting residents to high risks of food and water contamination. Fire evacuation plans were also found to be in need of revision and formalization.

Denial of Minimally Adequate Habilitation and Training

160. Habilitation is the teaching and training process required by persons with significant

disabilities so that they can reach their fullest potential in physical, social and mental growth.

164. Virtually all persons with significant disabilities have the capability, with proper education and training, to learn some basic self-care skills: to participate in feeding, toileting, mobility and other bodily needs. Nearly all the residents of the state developmental centers could, with reasonable, individualized instruction and adaptations, participate more in their self-help functioning.

161. Active treatment is the formal process of training, treatment and care that must be delivered to each Medicaid-eligible resident of an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Active treatment is a professionally designed, consistently and aggressively implemented program of training, treatment, and other services to enable each ICF/MR resident to function with the greatest self-determination and independence possible. 42 U.S.C. § 1396d(d); 42 C.F.R. § 483.440.

162. Active treatment requires the development and implementation of an individualized program of intervention that is based upon and accountable to a comprehensive assessment of the individual needs of the resident and an individual program plan (IPP). Assigning an ICF/MR resident to a generic activity (one that is generally available at a facility) is not active treatment unless the activity fulfills an individual goal or objective that, in turn, addresses an assessed need of the individual resident. 42 C.F.R. § 483.440(a), (c)(3), (c)(4), (d)(3).

163. No long-term view leading to greater independence, productivity and integration guides the program planning process for residents of the three developmental centers.

164. Individual program plans are meaningless as a guide to habilitation. They frequently ignore the residents' individual needs, even when those needs are obvious and

substantial.

165. Individual program plans at Clover Bottom and Greene Valley fail to specify the interventions needed to support the person toward independence; they fail to provide training in personal and functional skills essential for privacy and independence.

166. Individual program plans at Clover Bottom fail to identify the mechanical supports needed to achieve proper body position, balance or alignment, as well as the reasons for each support and the situation in which each is to be applied.

167. Individual program plans at Clover Bottom fail to include opportunities for individual choice and self-management. Class members are not offered reasonable treatment choices and alternatives. Individual program plans do not reflect the input of the class member or his family.

168. Goals are "canned," not individualized at all three developmental centers. Plans and programs for residents with different levels of ability are virtually identical.

169. Plans and programs are not revised and updated in light of the person's changing needs but remain unchanged from one year to the next.

170. The number of professional staff who work at these developmental centers is inadequate.

171. The professional staff who are employed at the centers do not adequately monitor the delivery of the programs they develop for class members. There is no effective method to ensure quality and consistency of performance among direct care staff.

172. Direct care staff at Clover Bottom have little knowledge of the persons for whom they are assigned to care. Often, they cannot even identify the persons for whom they have

caregiving responsibility and thus are completely unaware of the significant issues in their lives.

173. Direct care staff are not adequately trained to carry out their clients' individual program plans and often do not even know the content of those plans. They do not understand their clients' needs nor the techniques required to teach them functional skills. They do not know how to collect meaningful progress data.

174. Accurate and meaningful data are not kept on any developmental center residents that can show progress, regression or lack of change.

175. All three developmental centers lack the capability to deliver active treatment because the basic components of active treatment--adequate professional staff, functioning interdisciplinary teams, adequate assessments, professionally-designed individual habilitation plans, and direct care staff trained and supervised in the delivery of each resident's plan--do not exist.

176. Staff fail to implement active treatment programs for class members, especially to the those whose disabilities are severe. Class members spend only a fraction of their time in program-related activities.

177. Untrained, unsupervised, unfamiliar with their clients' needs and abilities and unaware of what is expected of them, staff stand idle in a roomful of their clients -- or they socialize with one another and ignore their clients.

178. Residents receive little attention from staff, and rarely interact with anyone other than a paid staff member. Most of their time is "dead time." They spent long periods of time "waiting" to go from one activity to another, self-stimulating, rocking, milling around, dozing, or simply doing nothing.

179. The interdisciplinary teams for each person do not have a sufficient array of services available to make reasonable habilitation decisions for meeting the needs of the individual.

180. Training programs at all three developmental centers depart substantially from professional judgment, standards and practice. They are inappropriate to the learning needs of persons with severe intellectual disabilities.

181. Training programs do not teach functional skills. Residents are denied the opportunity to learn the skills of daily living, such as dressing and tooth-brushing. In the living units, there are no materials that can be used to teach age-appropriate, functional skills.

182. Many residents are capable of going to the store, choosing and purchasing their food, cooking and serving meals and caring for their own living units, but they have no opportunity to do so. Staff cook and clean while the residents remain idle.

183. Residents are not provided with adequate individualized adaptations to enable them to do things for themselves. Adaptive equipment is not generally available to residents who need it in their education and living areas.

184. Communication and cooperation between cottage and school or adult education programs is virtually non-existent.

185. Residents' opportunities to interact with non-disabled persons and to spend time outside the institution are extremely limited. Residents of the institutions receive little or no community-based instruction; that is, they have little or no opportunity to learn skills that will enable them to function in their communities, such as acting and dressing appropriately in public, eating in a restaurant, going to a movie, crossing streets.

186. Few recreational or leisure time activities are available to plaintiffs. They spend

little time outdoors and have little or no opportunity to learn about life in the community.

187. Habilitation does not lead to greater independence, productivity, and social integration. The quality of life of persons at these centers is unacceptable because it offers no opportunity for progress, participation in valued life activities, daily life style choices, privacy, safety, dignity and hope for improvement.

188. Many of the school aged children living at the three developmental centers are denied the opportunity to be educated with children who do not have disabilities. Although their educational needs could be met in regular public schools and classes, many of these children must attend "school" on campus simply because they live in state institutions.

189. The Individualized Education Programs (IEPs) for school-age children are inadequate and do not assure the provision of a free appropriate public education to which these students are entitled. IEP goals and objectives are extremely limited--for example, it is common to find only two skills addressed in a student's IEP over a three-year period. Students do not receive the related services such as physical therapy to which they are entitled as part of their education due to the absence of interaction between therapy staff and educational staff.

190. The consequences of defendants' failure to provide active treatment at institutions, or to implement professional recommendations for placement elsewhere, are devastating to class members. Their basic needs are neglected, their time is wasted, their bodies are constricted, they develop behavior problems. They lose basic skills such as the ability to speak and to walk. They are deprived of the opportunity to live in a decent home and to build relationships with non-disabled people. Their human potential is wasted.

Failure to Provide Adequate Behavior Management

191. Behavior management is an important component of habilitation and active treatment. However, at all three developmental centers, programs to deal with plaintiffs' behavioral problems are seriously deficient. As a result, physical and chemical restraints are utilized as a substitute for appropriate care and programs; residents' behavioral problems are aggravated and escalate.

192. Residents do not have the environmental and physical supports to develop and maintain positive behaviors. Without those supports, behavior management techniques are ineffective and reduced to crisis intervention after harm and injury have already occurred.

193. The developmental centers do not properly conduct the assessments needed to develop effective programs of behavioral support. Few if any functional behavioral analyses, which are the foundation for developing adequate behavior intervention strategies, are conducted.

194. Programs are not individualized for each resident. Programs for different persons are virtually identical. The programs are incomplete, incoherent, and are not implemented. In a representative case, an older male resident of the Greene Valley Development Center who had a history of pica (eating foreign objects) documented in his record back to 1977 had no program to correct this behavior.

195. Documentation of residents' behavior is inaccurate, unreliable, inconsistent and incomplete. Data collected on residents' behavioral and skill training programs are identical from day to day, giving the appearance that data is fabricated or recorded at the end of the day, week or month. The meaningless quality of the data deprives professional staff of the information necessary to make professional, appropriate and safe decisions regarding training.

196. Staff do not have the skills and competence necessary to implement behavioral

interventions to manage inappropriate behavior or to implement individual program plans. Staff intervention to manage inappropriate behavior has no treatment or long term effect.

197. In place of adequate behavioral support, staff practice emergency physical restraint. This is an inherently risky procedure that placed residents as serious risk of injury and death.

198. Staff are unfamiliar with the behavior programs of the residents they supervise.

199. The inability of the staff to deal with continual behavior problems results in more frequent accidents and injuries to class members. For instance, a resident of the Nat T. Wilson Development Center suffered a dislocated elbow after a take-down procedure.

200. The behavior management practices are inadequate to prevent or reduce the incidence of abuse and injury to class members, or to ensure freedom from undue restraint.

Failure to Provide Adequate Physical Therapy and Physical Management

201. Many residents who have contractures or are non-ambulatory require physical therapy and frequent positioning and repositioning in order to prevent skin breakdown and muscle and joint deterioration.

202. Physical therapy services at Clover Bottom and Greene Valley are seriously deficient. Direct care and professional staff are untrained in how to properly position, transfer or move residents. Programs are not effectively implemented. Physical therapy staff is insufficient to meet residents' needs. For instance, there is only one physical therapist on staff at Greene Valley Developmental Center for a population of over 400 residents.

203. Class members are not positioned properly for sitting, eating or other activities requiring proper body alignment or support. The few staff actually engaged in physical therapy activities engage in many dangerous practices such as lifting or moving residents by grabbing

and pulling on their arms or legs, which easily can result in broken bones. Staff fail to take the most basic precautions such as locking wheelchairs before transferring residents in or out of the chair.

204. Developmental Center staff place residents with physical disabilities in inappropriate positions or allow them to remain in devices or postures that inhibit their ability to function and may even exacerbate their deformities.

205. Therapeutic equipment helps to hold a developmentally disabled person's body in alignment, prevent the progression of deformity and allow the person to move as normally as she can. With proper individualized therapeutic equipment, persons with severe developmental disability, severe physical disabilities and deformities and severe and profound retardation can achieve better alignment, better control of their muscles and limbs, and more normal and varied movements. They can learn to sit in more upright positions that facilitate growth and learning.

210. Adequate therapeutic equipment is lacking. Residents with severe physical disabilities and deformities use ill-fitting wheelchairs that do not provide adequate support and therefore cause progression of the person's deformity and increase the risk of accidental injury. The deficiencies are so severe as to represent an active threat to class members' health and safety.

206. Accurate documentation of residents' individual physical therapy status does not exist. This makes it impossible to determine whether any intervention has been effective or ineffective and whether modifications need to be made in residents' services. As a result, many residents are continued for years on the same programs despite lack of progress.

207. The developmental centers do not provide adequate assistive devices to enable

residents to walk and move. Plaintiffs who could walk and move with assistance are unreasonably prevented from doing so and lose the ability to walk altogether.

208. As a result of improper positioning and lack of adequate physical therapy, residents' deformities actually have increased. They have developed scoliosis, windswept deformities, frog-leg deformities and contractures that preclude the ability to sit upright. As a result of improper positioning and lack of adequate physical therapy, Clover Bottom residents who once sat upright in wheelchairs are confined to beds and carts.

209. Lack of proper positioning and therapy has also led to osteoporosis, kidney stones, digestive difficulties, circulatory problems, respiratory problems, and deterioration of normal function, growth, and sensory and cognitive abilities.

Failure to Provide Adequate Nutritional Management

210. Staff at Clover Bottom and Greene Valley are not trained properly to feed persons with severe disabilities. As a result, they fail to properly position residents during meals, utilize appropriate feeding techniques, and effectively monitor residents at meal time. Because of improper feeding techniques, residents face the serious, life-threatening risks of aspiration, choking and reflux.

211. Class members who need individual mealtime programs to instruct staff in how to feed them safely do not have them.

212. Class members who have regressed in their ability to chew and swallow are not provided oral-motor intervention to maintain those abilities. Together with improper feeding techniques, this compounds the risk of weight loss, dehydration, aspiration, and infection.

213. From being rapidly fed pureed food some plaintiffs have altogether lost the ability

to feed themselves or to eat a variety of solid foods.

214. Greene Valley and Clover Bottom staff fail to appropriately identify and treat class members with potentially fatal nutritional dysfunctions such as unhealthy weight loss, eating disorders, dysphagia or reflux.

Failure to Provide Adequate Occupational Therapy

215. Occupational therapy is a component of habilitation and active treatment. Occupational therapists assist people with disabilities to master the functional activities of everyday living and meet the demands of their environment.

216. Because occupational therapy is environmentally and contextually bound, the limitations of the environment at developmental centers limits the ability of occupational therapists to train or teach. Occupational therapists cannot adequately teach community living skills at all three institutions because the environments are completely unlike the community.

Failure to Provide Adequate Language and Communication Services

217. Communication services are an important part of habilitation and active treatment. If people with severe developmental disabilities are not provided with adequate intervention to address their speech and language needs, they will regress.

218. Little speech and language training is conducted at the developmental centers. As a result, residents do not receive the instruction and therapy they need to improve or maintain their ability to understand others and communicate their needs. Augmentative devices to enable residents to communicate are virtually non-existent or are not in use. Staff make no attempt to communicate with residents in sign language, although many residents could benefit from learning signs.

219. Defendants have failed to provide class members with assistive technology, facilitated communication and other methods through which many persons previously labeled severely and profoundly retarded have learned to communicate and express ideas. In this, and in their pervasive denial of habilitation and learning to class members, defendants have diminished and failed to protect the capacity of class members to produce ideas by thinking and learning, and to express those ideas through communication.

Failure to Provide Adequate Vocational Training and Opportunities for Employment

220. People with severe intellectual disabilities and challenging behavior can participate in productive work and work at real jobs in real workplaces.

221. With individualized systematic instruction and practice, the majority of these residents have the capability to learn and maintain vocational skills.

222. The opportunity to use and practice vocational skills in real work settings provides persons with severe disabilities not only with the benefits of earning wages and decreasing their dependence on public support, but also provides the benefits of participating in the community in a valued role--worker--and developing relationships with co-workers, friends and other non-disabled people who are not paid to be with them. Opportunities to work in real job settings allows for modeling and learning appropriate work habits and social behaviors from non-disabled peers--something that is not possible at the state developmental centers.

223. There has never been a systematic attempt to develop true vocational programs for developmental center residents. The programs called "vocational" are not truly vocational because they do not lead to jobs, nor do they teach skills that can prepare people for jobs.

Violation of Class Members' Basic Rights to Personal Choice, Dignity, Privacy, Communication, Access to Personal Property, Freedom of Association and Participation in

Community Activities

224. Residents are deprived of dignity. Staff interact with them either as children or as objects to be managed. Staff are allowed to treat residents with indifference, and to abuse them without consequence.

225. Residents are denied privacy because of the sheer numbers of residents and the lack of adequate staff to assist residents with intimate bodily functions in private.

226. Class members are routinely denied the basic rights of freedom of association and communication, access to personal property, and participation in community activities.

227. Residents are denied the right to marry or to enjoy intimate relationships. The policy and practice at the institutions is to separate residents who wish to engage in sexual activity.

228. The developmental centers fail to monitor the residents' personal property or to protect it from theft.

229. Class members are denied an adequate opportunity to participate in community activities. Some never leave the institution at all. During the entire summer of 1994, for example, 191 Clover Bottom residents did not go off-grounds for community or recreational outings.

230. Class members are denied the right to attend religious services in the faith and congregation of their choice. Most class members do not have the choice of attending services off campus because they are not provided with transportation to do so. In this, class members are denied their right to freely exercise their respective religious beliefs since the services offered at the institutions do not and cannot reflect the variety of class members' religious

preferences.

231. Residents spend nearly all their time in their living units and rarely, if ever, are allowed to recreate out of doors.

232. Residents experience acute social isolation. The living, learning and working environments of the vast majority of residents are completely segregated from the community. They have little or no opportunity to acquire and practice life skills in typical settings, such as home, school or job site. They have little or no opportunity to make nondisabled friends who are not paid staff.

233. Class members are denied the right to make the basic choices about their lives that other citizens take for granted. They have no opportunity to learn to make decisions for themselves.

234. The developmental centers have denied plaintiffs their right to freedom of association and expression by restricting their access to community activities, friendships and visitation. Plaintiffs are denied the opportunity to leave the facility to participate in outside community activities.

235. The size, scale, isolation and segregation of the developmental centers presents almost insurmountable impediments to the exercise of basic rights. Residents are assigned to large groups within the institutions because of the logistical needs of the facilities and cannot choose whom to associate with. The "group" approach to life precludes choice for most residents.

Unnecessary Restraint

236. In the absence of adequate programming to teach positive behavior, residents are

subjected to unnecessary restraint.

237. Medication for control of behavior is used outside of and not in conjunction with the individual program plan in violation of ICF/MR standards.

238. Residents are often physically restrained when the demands of individual residents become inconvenient for staff.

Failure to Provide Adequate Discharge Planning

239. Post-discharge planning and follow-along services are inadequate. Residents are discharged from the institution without adequate effort to assure that they will receive the proper support in an alternative setting. As a result, residents who have been discharged are at risk of harm and of readmission.

240. In the past year, through the Middle Tennessee Office of Community Services, Clover Bottom has discharged 73 residents, often without proper planning and provision of the services needed to meet the person's needs. Of the 73, 62 were discharged to community agencies or homes. Defendants themselves acknowledge that at least 16 of these persons are not doing well in their present placement.

241. Defendants also discharged 11 Clover Bottom residents to general nursing facilities during the last year. Nursing facilities are considered by professionals and federal regulators to be a totally inappropriate setting for persons with developmental disabilities since they do not provide the active treatment or services needed by persons with those disabilities. The staffing ratio in a typical nursing facility falls far short of the staffing needed to provide adequate care to persons with significant developmental disabilities.

242. Five of the eleven persons placed from Clover Bottom into nursing facilities in the

last year have died, some within a few weeks or days of placement. One died of airway obstruction, another of gastro-intestinal bleeding, and another of a bacterial infection.

243. Approximately 60 residents have been discharged over the past year from Nat T. Winston. 99 residents have been discharged from Greene Valley in the past fiscal year and of those five have returned.

Regression

244. As a result of the conditions set forth in paragraphs 128-243 above, residents have regressed at all three developmental centers. Their limbs are twisted and deformed, their bodies are bent and contorted, their bones have decalcified. Class members who could walk without support now need staff assistance, while others are confined in wheelchairs. Residents who could sit up now lie in carts.

245. Class members who were in good health now have serious, even life-threatening health problems, including damaged lungs and difficulties with breathing and digestion. Class members who could eat orally now are tube-fed.

246. From the numbing effect of idleness and the institutions' barren environment, class members have lost cognitive skills, the ability to relate to others and to respond to their environment. Class members have lost the ability to speak and communicate. From being denied the opportunity to engage in the activities of daily living, class members have lost those skills altogether.

The Inevitability of the Harms Experienced by Plaintiffs at the Developmental Centers

247. Custodial facilities like the defendant institutions inherently deny to plaintiffs the experiences, interactions and opportunities for growth and development enjoyed by other

members of society.

248. By segregating persons with significant disabilities from the rest of the community and isolating them at developmental centers with others who are disabled, defendants emphasize their "difference" from the rest of society, stigmatizing them for life.

249. Persons with significant disabilities, like other persons, vary in their needs, wishes and abilities. At different points of life, different activities and environments are appropriate to each person. The environment of the defendant developmental centers is designed for a single purpose--for custodial care and mass management of persons with severe disabilities. Plaintiffs' consignment to this environment deprives them of their individuality, of the possibility of habilitation, and of living freely.

250. In an environment designed for mass management of large numbers of residents, persons with severe disabilities cannot receive the consistent individual attention they need to grow, develop and avoid regression. Persons who cannot communicate in words need attention from others who know them well and understand their method of communication. Far more than those who can speak articulately and whose disabilities are less severe, people with severe disabilities and those who cannot speak need close personal attention which they can receive only in a family-scale setting.

251. Persons with complex needs fare the least well in large congregate settings. The more complex the person's needs, the smaller the setting must be, to enable to staff to focus on and provide consistent attention to the individual.

252. A congregate care facility is not a natural environment. It is an artificial environment in which persons with intellectual disabilities cannot learn real life skills or

functional activities. In such an environment, persons with developmental disabilities cannot receive what their specific learning needs require: the opportunity to learn real-life skills in the environments where those skills are practiced.

253. Congregate care facilities, particularly where there are one hundred or more residents, are dangerous because of a high risk that a resident will lose her own sense of personal identity and the reinforcing and stimulating aspects of direct handling in a stable and family-like atmosphere.

254. The threat of abuse of persons with significant disabilities is increased in an institutional setting to the extent that the institution congregates a large number of people with dependent needs.

255. Persons with challenging behavior need as "models" persons without maladaptive behavior. When persons with challenging behavior are congregated together, as they are at the developmental centers, there is an enhanced risk of learning maladaptive behavior from the example of the behavior of others.

256. The size and scale of the developmental centers is an impediment to the consistent, effective delivery of therapeutic activities and services. In a large setting, many more staff must be trained in consumers' therapy and management programs than would be the case in a smaller setting.

257. The maintenance of employee resolve and standards is much more complicated at a congregate care facility than it is in a small program. It is difficult in a large facility to hold staff accountable to deliver residents' programs. The complexity of the institutional bureaucracy and the lack of staff accountability in a large congregate environment make it difficult to get the

simplest thing done.

258. It is tremendously difficult to recruit qualified professional staff to work at developmental centers. This is due not only to the low pay but to the administrative barriers that staff must overcome to work efficiently in that environment.

259. Because so many persons with complex disabilities are congregated together at the developmental centers, their needs overwhelm the staff. Congregating a large number of persons with complex needs greatly increases the difficulty for staff of finding activities that are interesting, stimulating or meaningful for the residents. Conversely, however, when persons with significant disabilities spend time with persons without disabilities, each nondisabled person serves as a natural teacher, and opportunities for learning are multiplied.

260. The opportunity to share places with people who are not labelled "retarded" cannot be afforded to people with disabilities in institutions; it can only be afforded in communities. The opportunities and benefits of being around other people who do not have disabilities (including the benefits of modeling and learning personal and community living skills), the opportunity to form friendships with people who do not have disabilities, and the opportunity to gain the respect of members of the community are not available in institutions.

261. No matter how large the ratio of staff to clients in a large congregate care setting, such a facility can never achieve the same favorable results as a normal home with support. Increasing the ratio of staff to clients will only lead to a point of diminishing returns, at which one additional staff member will not result in any additional interaction with the people who live there. However, when only one staff person works with a very small number of residents, the quality of staff interaction with residents improves greatly.

The Ineffectiveness of Institutionalization as a Means to Provide Plaintiffs with Habilitation and Training

262. The state institutions embody the "medical" or "deficit" model of services to persons with developmental disabilities. The "medical model" is a paradigm or framework for providing services to people with disabilities that was current when most state institutions were built but is now obsolete. That model was based on the premise that a person with a disability should be placed in a special setting whose purpose is to "treat" his disability or deficit. An aspect of the medical model is the concept of the "continuum of care," that is, a continuum of residential settings from the most restrictive to the least restrictive, from the most heavily staffed to the least heavily staffed. According to the "medical model," a person is expected to move through the various stages of the continuum--from a state institution to a nursing home or large ICF/MR, to a small ICF/MR, to a group home, to a semi-independent living arrangement and finally to a home of one's own--as he "improves" and meets the exit criteria for each setting. According to this concept, people can move from a restrictive congregate setting such as one of the defendant institutions only by demonstrating their "readiness" for the next level of the continuum. In vocational services, the medical model dictates that the person earn his way along a similar "continuum of care": from a day activity center to a work activity center to sheltered work and eventually to a real job only as his skills improve.

263. Research and experience have shown conclusively that the medical model and the continuum of care are unnecessary and highly unsuccessful in preparing persons with developmental disabilities to live and work in more integrated and normal settings.

264. Research and experience have shown that institutions are not needed to serve persons with developmental disabilities, including persons with complex needs such as

challenging behavior or serious medical problems; that everyone can live in the community; and that people with developmental disability are better off in integrated community settings than in large congregate settings based on the "deficit" model.

265. Other states have reduced their admissions to state institutions to zero, demonstrating conclusively that the institutional model and the continuum of care are unnecessary. Other states serve people with disabilities as severe as those of the residents of any state institution in home and community-based settings. Still other states have concluded explicitly that they have no further need for state mental retardation institutions. New Hampshire, Rhode Island and Vermont have closed their state institutions. Other states, including Colorado, Maine, Michigan, New York and Wyoming, have explicit or implicit plans to close all their state institutions within the next five years.

266. No services are provided at state developmental centers that cannot feasibly be made available to class members in the community. To the contrary, critically-needed services such as physical therapy, communication, nutritional management and behavior management are provided inadequately and sporadically at state institutions, or not at all. In the community, the professional services class members need are widely available.

267. In a family-scale residence, it is easy for staff to become familiar with the person's needs, in a way that staff in the institution cannot.

268. Defendants' failure to make residential services available to class members with serious medical needs is irrational since in Tennessee as in other states all over the country, children with complex medical needs--children who are technology dependent, ventilator dependent, or have catheterization tubes--are living at home with their families with support

services funded by Medicaid, maternal health demonstration grants and the Tennessee Model 50 Waiver program. Adults with serious medical needs live in their own homes with support services provided by home health care agencies and other support services. The vast majority of Tennesseeans with serious medical needs do not go to institutions to receive medical, therapeutic or educational services, but receive those services in their own homes and communities.

269. The intent of Congress, in amending the Social Security Act in 1971 to allow the states to use Title XIX funds to pay for services in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), was to support "[t]he active provision of *rehabilitative, educational and training services* to enhance the capacity of mentally retarded individuals to care for themselves or to engage in employment." 117 Cong. Rec. 44720 (December 4, 1971). The unintended consequence of the use of ICF/MR funds by state officials including the defendants is most ICF/MR dollars have flowed to large, custodial institutions where little education and training takes place.

270. Under the federal ICF/MR program, federal funds pay for 66% of the cost of care at the developmental centers. The ICF/MR program in effect gives the states a right to draw against an open-ended federal bank account for their state institutions as long as the state's own surveyors continue to certify those facilities.

271. Tennessee is highly dependent upon the ICF/MR funding stream, not because of the professional judgment that persons with developmental disability are appropriately served in an ICF/MR facility, but because the ICF/MR program provides the most secure and stable and predictable form of federal financial assistance to states for service delivery to persons with

developmental disabilities. Defendants' use of ICF/MR funds to sustain its large, custodial state institutions inhibits and slows the growth and creation of alternative community-based services for persons with significant disabilities.

272. DH surveyors have an inherent conflict of interest when they survey a state facility. The state has a strong fiscal interest in continued Medicaid reimbursement for services at its developmental centers; that interest is jeopardized when surveyors find violations of the conditions of participation.

273. Defendants' ICF/MR survey process is inadequate. DH surveyors fail to ensure that Medicaid-certified facilities in Tennessee, including the developmental centers and other ICFs/MR, meet minimum standards for certification for the receipt of Medicaid funds pursuant to Title XIX of the Social Security Act. Under the Medicaid regulations, failure to meet all eight of the ICF/MR conditions of participation requires that the facility be decertified. However, DH surveyors ignore the myriad violations of the ICF/MR standards at the developmental centers; they routinely certify the facilities even though deficiencies are so massive that a reasonable surveyor could not find the institutions in compliance with the ICF/MR conditions of participation.

The Benefits to Plaintiffs
of Living in Normal, Integrated Community Settings

274. Professional judgment dictates that persons with significant disabilities be served in life patterns that are integrated with and similar to those followed by other persons. The vast majority of developmental disabilities professionals, public agencies and service providers now reject the medical or deficit model and see their purpose as that of supporting people with significant disability in normal, integrated residential and work settings. Professionals now

believe that the task of the service system is not to assign the person to a facility based on a diagnosis, but to support people in homes they choose themselves, where they can live with the people with whom they want to live. This paradigm shift from the "medical model" to the "support model" is reflected in the mission statements and the goals and objectives of all the major national organizations concerned with people with developmental disabilities.

275. Longstanding federal policy toward people with developmental disabilities, articulated and enacted over the course of nearly three decades, is based on the values of independence, productivity and integration of citizens with disabilities. That policy in turn mirrors the professional consensus that the proper place for people with developmental disability is in normal homes, schools and workplaces and not in segregated "facility-based" programs.

281. Defendants themselves recognize that it is good for people to live in the most normal setting possible. They know that persons with significant disabilities benefit enormously from opportunities to practice daily living skills in normal environments, and to exercise choice and judgment.

276. Defendants acknowledge and accept the professional consensus that persons with developmental disabilities should not go to large congregate institutions to receive services. In 1989, with the support of the Assistant Commissioner for Mental Retardation, a Tennessee state law was enacted to prohibit the licensure and operation of any residential facility which houses more than eight persons with developmental disability. If these developmental centers were new facilities, defendants would refuse to license them.

277. Defendants acknowledge that the most important concepts shaping the delivery of developmental disability services during the last decade include "normalization" and "community

integration" as formal objectives of state agencies administering services for persons with disabilities. "Normalization" in, in defendants' words, the principle that "the 'treatment' of persons with mental retardation and related conditions must recognize and reflect that individual's dignity as a person, his/her natural membership in a native society and community, and his/her right to live as closely as possible in the manner of the culture." "Community integration," according to defendants, is a concept "reflecting the value to people with developmental disabilities of sharing in community life" that includes the following key principles:

> "1) physical integration: to be a member of a community one must live in that community; 2) cultural integration: to be a member of a community one must exhibit culturally valued lifestyles and roles; 3) social integration: to be a member of a community one must enjoy reciprocal interpersonal relationships with other community members; 4) self-determination: to be a member of a community one must be able to affirm one's individuality through expressions of personal independence and preference within the limits and according to the standards of the community."

Defendants acknowledge that these principles "have moved over time from ideals promoted by advocates, to predominant professional perspectives, to principles guiding the administration and organization of public programs ... Today they are explicitly or implicitly recognized as important guiding principles by most state mental retardation/developmental disabilities agencies," including the Tennessee Department of Mental Health and Mental Retardation. State of Tennessee, Mental Retardation Services Master Plan, Fiscal Years 1989-1994 (Department of Mental Health and Mental Retardation, 1989) at 1-2.

278. Professionals who work at the developmental centers are in general agreement that all residents could successfully be placed in the community if provided with adequate support.

279. Research, demonstration and practice have shown conclusively that people with developmental disability are better off in integrated community settings than in large congregate settings based on the "deficit" model. Persons with disabilities grow and gain skills and overcome institution-imposed regression when provided with opportunities to learn and practice basic skills in small, well-structured, supervised community settings.

280. In the last twelve years, a body of research has developed showing what happens to the quality of life of people with developmental disabilities when they move from large congregate care settings to community living. The results of this research are remarkably consistent. They demonstrate that people are better off when they leave large congregate care settings for community living in small, family-scale homes.

281. For example, in a five-year study commissioned by the Secretary of the U. S. Department of Health and Human Services comparing the growth and development of persons moved from Pennhurst to family-scale community living arrangements, researchers monitoring residents for five years found that persons with severe disabilities placed in community living arrangements increased in skills and developmental growth while residents of the institution did not. The federal government study concluded that persons who moved from Pennhurst to community placements were "better off in every way." J. W. Conroy and V. J. Bradley, The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis, Temple Univ., Philadelphia, PA (1985). After the initial five-year study was completed, the authors of the Pennhurst Longitudinal Study continued to follow the 1700 members of the Pennhurst class and found significant continued gains in growth and well-being.

282. Similarly, a systematic longitudinal study of the progress of 1,350 class members

in CARC v. Thorne, No. H-78-653(TEC) (D. Conn.) concluded that "the people who have thus far moved from congregate care to community settings are, on the average, much better off in every way we know how to measure." J.W. Conroy et al., 1990 Results of the CARC v. Thorne Longitudinal Study (1991) (emphasis in original).

283. These and other systematic studies of what happens to institutional residents when they move to the community have found:

(a) When former institutional residents are placed in the community, they make highly significant gains in skills and development (adaptive behavior).

(b) Former institutional residents who move to the community make significantly greater gains in adaptive behavior than persons with comparable needs who remain at the institution.

(c) When people who are labelled severely or profoundly retarded move into family-like community settings, they show even greater gains, proportionally, in adaptive behavior than persons labelled mildly and moderately retarded. No support exists for the proposition that some people are "too low functioning" to succeed in the community.

(d) Although the initial gains in adaptive behavior following class members' placement in the community are generally the most dramatic, the gains do not level off but continue. Former institutional residents continue to make significant gains in the community.

(e) Former institutional residents make significant gains in reducing challenging or maladaptive behavior after they are placed in the community.

(f) An inverse relationship exists between the size of a residential setting and the

degree of community integration of its residents.

(g) Former institutional residents generally receive more hours of service in the community than they received at the institution.

(h) Before community placement, the majority of families of former institutional residents are strongly opposed to community placement of their relatives. However, after community placement, this pattern is completely reversed: The majority of family members become strongly supportive of community placement.

284. The experience of properly planned institutional closure in other states demonstrates that virtually all residents of state institutions can live in small, integrated residential settings in the community, and that closure can be accomplished without adverse effects to institutional residents.

285. The issue whether people with developmental disabilities are better off in family-scale, integrated settings than in large congregate settings (settings of more than 15 beds) is no longer an issue for scholars and professionals in the field. There is strong consensus among scholars who have studied the relation between size and quality of care that family-scale residences are better than institutions for people with developmental disability in every way that is measurable.

Defendants' Discriminatory Exclusion of Persons With Severe Disabilities From the Community

286. Defendants refuse to refer class members for community placement because of their severe and multiple disabilities. Professional recommendations for community placement cannot be made or acted upon because of the unavailability of community services for those class members.

287. Tennessee's mental retardation program embodies the obsolete "medical model." It is characterized by a system of "levels" of residential facilities from the largest and most heavily staffed (Level I) to the smallest and least heavily staffed (Level V). Level I facilities are institutions; Level II and Level III facilities are large group homes with a minimum of four persons; levels III.5, IV, and V are typical homes, duplexes or apartments where residents live semi-independently. Persons seeking services are classified by person's level of function and need for supervision and training, and then assigned to a facility of the corresponding "level." This system leads to the assignment of persons with severe disabilities and complex needs to the developmental centers. For the most part, only persons with mild disabilities are supported in typical homes, duplexes or apartments and in homes they choose themselves. This system is a substantial departure from the professional consensus of the field. By continuing to operate this system, defendants discriminate intentionally against persons with severe and profound intellectual disabilities, physical disabilities, challenging behavior, and serious health needs.

288. Defendants have failed to prevent their contractors (the community providers) from discriminating against class members with severe disabilities. Defendants have failed to provide funding on a per diem basis for community services that is equitable in comparison to the funding available to the institutions. The service system operated by defendants is characterized by absence of planning and lack of coordination between the separate agencies that share responsibility for serving persons with developmental disabilities.

289. The Tenncare Bureau and the Division of Mental Retardation have applied for and received a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services as provided under Section 2176 of the Omnibus

Budget Reconciliation Act of 1981. The Section 2176 waiver allows Medicaid funds to be used to support a variety of home and community based services for former ICF/MR residents or those who are at risk of ICF/MR placement. To obtain a waiver, the state must show the Health Care Financing Administration of the United States Department of Health and Human Services that it will use the waiver to close ICF/MR beds or refrain from opening new ones. The waiver provides the same federal match--66 cents for every 34 cents--that defendants receive for services at the developmental centers. Effective use of the Federal Medicaid Waiver Program would enable Tennessee to provide integrated services to persons currently residing at all of the state institutions at no greater expense to the state treasury.

290. Defendants have failed to use the waiver program to provide home and community-based services for residents with the most significant disabilities. Defendants arbitrarily limit the per diem rates paid to community providers under the waiver to $107, while the per diem at the developmental centers is at least $180. If community programs were funded at the same level as the developmental centers, community providers could develop services for virtually everyone. However, the $107 ceiling makes it difficult or impossible to develop community services for at least half the present residents of the developmental center.

291. Defendants' funding mechanisms arbitrarily exclude many developmental center residents with significant physical disabilities from the community. Many class members with physical disabilities could live in their own homes with modest staff support if the proper adaptive equipment and modifications to assure accessibility were made available to them. However, because defendants arbitrarily limit community contractors' start-up funds to $4,000 per person, it is rarely possible to purchase the equipment and the home modifications needed

by those class members and thus they are consigned to the developmental centers indefinitely.

292. Defendants do not plan for services based on the identified needs of individual clients. Plaintiffs are placed at the institutions because institutional beds are available, not because that service meets their individual needs.

293. Defendants have chosen to allocate the majority of their fiscal resources for developmental disabilities services to the institutions. This is a political, not a professional decision. Class members are denied community services, not because of the professional judgment that they should be institutionalized, but because the distribution of resources is skewed toward the institutions.

294. In their actions and inactions recited above, defendants have failed to exercise professional judgment. Defendants' actions and inactions are such a substantial departure from professional judgment, standards and practice as to demonstrate that they actually did not base their decisions on professional judgment.In their actions and inactions recited above, defendants have acquiesced, with deliberate indifference, in a policy and practice of failing adequately to train employees and in other policies, practices, customs and usages that are likely to result and have resulted in the violation of class members' constitutional rights.

295. Comcare, Inc., as guardian for class members with a duty to act in their best interests, has consented to, and thereby aided and perpetuated, the continued harm of class members' placement at developmental centers and the inadequate habilitation they receive there.

296. The actions and inactions of defendants that are recited above have resulted and will continue to result in harm, injury, and regression.

297. Plaintiffs have no adequate remedy at law.

Claims

Count I: Social Security Act

298. Defendants have violated the rights of plaintiffs secured by Title XIX of the Social Security Act, 42 U.S.C. Sections 1396, 1396a, 1396d(d), the regulations promulgated pursuant thereto, 42 C.F.R. Sec. 435.1009; part 483, subpart D; and part 456, subparts E, F and I, and by 42 U.S.C. § 1983, by

(a) Failing to exercise adequate operating direction over the institutions as required by 42 C.F.R. § 483.410(a)(1).

(b) Failing adequately to document plaintiffs' and class members' health care, active treatment, and other information as required by 42 C.F.R. §§ 483.410(c)(1) and 483.440(c)(5)(iv).

(c) Failing to allow and encourage plaintiffs and the class to exercise their rights as citizens, as required by 42 C.F.R. § 483.420(a)(3).

(c) Failing to enable plaintiffs and the class to communicate, associate and meet privately with persons of their choice, and to participate in social, religious and community group activities, as required by 42 C.F.R. § 483.420(a)(9) and (11).

(d) Failing to enable plaintiffs and the class to retain and use appropriate personal possessions and clothing, as required by 42 C.F.R. § 483.420(a)(12).

(e) Failing to promote participation of plaintiffs' and class members' parents and legal guardians in the process of providing active treatment to plaintiffs and class members, as required by 42 C.F.R. § 483.420(c)(1).

(f) Failing to implement procedures that prohibit physical, verbal, sexual and

psychological abuse or punishment, as required by 42 C.F.R. § 483.420(d)(1).

(g) Failing to provide an active treatment program that is integrated, coordinated and monitored by a qualified mental retardation professional, as required by 42 C.F.R. § 483.430(a).

(h) Failing to provide sufficient professional staff and adequate professional program services to implement the active treatment program defined by each plaintiff and class member's individual program plan, as required by 42 C.F.R. § 483.430(b).

(i) Failing to provide appropriately qualified, trained and competent staff in numbers that are sufficient to assist and supervise plaintiffs and the class in carrying out their individual program plans, as required by 42 C.F.R. § 483.430(c),(d) and (e).

(j) Failing to provide plaintiffs and class members with a continuous, aggressively and consistently implemented program of active treatment, consisting of needed interventions and services in sufficient number and frequency to enable plaintiffs to attain as much self determination, independence and optimal functional status as possible, as required by 42 C.F.R. § 483.440(a).

(l) Failing to provide plaintiffs and the class with adequate post-discharge plans, as required by 42 C.F.R. § 483.440(b).

(k) Failing to provide plaintiffs and the class with accurate, comprehensive functional assessments identifying their developmental strengths, their developmental and behavioral needs, and their need for services, without regard to the need for availability of services, as required by 42 C.F.R. § 483.440(c)(3).

(l) Failing to provide plaintiffs and the class with adequate individual program

plans setting forth the specific objectives necessary to meet the client's needs, as required by 42 C.F.R. § 483.440(c)(4).

(m) Failing to ensure that class members' individual program plans identify the mechanical supports needed to achieve proper body position, balance or alignment and specify the reason for each support, the situations in which it is to be applied, and a schedule for its use, as required by 42 C.F.R. § 483.440(c)(6)(iv).

(n) Failing to ensure that class members' individual program plans include opportunities for client choice and self-management, as required by 42 C.F.R. § 483.440(c)(6)(vi).

(o) Failing to ensure that each plaintiff's and class member's individual program plan is implemented by all staff who work with that person, as required by 42 C.F.R. § 483.440(d)(3).

(p) Failing to ensure that each plaintiff's and class member's comprehensive functional assessment is reviewed at least annually by the interdisciplinary team for relevancy and updated as needed, and that person's individual program plan revised as appropriate, as required by 42 C.F.R. § 483.440(f)(2).

(q) Failing to ensure that interventions for managing challenging behavior of plaintiffs and class members are employed with sufficient safeguards and supervision to protect their safety, welfare and civil and human rights, as required by 42 C.F.R. § 483.450(b)(2).

(r) Failing to incorporate the use of systematic interventions to manage inappropriate client behavior into class members' individual program plans, as required by 42 C.F.R. § 483.450(b)(4).

(s) Failing to assure that drugs for control of inappropriate behavior are approved by the interdisciplinary team and used only as an integral part of an individual program plan that is directed specifically toward the reduction of and eventual elimination of the behaviors for which the drugs are employed, as required by 42 C.F.R. § 483.450(e)(2).

(t) Failing to provide medical services necessary to maintain an optimum level of health for each individual and prevent disability, as required by 42 C.F.R. § 483.460(a).

(u) Failing to assure that health services are integrated into the class member's individual program plan, as required by 42 C.F.R. § 483.460(b).

(v) Failing to assure class members an adequate living environment, as required by 42 C.F.R. §483.470.

(w) Failing to assure adequate food, nutrition, and meal services, as required by 42 C.F.R. § 483.480.

(x) Failing to maintain the compliance of the developmental centers with the conditions of participation for intermediate care facilities for persons with mental retardation.

(y) Failing to determine whether services available at the developmental centers and other Title XIX facilities in which plaintiffs and class members reside are adequate to meet their health, rehabilitative and social needs and to promote their maximum physical, mental and psychosocial functioning, as required by 42 C.F.R. § 456.609(a).

(z) Failing to determine whether it is necessary and desirable for plaintiffs and class members to remain at the developmental centers and other Title XIX facilities, as required by 42 C.F.R. § 456.609(b).

(cc) Failing to review the appropriateness of plaintiffs' and class members'

continued placement at the developmental centers and other Title XIX facilities in which they reside and failing to determine the feasibility of meeting their needs through alternative noninstitutional services, as required by 42 C.F.R. § 456.609(c).

(aa) Failing to ensure adequate utilization review and discharge planning.

(ab) Failing properly to evaluate each plaintiff's need for admission prior to placement.

Count II: Rehabilitation Act

299. Defendants have violated the rights of plaintiffs secured by Sections 100 and 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §§ 720 and 794, and regulations promulgated pursuant thereto, 45 C.F.R. parts 84 and 1361, by:

(a) Denying plaintiffs and class members the benefits of federally assisted services and programs.

(b) Failing to provide plaintiffs and the class federally assisted services that are as effective and meaningful as those delivered to other citizens and that are delivered in less separate, more integrated settings.

(c) Denying plaintiffs and the class the benefits of federally assisted training, habilitation and other programs on the basis of the severity of their intellectual or other disabilities.

(d) Segregating residents of the developmental centers on the basis of their physical, behavioral or medical disabilities.

(e) Providing federally assisted services to persons with severe intellectual disabilities and for people with physical or behavioral disabilities only in segregated settings.

(f) Aiding and perpetuating discrimination against developmental center residents in federally-funded programs.

Count III: Due Process Clause

300. Defendants have violated the rights of plaintiffs secured by the Due Process Clause of the United States Constitution, and by 42 U.S.C. § 1983, by:

(a) Subjecting plaintiffs and the class to harm and injury, including abuse, injuries from accidents and neglect, regression, physical deterioration, deprivation of social relationships, and the harms arising from segregation and confinement.

(b) Failing to provide adequate shelter, clothing, food and health care.

(c) Imposing unnecessary restraints, physical and chemical.

(d) Failing to provide minimally adequate habilitation and training.

(e) Failing to give consideration to the habilitative placement and other needs and rights of each individual class member, treating him or her in accordance with his or her own situation.

(f) Conclusively presuming that class members cannot benefit from particular services or cannot live in non-institutional settings.

(g) Denying class members an adequate opportunity to be heard on the appropriateness of their habilitative plans, programs and environment.

(h) Failing to provide a friend-advocate to assist each class member to exercise his or her rights enumerated above.

(i) Failing, in the actions and inactions set forth above, to exercise true professional judgment.

Count IV: First Amendment

301. Defendants have violated the rights of plaintiffs and the class to the freedoms of expression and association secured by the First Amendment, by:

(a) Preventing class members from associating and assembling with others of their choice.

(b) Preventing class members from meeting and speaking privately with friends, advocates and others of their choice.

(c) Preventing class members from communicating with others of their choice.

(d) Diminishing and failing to protect the capacity of class members to produce ideas by thinking and learning, and to express those ideas through communication.

(e) Preventing and interfering with class members in the free exercise of religion.

Count V: Equal Protection Clause

302. Defendants have violated the rights of plaintiffs and the class secured by the Equal Protection Clause of the Fourteenth Amendment by establishing, encouraging and otherwise sanctioning in de jure fashion enactments, programs, policies and practices that have excluded, separated and segregated persons labelled retarded from the rest of society without any rational basis.

Count VI: Americans With Disabilities Act

303. Defendants have violated the rights of plaintiffs secured by Title II of the Americans With Disabilities Act of 1990, 42 U.S.C. §§ 12161-12165 and regulations promulgated pursuant thereto, at 28 C.F.R. Part 35.

(a) Denying plaintiffs and class members the opportunity to participate in, and the

benefits of, public services and programs that are as effective and meaningful as those delivered to other citizens and that are delivered in less separate, more integrated settings.

(b) Failing to make reasonable modification in policies, practices and procedures to enable class members to participate in integrated public services and programs.

(c) Imposing eligibility criteria that unnecessarily exclude certain classes of individuals with disabilities and that prevent class members from fully and equally enjoying public services, programs and activities.

(d) Failing to administer public services, programs and activities for class members in the most integrated setting appropriate to their needs.

(e) Failing to furnish appropriate auxiliary aids and services to enable class members an equal opportunity to participate in, and enjoy the benefits of, public services, programs and activities.

(f) Failing to remove architectural and communication barriers to enable class members to participate in public services, programs and activities.

(g) Aiding and perpetuating discrimination against developmental center residents in public services.

Relief

WHEREFORE, plaintiffs respectfully request that this Court:

304. Declare that defendants' actions and inactions, as described herein, violate plaintiffs' rights under Title XIX of the Social Security Act and implementing federal regulations, the Rehabilitation Act of 1973 and implementing federal regulations; the Due Process Clause of the Fourteenth Amendment to the United States Constitution; the Equal Protection Clause of the

Fourteenth Amendment to the United States Constitution; and the First Amendment to the United States Constitution.

305. After hearing, preliminarily and permanently enjoin the defendants:

(a) To arrange for the independent evaluation, by qualified professionals not employed by the State of Tennessee, of the individual habilitation and treatment needs of each class member, to determine whether adequate treatment consistent with constitutional standards is being provided to the class member, and to determine whether the class member has been injured as a result of constitutionally inadequate treatment at the developmnetal centers in the past;

(b) to develop community living arrangements for all members of the plaintiff class for whom such living arrangements are called for by the independent evaluation set forth in ¶ (a) above, together with the community services necessary to provide class members with minimally adequate habilitation, as defined in the independent evaluation and thereafter by an individual person-centered planning process that is consistent with contemporary standards of practice, until such time as the class member no longer is in need of community services.

(c) to provide services to class members in a manner which promotes their independence, enhances their dignity, and is as consistent as possible with societal norms.

(d) to provide each plaintiff and member of the plaintiff class effective developmental services in the most integrated setting appropriate to their needs;

(e) to make available with dispatch the necessary alternative residential facilities, home services and vocational and day services in the community, including:

(i) an effective, independent, conflict-free system of case

management and service coordination for class members;

(ii) identification of the support and services needed by class members by a process of person-centered planning;

(iii) service plans based on need rather than availability of services reflecting the value of supporting the person with relationships, productive work, participation in community life, and personal decision-making;

(iv) a system of personal advocacy and self-advocacy to assist class members in asserting their rights;

(v) an effective, systematic resource development capability, including but not limited to a program to ensure the availability of appropriate community residential services; appropriate medical, dental, psychiatric, therapeutic, and behavioral support services; appropriate community-integrated employment services and other day activities in community-integrated settings;

(vi) an effective quality assurance system in the community capable of detecting and remedying problems in class members' programs in systemic and coordinated fashion;

(vii) effective, mutually supportive management information systems in which systems of reporting, oversight and communication of information are organized and operational;

(viii) effective performance contracting systems.

(f) to provide class members and their families with an opportunity to be heard by a neutral decision-maker on the substance of their program and placement;

(g) to cease admitting persons to developmental centers or from transferring present residents from the developmental centers unless such transfer is to the most integrated community setting appropriate to their needs, and appropriate developmental services are provided; to establish a system to prevent abuse and neglect of developmental center residents, to thoroughly and promptly investigate allegations of abuse and neglect and to establish appropriate consequences for abuse and neglect of residents by staff;

(h) to hire sufficient numbers of professional and direct care staff at the developmental centers, including sufficient numbers of qualified physicians, physical therapists, occupational therapists, speech and language pathologists, psychologists, and aides;

(i) to provide adequate medical care to residents;

(j) to develop and deliver a professionally designed, consistently and aggressively implemented program of training, treatment, and other services to each resident to enable him or her function with the greatest self-determination and independence possible;

(k) to provide professionally designed therapeutic support services, including adaptive equipment, positioning, mealtime programs, behavioral programs, and other assistance necessary to protect each class member from harm and regression;

(l) to develop and provide adequate training programs for professional and direct care staff at the developmental centers, and assure that all staff are able to demonstrate the skills and competencies to provide active treatment to the class members they serve;

(m) to provide a safe environment for each class member at the developmental centers;

(n) to allow class members to participate in community activities, and to allow

reasonable access to the developmental centers and reasonable opportunities to communicate with class members at the developmental centers, to People First of Tennessee, other advocates, and members of religious and community organizations;

(o) to make available a friend-advocate to each plaintiff and member of the plaintiff class to assist each in securing the substantive and procedural protections aforesaid;

(p) to submit to plaintiffs and to the Court for its approval a plan for implementation of the aforesaid;

306. Award plaintiffs their costs and attorneys' fees;

307. Grant such other relief as is appropriate.

Submitted for entry,

Jack W. Derryberry, Jr. #3870
Ward, Derryberry & Thompson
1720 Parkway Towers
404 James Robertson Parkway
Nashville, TN 37219
(615) 244-0554

Edward G. Connette
Lesesne & Connette
1001 Elizabeth Avenue
Suite 1D
Charlotte, NC 28204
(704) 372-5700

Earle Schwarz
WARING COX
1300 Morgan Keegan Tower
50 N. Front St.
Memphis, TN 38103-1190
(901) 543-8000

Judith A. Gran
Jessica R. Lowenthal
PUBLIC INTEREST LAW CENTER
OF PHILADELPHIA
125 South 9th Street, Suite 700
Philadelphia, PA 19107
(215) 627-7100

Attorneys for Plaintiffs