May 20, 2003

The Honorable Ronnie Musgrove
Governor of Mississippi
The New Capital Building
400 High Street
Jackson, MS 39205

Re: CRIPA Investigation of the Reginald P. White Nursing Facility

Dear Governor Musgrove:

On March 21, 2002, we notified you of our intent to investigate the conditions of care at Reginald P. White Nursing Facility (RWNF) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. Consistent with statutory requirements, we write to report the findings of our investigation and to recommend remedial measures that are consistent with federal statutory and constitutional requirements.

We also would like to express our appreciation for the cooperation and assistance provided to us by RWNF administrators and staff. Such assistance allowed us to complete our on-site inspection in a timely manner and has since proven helpful in narrowing the issues that require our further attention. We hope to continue to work cooperatively with State officials and RWNF staff in addressing issues identified during our investigation.

In terms of the legal and factual background surrounding our investigation, residents of county-operated nursing home facilities, such as RWNF, have a right to reasonably safe living conditions, adequate health care, restorative and rehabilitative care services, freedom from unreasonable restraints, and a treatment setting that is the most integrated and appropriate based on individual resident needs. Youngberg v. Romeo, 457 U.S. 307 (1982); Olmstead v. L.C., 527 U.S. 581 (1999); Americans with Disabilities Act, 42 U.S.C. § 12132 et seq. (ADA); 28 C.F.R.

§ 35.130(d) (ADA integration regulations); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. § 794 (Section 504). Federal statutes governing the operation of nursing homes and their implementing regulations create similar rights. See, e.g.; Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1395i-3; 42 C.F.R. § 483 Subpart B.

In evaluating RWNF's compliance with federal requirements, we conducted our investigation with the assistance of a fire safety expert and expert consultants in the fields of geriatric psychiatry, medicine, and nursing. Our consultants reviewed policies, procedures, medical records and other documents; interviewed administrators, staff, and residents; and conducted an on-site inspection of the RWNF facility. At an exit interview conducted on the last day of our on-site inspection in August 2002, we conveyed our preliminary findings to RWNF administrators and attorneys.

RWNF houses approximately 226 residents and has a 228-bed capacity. RWNF participates in the Medicaid program and provides nursing home services for elderly residents with significant medical problems. According to facility data, approximately 23 percent of the residents depend on staff for assistance during meals, 33 percent depend on staff for assistance with dressing, 44 percent depend on staff for assistance with bathing, 34 percent use wheelchairs most or all of the time, and 56 percent are diagnosed with psychiatric illnesses not including dementia or depression.

Care at RWNF is positive in several respects. During our inspection, direct care staff generally appeared respectful to the residents, making appropriate eye contact and showing some responsiveness to resident requests for personal care. Nursing staff have access to a wound care center to assist in treatment of resident bedsores. Professional staffing included treatment by psychiatrists, not just general physicians. Facility housing and kitchen areas appeared sanitary. Residents received clean linens and clothing. Housing units generally met fire safety requirements.

At the same time, however, we conclude that certain conditions at RWNF violate the constitutional and statutory rights of residents at the facility. We find a number of serious deficiencies in nursing care, medical care, mental health care, discharge planning, and staff oversight. Our findings, the facts supporting them, and the minimum remedial steps that are necessary to address these deficiencies are set forth below.

I. FINDINGS

A. NURSING AND PHYSICIAN MEDICAL CARE

1. Assessment and Treatment Planning

RWNF has significant problems with its resident assessment and treatment planning process. Assessment and treatment planning serve as foundations for resident care, and weaknesses in relevant RWNF policies and practices are resulting in significant health problems for its residents. Problems with assessment and treatment at RWNF include deficiencies with the facility's written policies and medical assessment practices, and inadequate physician participation in the treatment process.

First, RWNH policies and procedures do not include adequate protocols for addressing loss of function, pressure sores, pain, contracture management, and other medical complications. The facility's assessment and treatment planning procedures are inadequate in terms of addressing individualization of resident care, prevention of declines in function, and restoration of abilities. RWNF's wound care policy does not address treatment for necrosis and infection; nor does the policy provide adequate guidance on nutritional interventions and use of pressure-relieving devices. RWNF does not have a written policy at all regarding resident pain management.

Second, assessments are not completed and incorporated into individual resident treatment plans as needed. Problems with inadequate assessments are especially pronounced with respect to residents suffering from acute changes in their physical or mental status. When a resident's condition changes significantly, generally accepted professional standards require staff to re-assess the resident to identify the reasons for the resident's changing condition. The failure to conduct such assessments can contribute to the development of significant health problems including pressure sores, loss of mobility,

falls, incontinence, and loss of self-care skills. Several cases illustrate this deficiency and the harm that results from this failure of care.

For instance, RWNF staff often do not assess the status of pressure sores, document whether sores are responding to treatment, or account for pain when treating pressure sores. In one case, a resident's skin condition deteriorated over the course of several months, yet staff repeatedly failed to assess the resident's declining condition to determine why this decline was happening. Earlier in this resident's stay, staff prepared a treatment plan that indicated that the resident might be at risk for pressure sores. The resident eventually developed three "stage III" pressure sores and a "stage IV" sore.[1] One of the sores was covered with necrotic (dead) tissue. To make matters worse, after staff finally realized that the resident had developed pressure sores, they treated the sores without doing a pain assessment. Staff would clean the resident's open wounds without giving the resident any pain relievers. Our consultant observed one such treatment session where the resident was grimacing and moaning in obvious pain. Staff did not seem to recognize the resident's distress.

Similarly, RWNF staff do not regularly assess residents after they fall or injure themselves. Falls, accidents, and resulting injuries are often due to problems with treatment. It is important for staff to assess residents to determine why they are repeatedly falling or injuring themselves and then take appropriate, individualized corrective action. Yet, such assessments are not taking place regularly at RWNF, and when they do take place, the resulting interventions are frequently generic or even inappropriate. For instance, we learned of a resident who had a history of falls, and yet, staff did not develop a plan to address issues of immobility and incontinence that might have been factors contributing to his repeated injuries. In another case, a resident complained of dizziness, but staff failed to evaluate thoroughly the reasons for her dizziness or take other appropriate steps to minimize her risk of injury.

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[1] Stage III pressure sores typically appear as a crater in the skin and flesh. Stage IV pressure sores are the worst class of sores and typically include extensive tissue destruction, necrosis, and damage to muscle, bone, and supporting structures.

Facility staff also do not conduct adequate assessments of many residents who need restorative care. Such residents have problems with contractures, toileting, and physical function. Proper assessments would identify what skills the residents retain, what activities they would enjoy, as well as what steps could be taken to prevent further declines in function. When assessments are not conducted and treatment is not provided, such residents become predisposed to contractures, loss of food intake, and urinary tract infections.

A final example of serious problems with RWNF's assessment and treatment process involves a troubling resident death. RWNF recently admitted a resident who had a history of elopements and was assessed as having cognitive impairments. RWNF failed, however, to address adequately this resident's supervision needs as part of the resident's overall program of care. Just a few months after admission in early 2003, the resident wandered away from RWNF. About 60 miles away from the facility, he was struck by a car and died.

Third, physicians are not involved sufficiently in treatment planning. Physicians only attend approximately 10-20 percent of treatment team meetings, and their lack of involvement is noticeable in the resident charts. Physicians do not regularly conduct history and physical exams when residents return from a hospital admission. When they do conduct histories and physicals, the assessments are often inadequate, with only superficial information about a resident's medical problems, functional status, and physician analysis. Physician progress notes similarly lack adequate information and analysis. Attending physicians also lack adequate experience or knowledge of federal nursing home regulations, non-pharmacological approaches to care, and generally accepted professional standards.

In total, these systemic problems hamper RWNF's ability to treat and prevent serious medical problems commonly found in a geriatric population.

2. Mechanical restraint

At least half the RWNF residents observed by our consultants use bed "siderails," "gerichairs," "lap buddies," and other types of restraint. While not as restrictive as some restraint techniques, these types of mechanical restraints can result in

harm to residents. It is therefore important that staff follow proper procedures and generally accepted professional standards before using such restraints.

Since any restraint use is problematic when caring for an often physically fragile population, restraints should only be used after completing careful, structured evaluation of the potential risks associated with restraint use. Instead, at RWNF, many staff seemed only minimally aware of the hazards associated with restraints, and they use restraints without performing a careful analysis necessary to ensure resident safety. For example, staff told our consultants that they use "siderails" to prevent resident falls. Geriatric residents, especially disoriented ones, may injure themselves when they try to climb over "siderails," such as when they go to the bathroom at night. Since "siderails" can increase the risk of resident injury, generally accepted professional standards and federal law require that their use be clearly justified and monitored. That is not the case at RWNF. Almost a quarter of the charts reviewed by our nursing consultant included examples of "siderail" restraints being used for residents without adequate evaluation of the need for such restraints.

Similarly, we found residents who were restrained to their chairs with "lap buddies," a device designed to wrap around a resident and discourage him from getting up. Ostensibly, these restraints were also used to prevent falls, but this restraint technique can increase the risk of resident injury. "Lap buddies" and similar restraints may result in physical immobilization and loss of strength, both risk factors for resident falls. More generally, restraint use is often associated with the development of medical problems such as contractures, weight loss, and pressure sores. Failing to assess adequately the medical consequences of restraint use puts residents at risk of serious harm.

RWNF staff also fail to assess thoroughly alternatives to mechanical restraints. For instance, sleeping mats and nighttime continence plans can reduce falls and nighttime injuries. Before using "siderails," RWNF staff should consider such alternatives. Alternative seating, pain relief, restorative care, and meaningful structured activities are other alternatives to mechanical restraints. RWNF staff do not routinely use such alternatives.

3. Mealtime assistance and nutrition

When nursing home residents experience significant weight changes, this can often be an indicator of significant health problems. Generally accepted professional standards require that staff address such weight changes before they become a serious health threat.

Our expert consultant closely evaluated extensive medical records for nursing home residents with significant weight gain or loss at RWNF. In every case, RWNF staff failed to document an action plan to address significant weight changes.

Given the lack of such planning, it is not surprising that in practice, RWNF staff often fail to address factors that may be related to the residents' weight problems, such as decreased cognition or loss of physical function. For instance, during mealtimes, staff regularly fail to provide residents with assistive devices and proper seating. Our consultant also observed staff restrain some residents during meals, hampering the residents' ability to feed themselves. Over time, such deficient mealtime practices may cause residents to lose even more independent living skills.

4. Restorative care and therapeutic activities

Restorative care and therapeutic activities play a role in helping residents improve functioning or in preventing further declines in functioning. RWNF does not provide adequate restorative care and therapeutic activities necessary to improve or maintain resident function.

Nearly a third of the charts examined by our expert consultant did not include appropriate restorative care plans to address loss of resident function. These sampled residents often retained some self-care skills, but staff did not involve them adequately in self-care. Without more attention to restorative care issues, these residents may continue to lose their ability to bathe, exercise, and use a toilet.

Likewise, many RWNF residents are regularly excluded from meaningful participation in therapeutic activities. For instance, group programs offered by RWNF often cannot accommodate residents with disabilities such as hearing loss, vision impairment, or aphasia (non-verbal residents). Even residents

with limited cognitive functioning may benefit from individualized psychosocial treatment and activity planning. At RWNF, however, the limited activities that exist are designed principally for higher functioning residents. Residents with significant loss of function are brought to the common room when such activities take place, but these residents cannot participate in many of the generic activities. Such deficiencies can lead to the unfortunate isolation of RWNF residents. For instance, we found one blind resident who apparently spends much of her time in her room, since she cannot participate in activities. We also found residents with memory loss problems sitting at the periphery of a group session. Even though present, they could not meaningfully participate in the session, since the activity staff were communicating in a manner that did not account for these residents' limited powers of recall and attention.

The lack of adequate facility policies exacerbates problems with restorative care and therapeutic treatment. RWNF does not have clear operating procedures regarding restorative care. In general, restorative care is not provided in a systemic way. RWNF staff do not consistently conduct timely evaluations, follow-up on the efficacy of care programs, and individualize activity planning. Social workers generally do not participate in therapeutic planning, even though they may have critical knowledge regarding each resident's psychosocial needs.

RWNF's physical layout also complicates matters. The current layout does not include much space for activities and treatment.

Finally, we note that some of the equipment provided is in poor condition. For instance, many wheelchairs are missing footrests, and a number of them are filthy.

B. MENTAL HEALTH CARE

RWNF is located on the campus of a mental health hospital. Facility administrators report that many RWNF residents have significant mental health disorders in addition to their other geriatric medical problems.[2] The nursing home fails to provide

[2] Contrary to generally accepted practices regarding documentation of resident mental health needs, RWNF's mental

the mentally ill residents with appropriate mental health care treatment. More particularly, RWNF's system for providing mental health care results in inappropriate use of multiple medications (polypharmacy), excessive reliance on psychotropic medications (chemical restraints), inadequate monitoring of medication side effects, and deficiencies with mental health assessments and treatment planning.

1. Polypharmacy

Federal regulations require that a nursing home resident be free from unnecessary anti-psychotic medication. See, 42 C.F.R. § 483.25(l)(1). Unnecessary medication is defined as any medication that is excessive in dose or duration; used without adequate monitoring or indication for use; used in the presence of adverse consequences, indicating that the medication should be reduced or discontinued; or used without specific target symptoms. 42 C.F.R. § 483.25 (l)(1)(i-iv). The use of polypharmacy (the practice of using multiple anti-psychotic drugs to treat a single ailment) may be appropriate in some limited circumstances, but must always be justified.

Chart reviews and physician interviews revealed a significant number of cases in which medical staff improperly prescribed multiple anti-psychotic medications to RWNF residents. In these cases, neither the psychiatrist nor the prescribing physician could justify the use of multiple anti-psychotic medications.

The following examples highlight the facility's unjustified use of polypharmacy:

- A resident was prescribed two atypical neuroleptics, a treatment strategy that is problematic by generally accepted professional treatment standards. When the resident's physician (who actually prescribed the medications) and psychiatrist were asked about these prescriptions, neither of the physicians could recall the clinical rationale for

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health assessment and data collection systems made it difficult to verify independently the number of RWNF residents with mental health needs. Facility data indicates that 56 percent of the residents are diagnosed with psychiatric illness -- not including dementia or depression -- but that likely is under-inclusive.

these prescriptions.

- A resident was prescribed a combination of psychiatric medications, including lithium. The resident's records showed that the lithium was at sub-therapeutic levels. Neither of the doctors responsible for this resident's care could explain the rationale for keeping the resident on multiple psychiatric medications including the sub-therapeutic level of lithium.

- A resident was prescribed a combination of oral haloperidol, haloperidol decanoate, and an atypical anti-psychotic, olanzapine. During an interview with the prescribing physician, who was not a psychiatrist, we found that the doctor was unable to explain the rationale for combining these medications. No written documentation in the resident's chart existed to support the doctor's decision to prescribe these three psychotropic medications.

Additional chart reviews and staff interviews revealed that many residents are prescribed multiple anti-psychotic medications within the same class of drugs. In other words, RWNF staff use multiple drugs that individually should be adequate to achieve similar clinical results. The charts reviewed and the staff interviews provided insufficient medical justification for these practices.

2. Monitoring of drug side effects

Federal regulations require that nursing home staff monitor the side effects that residents experience while taking psychotropic medications. 42 C.F.R. 483.25 (l)(v). Monitoring side effects of psychotropic medications is crucial because these powerful medications can cause physically debilitating conditions.

At RWNF, we found that staff failed to document medication-induced side effects. For example, we reviewed the chart of a resident who was prescribed unusually high dosages of benztropine, olanzapine and haloperidol decanoate. Our expert consultant examined this resident and found that the resident was severely rigid in the limbs. Staff should have been regularly monitoring this resident and identifying the development of such obvious medication-induced side effects. Instead, this resident's chart contained no documentation of his rigidity. Staff on the unit told us that they had not been monitoring the

resident for side effects and had just assumed that his physical limitations were age related. Staff's failure to document conspicuous symptoms highlights the deficiencies in the nursing home's monitoring practices and the level of physical harm to which a resident at RWNF may be exposed.

RWNF's failure to monitor medication side effects is illustrated by another example. Psychotropic medications increase an individual's sensitivity to the sun and heat. When geriatric residents are on such medications, staff need to carefully monitor and evaluate their condition for adverse reactions to excessive heat exposure. Temperatures during our August tour exceeded 85 degrees in the shade. Yet, during our inspection, our expert consultant observed several residents on psychotropic medications sitting outdoors in direct sunlight for over a half hour with no supervision. Water was not made available to these residents while they sat outside. When staff were asked about this situation, they said they do not monitor residents who sit outdoors. This is a potentially dangerous practice given the fact that many residents receiving psychotropic medications suffer from dementia or other cognitive impairments. They are often unable to care for themselves and leaving the residents unattended in sweltering heat unnecessarily exposes them to potential dehydration or phototoxicicity.

3. Chemical Restraints

Federal regulations require that appropriate non-psycho-pharmacological interventions be provided to a nursing home resident before psychotropic medications are prescribed. The regulations also require that residents receive gradual dose reductions of psychopharmacological medications in an effort to ensure the least restrictive conditions. 42 C.F.R. §483.25(l)(2)(ii). RWNF's failure to meet these standards results in the inappropriate use of medications and is impermissible chemical restraint.

Staff informed us that RWNF residents identified as requiring psychiatric services typically see a psychiatrist only once a year. RWNF does not have clearly defined procedures allowing an exception to this practice when necessary. Such limited access to psychiatrists significantly hampers prevention of resident mental health crises and ignores the facility's obligation to systematically evaluate and decrease psychotropic medication use if possible. Erratic psychiatrist staffing may

contribute to this problem. The psychiatrists at RWNF split their time between the facility and the state mental health hospital on the same campus. They are reportedly required to spend about 30 percent of their clinical hours at the nursing home, but because of weaknesses in professional oversight, it is unclear if this requirement is met. As one psychiatrist advised us, "it would be nice" to conduct more frequent reviews "but we don't have time." By not providing such services, however, the facility is not in a position to reduce medication use to less restrictive levels.

Additionally, physicians may be prescribing medications for the convenience of staff rather than based on the exercise of appropriate professional judgment. A treating physician told us that he prescribed two different atypical neuroleptic medications for one RWNF resident because the resident "bothered staff." Reliance on psychotropic medications for the convenience of staff and as a substitute for other interventions represents a significant departure from generally accepted professional standards.

4. Psychiatric Assessment and Treatment

As mentioned previously, RWNF has significant problems with its assessment and treatment planning process. Such problems affect not just medical care. They also have adverse consequences for residents with mental illness.

First, just as general physicians do not participate with sufficient frequency in treatment planing meetings, psychiatrists are also frequently absent. Instead of providing an adequate interdisciplinary process, RWNF treatment teams consist generally of only support staff and nurses, who gather together and only briefly discuss the treatment goals for each resident. We found that resident care meetings consisted of caring, well intentioned staff, however, they failed to produce the type of interdisciplinary review that is required in caring for geriatric residents with complex mental illnesses.

Substantively, treatment approaches considered by treatment teams do not include adequate behavioral and therapeutic activities planning for RWNF residents with mental illness. For instance, RWNF does not provide adequate psychological care for residents with depression. Counseling therapy for depression is not available, so the nursing home tends to rely on medications

as a substitute for therapeutic intervention. Similarly, some of the problems with polypharmacy and chemical restraint use suggest over-reliance on medications rather than less intrusive behavioral or therapeutic interventions when dealing with some behaviorally challenged residents.

Poor clinical documentation contributes to problems with resident mental health and medical treatment. Generally accepted professional standards for mental health practice require that a doctor provide documentation in each resident's chart to justify his or her prescribing practice. Appropriate documentation includes the following information:

- the resident's present symptomatology and functioning;
- mental status exam;
- assessment, formulation, and plan; and
- notes to document whether the resident is experiencing side effects from current medications.

At RWNF, progress notes and records were often missing information necessary to evaluate resident mental status, conduct adequate assessments, and develop treatment plans. As discussed previously, the result is that psychiatrists and physicians are prescribing psychotropic medications without adequate justification. Improved progress notes would help explain a physician's choice of medication for a resident and indicate the symptoms the medication is intended to treat. Nurses and support staff could use the data to assess the resident's progress and monitor the resident's side effects. The progress note is also a valuable tool for physicians because it enables a physician to evaluate whether a resident's current medication regimen is appropriate.

C. SERVING PERSONS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR INDIVIDUAL NEEDS

Under federal law, a nursing home must ensure that its residents are treated in the most integrated setting appropriate to their individual needs. RWNF staff prepare discharge plans and consider the appropriateness of their facility as a placement for residents. This is commendable. At the same time, however, systemic weaknesses in resident treatment planning and facility end-of-life practices result in unnecessarily restrictive and segregated living conditions for some RWNF residents.

First, when developing resident treatment plans, RWNF staff do not adequately consider integration issues. This may partly be due to the fact, as noted above, that staff do not have the ability to obtain necessary restorative care and similar medical services. Alternatively, staff may simply be unaware of the issue and their legal obligations. Regardless, the result is that residents end up losing their independent living skills and ability to move to a less restrictive setting.

To illustrate, RWNF staff often fail to provide appropriate adaptive equipment or plan accommodations to address residents' disabilities. Residents who might be able to feed themselves if given adaptive utensils do not consistently receive such items. Facility staff rely heavily on wheelchairs in place of other equipment or treatment services that might allow mobility-impaired residents to improve their ambulation skills. Residents are placed at bedside tables that are so tall, they have difficulty accessing items on the tables without staff assistance. All of these situations can prevent residents from improving their independent living skills or even cause a loss of functioning.

Second, RWNF physicians do not analyze appropriateness of end-of-life care. For some residents, spending their final days in a hospice setting might be more appropriate than in an emergency room. Yet, RWNF doctors do not seem to give much consideration to this option when deciding where to transfer a resident near the end-of-life.

D. STAFF TRAINING AND OVERSIGHT

Given the complexities of caring for geriatric residents, it is important for a nursing home to have strong staff training and administrative oversight. At RWNF, weaknesses in these areas contribute to many of the problems in the facility's overall delivery of care.

First, weaknesses in staff training and clinical oversight have an adverse effect on resident care at RWNF. Administrators, physicians, and direct care staff all require more training and expertise on issues specific to geriatric resident populations. The facility would benefit from having a Medical Director assigned directly to RWNF. Currently, the Medical Director has many responsibilities outside of the nursing home and in the mental health hospital on campus. A nursing home like RWNF has

unique issues and regulatory requirements, and a medical director with special expertise in geriatric care would improve significantly overall facility operations. Similarly, while many of the nurses and direct care staff seem caring and dedicated, they often lack the training needed to care for a geriatric population. Among other things, they would benefit from improved training on behavioral interventions for aggressive or agitated resident behavior, restraint use, psychosocial planning, restorative care concepts, and the role of an interdisciplinary treatment team. Finally, the physician staff would also benefit from training on their obligations under federal nursing home law and generally accepted professional geriatric standards.

RWNF's "informed consent" practices are a good illustration of what can happen when there is inadequate oversight of medical professionals. Generally accepted professional standards require that residents receive information necessary to make health care decisions. Federal regulations require that residents be informed of the benefits and risks of treatment and reasonably available alternatives. 42 C.F.R. § 483.10 (d)(2). At RWNF, staff often do not obtain the requisite consent of a resident (or guardian) before giving the resident medication. Charts lacked documentation that a nurse or staff person explained to a resident why the doctor thought it was necessary to prescribe medications. Records also suggest that the goals of such treatment were sometimes poorly articulated, if explained at all. The charts also lacked documentation to demonstrate that staff inquired into whether each resident understood the benefits and risks associated with suggested treatment. One especially striking example of this problem involves placebos. Some RWNF residents are currently taking placebos without having given consent. Professional staff did not seem to recognize that this practice is archaic and professionally inappropriate.

Second, weaknesses in care provided by the staff are not recognized promptly, in part because the facility's quality assurance procedures themselves reflect a lack of attention to specific geriatric concerns. For instance, the current staff oversight and quality assurance system does not systematically track the use of "siderail" and other restraints. The system also does not include adequate review of the care provided by physicians and psychiatrists, nor does the system include careful, periodic evaluation of physician treatment by a qualified clinical medical director. Finally, the current system does not track or trend patterns of abuse and injury. Without

such data, it is difficult for the facility to improve care or proactively prevent problems from developing.

II. MINIMAL REMEDIAL MEASURES

In order to remedy these deficiencies and to protect the constitutional and federal rights of RWNF residents, RWNF should implement, at minimum, the following measures:

A. Assessment and Treatment Care Planning

RWNF must develop and implement formal policies for several critical aspects of geriatric care that are not adequately addressed by current policies. These include loss of function, pain management, care for pressure sore infection and necrosis, staff supervision of geriatric residents, restraint use, medical documentation review, and monitoring of drug side effects.

RWNF must conduct timely and appropriate assessments of residents. Specific attention should be given to assessing residents for pain, restraint use, acute health changes, mental illness, and restorative care needs. Assessments should also include evaluation of each resident's functional status and associated adaptive needs.

Treatment planning needs to be interdisciplinary, with active participation by all appropriate staff, including physicians and psychiatrists. Social workers must be included in care planning to ensure that residents' psychosocial needs are addressed. Greater attention should be given by the social work and medical staff to end-of-life care, depression screening, and the securing of informed consent for treatment.

1. Pressure Sores

RWNF must proactively treat residents at risk of pressure sores by conducting more timely assessments and interventions. Residents identified as at risk for skin breakdowns should be given appropriate treatment and follow-up by direct care staff and treatment teams. Facility protocols for prevention and treatment of pressure sores should include wound assessments, nutritional assessments and intervention, pain management, infection and necrosis management, and notification to the resident and the resident's responsible party.

2. Falls

RWNF must develop and implement policies that clearly describe appropriate procedures for conducting fall assessments and interventions. Staff must be trained on such procedures and provided practice guidelines that meet generally accepted professional standards of practice. In preventing falls, RWNF staff should give special attention to the problem of falls caused by inappropriate restraint use and damaged equipment.

3. Restraints

In order to minimize the use of mechanical and chemical restraints, RWNF must develop and implement meaningful alternatives including provision of restorative care, activities, and environmental manipulation. Residents must not be restrained without proper evaluation.

When restraints are recommended by staff to prevent falls, RWNF must ensure that there has been an appropriate evaluation of the reasons for the falls and alternatives to restraints. RWNF should assess specifically whether addressing a resident's need for alternative seating, strength building exercises, adapted communication, toileting, pain, or anxiety may be a more appropriate solution than restraints.

Even if restraints may be appropriate, RWNF staff must periodically reassess the perceived need for such restraints and attempt alternative approaches, if indicated.

Facility administrators must specifically evaluate restraint use as part of the facility's quality assurance and improvement process. Clinical outcomes associated with restraint use, such as weight loss and trauma, should be evaluated as part of this process. Data and trends regarding restraint use should be identified for both individual residents and the RWNF system as a whole.

4. Mealtime Assistance and Nutrition

RWNF must include nurses in the coordination of staff response to residents' significant weight changes. Nurses should be trained in conducting appropriate weight evaluations and supervised to ensure appropriate follow-through when significant weight changes occur. All RWNF staff must also be educated on

generally accepted professional approaches to promoting improved function, safety, and nutrition during mealtimes. To assist with self-feeding, residents must be provided with appropriate assistive devices and seating.

5. Therapeutic Activities

RWNF must increase activities for all residents. Such activities should be designed to address complications associated with inactivity such as pressure sores and clinical depression. Programs need to be developed and implemented specifically for residents with limited physical or cognitive function (e.g. dementia, depression, aphasia, visual impairments and hearing loss).

B. Mental Health Care

RWNF must provide adequate and appropriate psychiatric and mental health services in accordance with generally accepted professional standards. In order to accomplish this, the nursing home must:

1. Educate staff about federal regulations pertaining to nursing homes and the nursing home guidelines set forth in the Omnibus Budget Reconciliation Act;

2. Provide medical and nursing home staff with educational instruction on methods of evaluation, diagnosis, and treatment of residents with psychiatric and/or behavioral problems;

3. Provide continuing medical education on age-related mental health issues;

4. Ensure that a qualified medical director makes it a priority to review resident charts and medication practices to ensure that the use of polypharmacy is justified, physicians and staff record their respective treatment decisions, staff monitor residents, and resident's medical care is aimed at improving quality of life; and

5. Ensure that psychopharmacological practices comport with generally accepted professional standards. The use of medications must be professionally justified,

carefully monitored, documented, and reviewed by qualified staff. Doctors must justify the use of medications based on clinical need.

C. Treatment in the Most Integrated Setting Appropriate to Individualized Needs

RWNF must provide residents with restorative care, adaptive devices, and treatment necessary to maintain and improve resident functioning. The facility must develop and implement an equipment management program to ensure that equipment is in good functioning order.

RWNF must develop and implement a policy for discharge planning that includes consideration of hospice care and more integrated settings for end-of-life residents.

D. Staff Training and Oversight

RWNF must improve clinical and facility management. Mississippi officials should consider hiring a separate, dedicated medical director for the facility, with expertise in running a geriatric nursing facility. RWNF should develop and implement policies and procedures to ensure adequate oversight of all staff, including physicians.

RWNF must develop and implement a gerontologic core training program that meets current accepted professional standards. This training needs to be complemented by a competency evaluation of staff to ensure that staff are proficient enough to implement their training. Peer review should also be considered in order to assist staff and improve overall resident care.

Substantively, staff must be trained and educated on "restraint-free" treatment approaches so that they can properly evaluate the alternatives to restraints. Staff also need to be trained on their roles in an interdisciplinary treatment planning process, medication side effects, individualization of resident assessments and treatment, resident psychosocial needs, resident therapeutic activities, medical issues specifically related to the aging process, and federal regulations.

RWNF must develop and implement a quality assurance and improvement system that monitors clinical outcomes and associated practices. More specifically, RWNF must identify and address

trends in mistreatment, such as excessive restraint use, psychoactive use, falls, and pressure sores. Corrective action must be taken systematically when problems are identified.

RWNF must establish and implement policies to safeguard residents' "informed consent" rights. RWNF must stop giving residents placebos without adequate professional justification.

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In light of the State's cooperation in this matter, we have decided to provide our consultants' reports as technical assistance. The expert reports will be sent under separate cover. Although our experts' evaluations do not necessarily reflect the general conclusions of the Department of Justice, their independent observations, analysis, and recommendations further elaborate on the issues discussed in this letter and provide practical assistance on addressing deficiencies.

We invite the State to discuss with us the above remedial recommendations, with the goal of remedying the identified constitutional and statutory violations without resort to litigation. In the event we are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or otherwise protect the rights of RWNF residents, 49 days after the receipt of this letter. 42 U.S.C. § 1997b (a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. Civil Rights Division lawyers will soon contact your attorney to discuss in more detail the measures that the State must take to address the deficiencies identified in this letter.

Sincerely,

/s/ Ralph F. Boyd, Jr.
Ralph F. Boyd, Jr.
Assistant Attorney General

cc: The Honorable Michael Moore
Attorney General of Mississippi

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Reginald P. White Nursing Facility

Ms. Kerry Bynum
Administrator
Reginald P. White Nursing Facility

The Honorable Dunn O. Lampton
United States Attorney
Southern District of Mississippi