The Parties

Disability Rights Center of Arkansas, Inc. (DRC) is the federally authorized and funded non-profit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for individuals with disabilities in Arkansas. DRC is authorized to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

[DRC client information redated]

Arkansas Department of Human Services (DHS) is composed of fifteen (15) divisions and offices, including the Division of Behavioral Health Services (DBHS), which operates the Arkansas State Hospital (ASH). David Laffoon is the Director of DBHS. Charles Smith is the CEO of ASH, with Steven Domon, M.D., serving as Medical Director, Joe Alford, Ph.D., Director of Clinical Services, James Scoggins, Director of Nursing Services, and Karen Finch, Director of Risk Management.

Background:

In September 2007, ASH opened a unit for treatment of adolescents with co-occurring mental illness and developmental disabilities on Unit 3 Lower of the hospital. When ASH dedicated its newly constructed hospital building in 2008, the adolescents on Unit 3 Lower continued to be housed in the old location and were not moved to newly constructed hospital units. (Forensic adults also remained in the older forensic services treatment building.) As of the writing of this complaint, there are eleven (11) adolescent males housed on Unit 3 Lower.

DRC has long been concerned about the care and treatment provided to these adolescents, as well as the physical environment of their treatment unit. Some of those concerns were relayed to Steven Domon, M.D. by Dee Blakley, Advocate/Investigator and me in a meeting with Domon on September 9, 2010.

During a routine monitoring visit of Unit 3 Lower on March 11, 2011, Dee Blakley noted a boy sitting on the floor in an empty bedroom pod area of the unit. Blakley asked why the child was there by himself and was told by unit staff that he was "on ITP," a reference to an Intensive Treatment Protocol, whereby an adolescent has been determined to be too disruptive to remain in the milieu, and by physician order, is separated from it in twenty-four (24) hour periods of time. The child was [client information redacted].

Since the child's peers were attending school elsewhere on the unit, Blakley asked why he did not have classroom assignments, work sheets, puzzles, or something to keep him productively occupied. Staff responded that he did. It was apparent that there were no materials with the child, who was wrapped up in a winter coat, with another jacket lying on the floor beside him. Blakley decided to take her concern higher up the chain of command. Later that day, Blakley sent an email to the nurse in charge of ASH's adolescent units, asking for clarification of what she witnessed.

By March 15, there had been no response to Blakley's email. She forwarded the original email to ASH administrators, along with written notification that she would arrive at the hospital on the morning of March 16 to begin an investigation, and asked for contact information for the child's parents/guardians, unless he was in the custody of the State. Contact information was provided, and Blakley contacted the parents to explain her concerns, as well as obtain their signatures on relevant authorizations. The parents had additional concerns about their son, not the least of which was that in the four (4) months he had been at ASH, he had never been allowed to leave on a pass to return home and visit with his family.

Blakley began the investigation with a review of treatment and education records for the client. Her request for review also included video footage of the days he was on ITP, and it was during review of video that Blakley discovered that the child in question was already the subject of an internal ASH abuse investigation, resulting from video and audio coverage of the unit that revealed some of the worst verbal and psychological abuse of a child by unit staff that Blakley had ever witnessed.

ASH's Risk Management Unit (RMU), headed by Director Karen Finch, explained that three (3) staff had already been sent home on administrative leave, pending the outcome of the investigation, but for DRC, that was insufficient. An additional six (6) staff had witnessed the abuse and done nothing to protect the child, or report the abuse. Blakley asked for a meeting with Charles Smith, CEO, and was accompanied to the meeting by RMU Director Finch, as well as [Name redacted], Director of Social Work for ASH Adolescent Services. When they arrived, Steven Domon, M.D. was also present in the room.

Blakley outlined individual and systemic concerns about the unit to ASH administrators and gave them forty-eight (48) hours to come up with an alternative staffing plan that did not include any of the staff present on the unit during the time [client information redacted] was subjected to verbal and psychological abuse, stating that these staff had failed to comply with ASH's own policy on reporting allegations of abuse and keeping patients safe. In addition, she requested that human monitors from other areas of the hospital be placed on the unit to observe staff/patient interactions, and that twenty-four (24) hour retrospective review of video footage of the unit be conducted for a period of at least thirty (30) days. Further, she requested copies of all video footage in which [client information redacted] appeared for the duration of the time he was on ITP, from approximately February 23, 2011 through March 4, 2011 and again from March 10 through March 11, 2011. ASH voluntarily suspended the practice of ITP on Unit 3 Lower indefinitely.

As DVDs were provided to DRC, Blakley began to identify chronic and long-standing systemic failures in the operation of Unit 3 Lower.

Issues:

Active marketing of admission to Unit 3 Lower as a means to qualify children with

intellectual disabilities for eligibility for the Division of Developmental Disabilities Services (DDS) ACS Medicaid waiver:

[Name redacted], the psychiatrist in charge of the operation of Unit 3 Lower, did a presentation about the unit for an annual training held May 6/7, 2010, *Children and the Courts*, directed to juvenile court judges, state agency staff, and attorneys practicing in that area. I attended the presentation and heard [name redacted] "advertise" the unit as a place that children with developmental disabilities and behavior problems could be sent in order to get them on the DDS ACS Medicaid waiver in nine (9) months.

In addition, the parents of both of DRC's adolescent clients reported that they were encouraged to admit their sons to the unit in order to qualify them for DDS waiver services, as there is a priority in Arkansas' extensive waiver waiting list for waiver service delivery for individuals who are currently institutionalized. For non-institutionalized individuals, the waiting list is about ten (10) years long.

DRC views this as the state sponsored service delivery equivalent of the retail gimmick, "bait and switch." Not only are the adolescent males on Unit 3 Lower no closer to DDS waiver services now than they were prior to their admission to ASH, they are inappropriately placed there. If they could just as easily be served by the DDS waiver in the community, then the cramped and chaotic environment of ASH's Unit 3 Lower is not the most integrated setting appropriate to their needs, as defined by Title II of the Americans with Disabilities Act. The true beneficiary of the admission of these young men to the hospital unit is the State of Arkansas, which gets to bill Medicaid daily for their extended hospitalization, plus whatever funds are available under IDEA.

A "one-size-fits-all" unit program manual that is punitive in nature:

The *Unit 3 Lower Program Manual* is an inordinately complex document, not understood by unit staff, and is frequently misinterpreted by staff to the patients, as witnessed during review of recorded video and audio footage of unit activities. The Program Manual describes Unit 3 Lower as "a 16 bed, structured rehabilitation program which utilizes the Community Integration Model to treat individuals in the recovery phase of their illness." In addition, the program incorporates concepts and terms relevant to the operation of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), and references documents such as individualized rehabilitation plans (IRPs) and individualized program plans (IPPs), which do not exist in the treatment file of DRC's clients.

Not that DRC would expect to see IRPs or IPPs in a hospital patient's chart, for ASH is not an ICF/MR. The beds on Unit 3 Lower are licensed as all other hospital beds with the Arkansas Department of Health, and are subject to federal regulations governing the *Conditions of Participation for Hospitals* found at 42 CFR, Part 482, and 42 CFR §482.60, *Special provisions applying to psychiatric hospitals*.

In addition, the Program Manual states, "Patients will receive three hours daily (Monday through Friday) instruction in the classroom..." This statement completely fails to take

into consideration how much classroom instruction may be required by each patient's Individualized Education Program (IEP) pursuant to regulations implementing the Individuals with Disabilities Education Act (IDEA). However, this failure is only the tip of the iceberg with respect to violations of IDEA, which are more fully discussed below.

Failure to provide appropriate mental health treatment, as well as failure to provide effective programming for children with intellectual disabilities:

As much as we would like to, we cannot separate these two issue areas.

The most critical flaw in the operation of Unit 3 Lower is the failure of clinical staff to develop individualized programming tailored to the cognitive and intellectual abilities of the children in their care. Independent Living Skills (ILS) training topics cover such things as counting money, socially acceptable manners in sit-down restaurants, and completing job applications, when many of the unit's patients need ILS training in such areas as brushing their teeth, bathing properly and combing their hair.

In a meeting characterized to her as "Family Therapy" on April 20, 2011, one mother asked why her son frequently appeared dirty when she came to see him. She had been assured at his December 2010 admission that ASH would teach him how to handle his own personal hygiene, and she had seen no progress to date. She felt she had been misled.

[Name redacted] told the mother that the reason there had not been a focus for the four (4) months of her son's admission at ASH on the independent living skills was that ASH's funding means that they have to focus on behavior, and behavioral health, in order to get paid.

In other words, her son needs to look mentally ill, even if his primary diagnosis is developmental disability. Otherwise, anyone reviewing his case will say he is not acutely ill enough for ASH to get paid.

Likewise, clinical staff make quantum leaps to characterize behaviors commonly seen in individuals with developmental disabilities as aberrant, and therefore a "target symptom" of a psychiatric illness. These include such behaviors as inability to toilet properly, rushing to greet family members without being given permission to hug and/or kiss (inappropriate boundaries), and concrete thinking (non-compliance). Staff rarely appreciate that any positive reinforcers for desired behavior need to be given promptly if the desired behavior is to be truly reinforced.

DRC's observations of unit include abrupt transitions from one activity to the next, frequently causing upset among the patients, who do not make abrupt transitions well. Program staff on Unit 3 Lower do not understand that the failure of the patients to make abrupt transitions is common among people with developmental disabilities. DRC has frequently heard staff (both in-person and while watching video) tell the patients, "Well, you should have heard me the first time."

If, for the sake of debate, all of the behavior issues displayed by the patients on Unit 3 Lower were truly symptoms of psychiatric illness, it's hard to see how and when they would be given skills to deal with those symptoms. During a three month period in the winter of 2010/2011, therapy groups designed to teach such skills were cancelled primarily due to absences of the therapists who were supposed to conduct the groups.

Through review of the clinical chart of one patient, DRC found the following group therapies cancelled:

12/21/10 Stress Management cancelled due to group leader being on annual leave until 1/4/11
12/22/10 Human Growth and Development - emergency on another unit
12/22/10 Anger Management - cancelled due to delay in med time
12/22/10 Healthy Relationships cancelled due to holidays
12/23/10 - Self Help group - cancelled due to holidays
12/23/10 Character Development - alternate Xmas activity held
1/10/11 Anger Management
1/17/11 Anger Management cancelled due to federal holiday
1/27/11 Anger Management cancelled due to group leader's absence
1/31/11 Self Help cancelled due to alternate activities
2/3/11 Stress Management cancelled due to group leader's absence
2/4/11 Anger Management cancelled due to group leader's absence
2/7/11 Anger Management cancelled due to group leader's absence
2/9/11 Anger Management cancelled due to group leader's absence
2/16/11 Anger Management cancelled due to group leader's absence
2/21/11 Anger Management cancelled due to federal holiday
2/22/11 Stress Management
3/3/11 Self Help cancelled due to alternate activities
3 /4/11 Social Skills cancelled due to therapist conflicting engagement
3/7/11 Anger Management cancelled due to group leader's absence
3/11/11 Social Skills/Problem Solving cancelled due to therapist conflicting engagement
3/14/11 Stress Management cancelled - group leader at state training
3/18/11 Social Skills cancelled - group leader on vacation

Even when groups occur, observation of those groups provides further evidence that ASH staff just don't "get it." Excerpted from a four page narrative given by Dee Blakley to on-site CMS surveyors on April 11, 2011:

> 3/10/11 16:00 through 17:00 Camera in front of nurses' station where several patients are supposed to be watching an educational DVD on dolphins. Two patients seated beside the TV instead of in front of it, and multiple staff who cross through the middle of the group on their way to somewhere else, as well as delivery of snacks during viewing time. Group leader has discussion with patients afterward, asking them what they "took" from the video. Apparent that group leader is clueless about how these patients think in concrete terms, and

when she does not get the answers she wants, resorts to the "Prompt 1, Prompt 2, Prompt 3" rapid fire protocol from her Unit Program Manual (provided to CMS on this disk), followed by "Separation Timeout for 2 minutes," and then the patient begins to object, extends the timeout to 15 minutes. Another child says what he saw, and gets cut off at the pass by the group leader who snaps, "I didn't ask you what you saw, I asked you what you took from it."

4/5/11 – [Name redacted] came into a pod area where a mathematics class had been in progress to try "something new" with five male patients there. She seemed unable to engage all the patients to "check in with our feelings," and wound up with two boys in the room after completely losing control of the group and going to the door of the pod, saying, "I need help in here!" Watching this session twice, I have been unable to determine what [name redacted]'s objective was. I have asked for that to be answered. (CMS has been provided with a DVD on which this therapy session can be viewed. [Name redacted]'s arrival in the pod occurs approximately 32 minutes into viewing.)

Generally speaking, when DRC begins an investigation of allegations of abuse/neglect/rights violations of an individual with a disability in a program or facility, the response of the program or facility being investigated is to immediately begin taking steps to protect the individual with the disability. However, in the cases of the two DRC clients discussed in this Complaint, evidence appears to indicate that the boys are actually being targeted by ASH staff. Specifically, each boy's clinical records are beginning to reflect that subsequent to DRC's involvement, he is violent and/or aggressive.

Ironically, neither of the boys is aware of the nature of DRC's interest in them. However, ASH is.

Failure to provide appropriate education consistent with requirements of IDEA:

DRC has yet to review educational records for any patient on Unit 3 Lower (the two DRC clients, and additionally, four (4) adolescent males in the custody of the Department of Human Services, Division of Children and Family Services) that comply with the procedural or substantive requirements of IDEA. ASH fails to develop appropriate IEPs for its students. Nor are there appropriate behavior programs developed within those IEPs for these children who, according to [name redacted], must all have behavioral issues in order for ASH to get paid for treating them. (*See* previous discussion at page 4, in the section entitled, Failure to provide appropriate mental health treatment, as well as failure to provide effective programming for children with intellectual disabilities.)

In addition, the Unit 3 Lower classroom is staffed by two teachers, [Teacher 1] (a provisionally certified special education teacher) and [Teacher 2] (a certified special education teacher). Rarely have the teachers been observed teaching the core academic subjects listed in student's IEPs, although [Teacher 1] teaches and interacts more frequently with the students than does [Teacher 2]. School frequently begins late and ends early, and is continuously disrupted by the arrival and departure of unit staff through

an exit door in the classroom, although there are alternate exit doors from the unit that would be more appropriate for staff to use.

During one of the times [Teacher 2] did begin to teach academics, he was interrupted by the Milieu Coordinator, [name redacted]. [Name redacted]'s interruptions on April 13, 2011 were so intrusive that [Teacher 2] temporarily stopped teaching until [name redacted] was finished.

After DRC requested a copy of the missing pages of [client information redacted]'s IEP, DRC was provided with a copy of a *Behavior Management Program* attached to his IEP (with more pages added to it since its creation on March 28, 2011) dated April 7, 2011, and authored by [named redacted]. The program states, in part:

> [client information redacted] will earn 30 minutes of basketball (weather permitting, with staff) twice a day if he has not hit staff or peers during time since the previous reward interval. These reward times will be flexible but should occur prior to lunch (1100-1230) and prior to dinner (1600-1700). He will have a calendar in his possession, and he will be given a sticker for time that he earns the basketball reward. This calendar will serve as a visual reminder of his goal and his progress... Every day that [client information redacted] earns his reward activity at before (sic) lunch/dinner, the designated staff member working with him will allow him to choose a sticker from the sticker book maintained in the nursing conference room. Additionally, a notebook for documenting each occurrence of the reward activity will be maintained in the nursing conference room.

DRC has concerns about the *Program* in several areas, all of them practical, and given no apparent consideration by [name redacted].

First, [client information redacted] is supposed to attend school between 0830 and 1130 each week day. Second, after inquiring about whether educational or unit staff were supposed to implement the program, the response we received was that the staff implementing the program were nursing and clinical staff.

Nursing and clinical staff are not present in the classroom. Is [client information redacted] not eligible to earn his morning reward without them present? If he earns it, how will nursing and clinical staff know? If they are advised, will [client information redacted] be removed from the classroom to select his sticker, and if so, will the classroom activity be stopped while he is gone, or will they carry on without him? Does earning a morning reward mean [client information redacted] loses one half hour of education? All of these questions show the complexity and complete inappropriateness of his behavior plan.

Based on the allegations made above, review of documents and video DRC, alleges the following allegations under IDEA.

- ASH fails to provide clients with a Free Appropriate Public Education (FAPE).

- ASH fails to develop and maintain documents in compliance with IDEA.
- ASH fails to use any positive behavior intervention supports (PBIS).
- ASH fails to develop appropriate behavior plans that meet the unique needs of their patients.
- ASH fails to provide any occupational, speech or physical therapy evaluations and/or services.

In addition DRC alleges that ASH fails to provide enough hours of instructional time to meet the minimum amount of 6 hours required by Arkansas state law to equal a school day. *See* ACA § 6-16-102. DRC has witnessed that often ASH does not meet the 3 hour instructional requirement to even equal a half a school day.

DRC has monitored and investigated in juvenile detention facilities, human development centers, treatment facilities, etc., and has never seen a population of kids who were receiving "treatment" entitled to less education than the rest of the population, and cannot fathom why ASH believes it is exempt from the law.

Failure to train staff on appropriate staff/patient interactions:

DRC observed many inappropriate staff/patient interactions, both in person and through review of video footage of the unit activities during the course of the DRC investigation. Examples include:
2/22/11 9:42 (a.m.) – Female staff going over the unit "rules" with the patients and telling them that they have three chances to follow directions before there are consequences, "that's the unit behavior program." (As stated previously, there are no appropriate behavior programs designed to meet the individualized needs of the patients.)

But that's not even the "unit behavior program," as stated by the staff member – refer to *Unit 3 Lower Program Manual*, which states in relevant part:

> Staff may also withhold a "medal" for any time slot where five or more prompts/redirecting efforts by staff were needed for successful completion of activity.

Same date, a few minutes later, the staff and the patients found out that the morning groups were not going to be held. Some of the patients asked questions about the change and were told, "When we make changes to something, you just go along with it…it ain't your business why…"

2/23/11 18:20 – [client information redacted] was placed in open door seclusion for interfering with the delivery of a food cart to the unit. The interference consisted of [client information redacted] placing his right hand on the edge of the cart and walking alongside it to the door of the pod to which he was confined while on ITP. At 18:32, a male staff decided to engage [client information redacted] in a spelling quiz, asking him to spell, among other words, "very bad kid," and "in seclusion."

20:12 – [client information redacted] was placed in an open door seclusion room. Staff wanted to make sure he knew he was not to come out for fifteen (15) minutes, or the door would be closed. As this was explained to him, the staff can be heard slapping the door with an object to the beat of each word spoken, saying, "If (slap) you (slap) come (slap) out (slap) you (slap) are (slap) going (slap) to (slap) be (slap) closed (slap) up (slap)."

Later, at 21:23, as the patients are getting ready for bed, a female staff voice in the background intoned the unit rules. This included an admonition to an unseen patient, "You're not paying my salary."

During a treatment team meeting for one of DRC's clients on March 25, 2011, DRC Advocate/Investigator Dee Blakley asked for an outline of the training ASH proposed to use with current and future unit staff to ensure that staff had the skills necessary to interact effectively with the patients. ASH Director of Clinical Services Joe Alford, Ph.D., said the outline would be ready in about one (1) week.

DRC has requested the outline on numerous occasions since March 25, and to date, has not received it.

Failure to provide appropriate medical treatment:

[Client information redacted.]

Failure to protect patients from abuse/neglect:

As stated previously, on the first day of DRC's investigation, Advocate/Investigator Dee Blakley insisted that all staff present during the time DRC's client had been subjected to verbal and psychological abuse be removed from the unit and placed on administrative leave, because even the staff who had not engaged in the abuse had failed to report it, as required by ASH's own policy.

On March 23, 2011 (one week after DRC began its investigation), Blakley received a phone call from Karen Finch, Director of Risk Management, asking about Blakley's thoughts on returning some of the nine (9) staff to work on the unit who had been placed on administrative leave pending the conclusion of ASH's investigation, as long as they were not staff who had actively participated in the abusive acts, and were monitored as they worked.

After their telephone discussion, Blakley sent an email to Finch to make a record of the discussion.

> You left a voice mail message for me earlier today, asking that I call you with my thoughts about returning a few of the nine (9) staff from Unit 3 Lower to work, as long as monitors were present on the unit when they worked. You explained that some of the individuals in question may not actively have participated in the

verbal and psychological abuse of DRC's client as considered by ASH administrative staff.

As we discussed, these are my thoughts.

Subsequent to the 2005 multiple count abuse investigation conducted by DRC at ASH, ASH became a "zero tolerance" hospital - or reaffirmed its intent to become a zero tolerance hospital.

To DRC, that means exactly what it says - that abuse (and neglect and rights violations) will not be tolerated. Period.

Which necessarily means that when staff who are not committing such acts witness them, they prevent continued harm from coming to a patient, and they report them.

As we discussed in our late afternoon meeting one short week ago, at which you, [Name redacted], Steve Domon, Charles Smith and I were present, there was not a single staff member on that unit on February 23 from either the 7p to 7a shift, or the 7a to 7p shift who stepped up the plate, rescued DRC's client, and reported what happened.

Not one.

For any of the hospital administration to hope that DRC believes that one week on administrative leave has cured that problem is simply incredible.

In addition, I received the first three days (from Feb 22 through 10p on Feb 25) of video today. I have not begun to watch it, as I was moving out of my office to accommodate other displaced DRC staff today. In addition, Dana McClain will not return to the office to begin viewing video until Monday, March 28.

So I have no idea exactly what either of us will see and hear. It would not surprise me, given our respective vast differences in views of previous camera footage of allegations of abuse, that she and/or I may disagree with ASH administrative staff about culpability of actors.

For all of the reasons above, we would consider the return of any of the nine (9) ASH staff currently on administrative leave to be precipitous and very unwise. I realize that this is creating a staffing issue for the hospital, but unfortunately, if the unit had been operating in a manner that evidenced zero tolerance for abuse, DRC's client would not have been harmed and none of us would be in this very grave situation.

I hope this fully answers your question. If not, I am just a phone call away.

Inappropriate denial of patient contact with family as a means to compel compliance with treatment:

One of the front line means of compelling compliance with treatment programs at ASH is restricting and denying youth contact with their families. [client information redacted] was threatened with that routinely during a period of time that encompassed February 23, 2011 through March 25, 2011.

It was on March 25 that a DRC requested treatment team meeting was held to address [client information redacted]'s parents' concerns that their son had not been allowed to have a several hours' pass to go home with his parents since his admission to ASH on November 16, 2010. DRC Advocate/Investigator Dee Blakley attended the meeting with the [client information redacted]'s parents and pointed out to the treatment team that if they thought keeping [client information redacted] from his family was having any positive effect on his compliance with treatment, the hospital's own records on the matter showed the opposite to be true. She also told the team that DRC considered such interference with patient and family relationships to be a violation of patient rights.

After Blakley left the meeting, video footage showed that Joe Alford, Ph.D. voiced his concerns that the practice was a violation of human rights. Both DRC clients have begun to be able to have passes to see their parents, but their charts are consistently marked that the passes are "AMA," i.e., against medical advice.

Video monitoring of patient units:

ASH patient units all have video monitoring to help ensure safety of the patients. On Unit 3 Lower, as well as the adult forensic units, video monitoring is enhanced with audio.

However, ASH only retains video for a period of twenty-six (26) days before the recording "loops over" previously recorded footage. In addition, ASH does not have the technical capability to watch video at the same time it is being saved on removable media such as a DVD.

This is a critical flaw in a system supposedly designed to protect patients from abuse and neglect, particularly in the environment of Unit 3 Lower, where serious verbal and psychological abuse of a child went undetected and unreported, in violation of ASH's own policy.

[Redacted]

Enforcement Action to Date:

On March 29, 2011, DRC filed a complaint with the Centers for Medicare and Medicaid Services (CMS), which was investigated by on-site CMS surveyors from April 11, 2011 through April 13, 2011. On the afternoon of April 12, 2011, DRC Advocate/Investigator Dee Blakley received a telephone call from one of the on-site CMS surveyors, advising

her that at approximately 2:30 p.m. on that date, CMS had issued a finding of Immediate Jeopardy against ASH. The surveyor also stated that CMS had substantiated each of DRC's allegations. As of the writing of this complaint, the Immediate Jeopardy has not been lifted.

On April 15, 2011, DRC filed a complaint against ASH's hospital license with the Arkansas Department of Health, and was advised on April 19, 2011, that the complaint had been accepted for investigation.

On April 21, 2011, DRC supplemented its March 29, 2011 complaint to CMS with additional information.

On April 26, 2011, DRC contacted the Medicaid fraud unit, housed in the Department of Human Services, Division of Medical Services, to file a complaint alleging Medicaid fraud.

Remedies Sought:

DRC requests the Department of Justice investigate the allegations contained in this complaint, and upon substantiation of the allegations, seek the appropriate legal remedy to close Unit 3 Lower, and provide for delivery of services to the patients on the unit in the community.

Respectfully submitted,

Dana K McClain
Senior Staff Attorney
Disability Rights Center of Arkansas, Inc.

Date: 4-26-11