U.S. Department of Justice

Civil Rights Division

Assistant Attorney General

950 Pennsylvania Avenue, N.W. - MJB
Washington, DC 20530

April 21, 2004

The Honorable Bill Purcell
Mayor of the Metropolitan Government
of Nashville and Davidson County
Metro City Hall
225 Polk Avenue
Nashville, TN 37203

Re: Nashville Metropolitan Bordeaux Hospital

Dear Mayor Purcell:

On March 12, 2003, we informed the Metropolitan Government that we were investigating conditions at Nashville Metropolitan Bordeaux Hospital ("Bordeaux"), in Nashville, Tennessee, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Bordeaux is a nursing home that provides skilled nursing care and intermediate care to its residents. We conducted two tours of Bordeaux during the weeks of June 9 and July 28, 2003, with expert consultants in various disciplines. We held exit interviews on the last days of each tour, in which we verbally conveyed our preliminary findings to counsel and to facility administrators and staff. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings, along with the minimal actions that are necessary to remedy the deficiencies we found.

As a threshold matter, we wish to acknowledge, and express our appreciation for, the cooperation and assistance provided to us, particularly by counsel and the facility's Chief Executive Officer, Chief Operating Officer and Administrator, Medical Director, Director of Nursing, and Director of Advocacy, Quality & Regulatory Services. Further, we note that it was apparent that many Bordeaux staff members are dedicated individuals who are genuinely concerned for the well-being of the persons in their care. We hope to work with the Metropolitan Government and Bordeaux administrators and staff in the same cooperative manner in addressing the problems that we found.

I. INTRODUCTION

During our investigation, we evaluated whether residents of Bordeaux have been afforded their constitutional and statutory rights. Under the United States Constitution and federal law, residents of public nursing homes have a right to live in reasonable safety and to receive adequate health care, along with habilitation, to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See U.S. Constitution Amendments I, XIV; Youngberg v. Romeo, 457 U.S. 307 (1982); Terrance v. Northville Regional Psychiatric Hosp., 286 F.3d 834 (6th Cir. 2002). Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. §§ 1395hh, 1396r and implementing regulations, 42 C.F.R. § 483 Subpart B (Medicaid and Medicare regulations). The Metropolitan Government also is obligated to provide services in the most integrated setting that is appropriate to individual residents' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; see Olmstead v. L.C., 527 U.S. 581 (1999).

We conducted our investigation by reviewing medical and other records relating to the care and treatment of individuals; interviewing administrators, staff, and residents; and conducting on-site reviews of the facility. We were assisted in our investigation by expert consultants in medical care, nursing, and nutrition. Our findings are supported by the assessments contained in our expert consultants' reports, which will be provided under separate cover.

At the time of our June 2003 visit, Bordeaux had an overall capacity of 480 beds: 420 nursing facility beds and 60 long-term acute care hospital beds. Bordeaux's actual census was 365 persons in the nursing facility beds and six persons in the acute care ward. Of the 420 nursing facility beds, 180 are certified as skilled nursing facility beds and 240 as intermediate care facility beds. The facility is divided into two buildings: Riberio and Birmingham, each with four units. Approximately 45 percent of the residents are under the age of 65. These younger residents often have suffered from strokes or trauma.

II. FINDINGS

As a nursing home, Bordeaux is required to provide medical, nursing, and related services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 U.S.C. § 1396r(b)(4)(A). Bordeaux is to be commended for its performance in several areas. Bordeaux has

made positive changes in the areas of leadership and staff education. Administrator May Bennett, Medical Director Dr. Jean Lessly, and Director of Nursing Shara Stodola, among others, have had a positive impact on resident care, staff job satisfaction, and the delivery of medical care. Pharmacy services are also praiseworthy, as the facility has an on-site pharmacy that is staffed by well-trained pharmacy professionals.

The Bordeaux staff has positively contributed to the general environment of the facility. Bordeaux's environment appears to be clean, homey, and cheerful. Overall, Bordeaux appears to be a pleasant and comfortable facility. Bordeaux also recognizes the importance of therapeutic activities, and provides appropriate activities for its residents.

However, in the areas of general medical care, psychiatric care, restorative and wound care, nutritional management, incident management, resident rights, and community placement, Bordeaux does not provide levels of care that are consistent with federal law. These deficiencies place residents at risk of harm. Our findings, the facts supporting them, and the remedial steps that we believe are necessary to address the deficiencies are set forth below.

A. GENERAL MEDICAL CARE

According to federal regulations governing nursing homes, Bordeaux must provide medical, nursing, and related services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 U.S.C. § 1396r(b)(4)(A). Although Bordeaux's administration is working to improve the facility's provision of medical care, significant systemic deficiencies in medical care persist. More particularly, medication management, oversight and management of medical care, and medical notes and documentation substantially depart from generally accepted professional standards of care. These deficiencies place the residents at risk of serious physical harm.

1. Medication Management

Generally accepted professional standards of care dictate that the use of medications, especially those having potentially harmful side effects, be clinically justified. This is particularly true when drugs used in combinations increase the risk of harm and when drugs pose particular risks for the elderly. Generally accepted professional standards of care also require monitoring for drugs having therapeutic ranges below

which the drug is ineffective and above which it is potentially toxic to ensure that the drug is helping, not harming, the resident. Medical staff also must evaluate on a routine basis whether the continued use of medications and the amounts prescribed remain appropriate, or whether they can be tapered down or replaced by others having fewer adverse side effects. In general, the pharmacy services at Bordeaux are adequate. However, our review revealed other medication management deficiencies.

a. Lack of Clinical Justification for Prescribed Medications

According to generally accepted professional standards of care, each drug administered must be prescribed for a specific diagnosis or prevention of a disease. A number of Bordeaux's residents, however, are prescribed medications without clinical justification. In particular, some medical records contained no clinical justification for medications, and some medications appeared to be prescribed inappropriately. For example, resident Margaret M.[1] had diagnoses of dementia and endometrial cancer and was prescribed Aricept without clear diagnosis and documentation of the benefit of this medication. Aricept is used for mild Alzheimer's disease and can cause serious side effects, including gastrointestinal upset, nausea, vomiting, and diarrhea. Aricept should not be used without clear, documented justification.

Resident Earl C. was prescribed the medications hydrochlorothiazide and clonidine, both of which are used in the treatment of hypertension. However, Earl C.'s medical records and notes did not indicate a diagnosis of hypertension. Similarly, Charlene H. was placed on Sinemet, a drug that is specifically used in the treatment of Parkinson's Disease, but her medical records contained no diagnosis of Parkinson's Disease. In each of these instances, Bordeaux administered medications to residents without clear, clinical justification, thereby placing the residents at risk of untreated or inappropriately treated illness as well as unnecessary side effects of medication.

Under generally accepted professional standards, the use of more than one medication may be appropriate, but the combination

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[1] To protect the residents' identities, we use pseudonyms throughout this letter. We will separately transmit to counsel for Bordeaux a schedule cross-referencing the pseudonyms with resident names.

of the drugs must always be clinically justified. In some cases, Bordeaux residents were administered multiple medications for which no clear clinical justification was provided. Resident Charlene H. was concurrently administered the antidepressants Remeron and Celexa. Both medications have serious side effects, including sedation and gastrointestinal effects. Using them together without justification places the resident at serious risk of harm. Resident Tina M. was prescribed numerous medications, including Vioxx, aspirin, and Fosamax, despite a history of Gastroesophageal Reflux Disease (GERD).[2] Vioxx is a non-steroid anti-inflammatory that in rare cases can cause serious stomach problems, and more commonly can cause heartburn and stomach pain. Taking aspirin and Vioxx creates a higher risk of serious stomach problems. Fosamax, used to treat osteoporosis, can cause numerous digestive reactions. The use of all three medications for this resident placed her at unusually high risk of gastrointestinal bleeding and death.

b. Inadequate Monitoring to Ensure Medications Are Therapeutic

Generally accepted professional standards of care require that medications must be monitored to ensure that their dosages are neither ineffectively sub-therapeutic nor toxically high. Bordeaux substantially departs from these standards. Charles H. was placed on diltiazem (a calcium channel blocker that slows the heart beat to reduce blood pressure) and Atenolol (a beta-blocker that reduces blood pressure when used twice daily) for hypertension. Due to the significant side effects presented by this unusual combination of drugs, Bordeaux should have closely monitored the medications and their side effects, and attempted to taper the resident off these medications as appropriate. However, the chart did not show any tapering, and did not document the need for this unusual combination of medications.

Tina M. was prescribed Zyprexia and Zoloft, both powerful psychotropic drugs that can have significant side effects, including movement disorders and gastrointestinal effects, and require psychiatric monitoring. However, Tina M.'s last psychiatry visit was on January 2, 2002 (approximately 17 months before the date of our review). The psychiatrist's note reads: "Reconsult me if you have any concerns or questions." Based on the resident's mental status and ongoing treatment with an anti-

[2] GERD refers to the back-flow of acidic contents from the stomach into the esophagus, and is characterized by chronic heartburn and the regurgitation of acid.

psychotic and anti-depressant, follow-up consultation was required, but not accomplished. In another case, resident Victor N. was placed at risk for harm because of continued treatment with the medication Aricept, despite several indications that Aricept was not appropriate for him: a psychiatrist's note requested the use of this medication be reconsidered; a computed tomography (CT) scan of the head showed moderately severe atrophy of the brain, indicating a condition that would not be helped by Aricept; and the resident's response to Aricept was not monitored. The medical staff did not appear to follow up and consider whether changes in the existing drug regimen were required or warranted.

2. Oversight and Management of Medical Care

Federal law and generally accepted professional standards of care dictate that nursing home residents receive adequate medical care. See 42 C.F.R. §§ 483.25, 483.40. Specifically, residents should receive medically necessary physician care, and physicians should visit each resident as often as medically necessary. Such care includes accurate and timely assessments by medical staff, proper diagnosis of assessed conditions, appropriate and effective treatment based upon a resident's diagnosis, monitoring of the resident's condition and efficacy of treatment, and revised diagnosis and treatment, as appropriate. In addition, residents are entitled to receive adequate and appropriate palliative care, which focuses on eliminating unnecessary pain as the end of life approaches. Without such elements of care, nursing home residents are at risk of inadequate medical care and great harm.

All residents should receive timely medical care that is in accordance with generally accepted professional standards of care by a physician. The initial visit and formulation of a care plan should be performed by the attending physician and cannot be delegated to a nurse practitioner. See 42 C.F.R. § 483.40(c)(4). Under generally accepted professional standards, the attending physician should see the resident within 48 hours of admission, unless the resident has been seen by a physician within five days prior to admission. After the resident has been in the facility for 90 days, during which time the resident should be seen at least every 30 days, physicians can visit the resident every 60 days, with a ten day grace period. 42 C.F.R. § 483.40(c)(1). However, generally accepted professional practices still require the attending physician to see each resident as often as medically necessary. Many nursing home residents have medical conditions that require more than the regulatory minimum number of physician visits in order to receive medically necessary care.

Bordeaux's physicians do not evaluate residents when medically necessary. Rather, their visits are scheduled and generally performed as perfunctory regulatory reviews at the outermost limits of the minimum regulatory time frames, which require a physician visit every 60 days after the resident's first 90 days of residency, with a ten day grace period. Residents commonly waited 60 to 70 days to be seen by a physician, instead of being seen when medically necessary. We found no justification in any resident charts to support the infrequency of physician visits. In fact, we reviewed numerous charts that indicated the need for physician care, but without indication that care was rendered timely. Bordeaux has not developed a review process to ensure that each resident receives medical care rendered by a physician as often as medically necessary. Medical care is primarily provided by nurse practitioners, who often operate beyond the limits of their training, while the attending physicians frequently serve as consultants and, in some instances, provide merely cursory care.

Such practices substantially depart from generally accepted professional practices. For example:

- Lance R. was admitted to Bordeaux on May 16, 2003. No documentation indicates that the attending physician ever evaluated this resident. The resident was receiving numerous medications to treat chronic obstructive pulmonary disease, hypertension, depression, insomnia, and hepatitis C. A nurse practitioner's progress note dated May 27 indicated that the attending physician would be consulted about the medications used, but there was nothing in his chart to suggest that this consultation occurred. On May 28, a nurse practitioner abruptly decreased his prednisone, a steroidal anti-inflammatory that should be tapered gradually, from 80mg daily to 20mg daily. The following day, the resident decompensated[3] and was emergently discharged back to a hospital.

- In the case of Margaret M., the attending physician visited the resident twice from January to June 2003, while the nurse practitioner saw the resident on seven occasions. During that period the nurse practitioner diagnosed the resident with endometrial cancer, but did not obtain tissue confirmation. Nothing in the resident's medical record

[3] Decompensation is the inability of the heart to maintain adequate circulation.

indicated that the attending physician had any input or oversight in the diagnostic process. This is beyond the scope of a nurse practitioner and thus placed the resident at serious risk of harm.

- As of June 12, 2003, the attending physician had seen resident Janet B. only once in the year 2003 (on February 27) despite a multitude of medical problems listed in her medical record, such as morbid obesity, diabetes, depression, and cor pulmonale (failure of the right side of the heart).

- In another case, the nurse practitioner noted that resident Greg L. lost 20 pounds between September 2002 and February 2003, but did not notify the attending physician. When the attending physician saw the resident in March 2003, the physician did not mention the significant weight loss in the medical notes.

3. Medical Notes and Documentation

In order to provide appropriate and timely medical care, medical records must be well organized and contain information that is appropriate, informative, and accessible. Bordeaux, however, substantially departs from the generally accepted professional standard of care in this area. We found significant deficiencies in the majority of reviewed charts including, but not limited to, the following: significant information often is omitted from the medical notes; sections of the charts (such as immunization records, advance care planning documents, and health maintenance sections) are not completed consistently; and sections of records are occasionally loose or missing from the chart.

The cases of Charlene H., Ethel P., and Victor N. illustrate a number of these problems. The attending physician examined Charlene H. on February 28, 2003, but did not document any physical examination on that date in the chart. The chart did not contain any notes from the attending physician (although progress notes from an "overflow chart," which apparently is used to store medical records in addition to those in the resident's chart, were provided to us weeks later). Moreover, Charlene H.'s Palliative Care Plan contained contrary instructions, stating both that "the resident be transferred to an acute care facility" and that "the resident will not be sent to an acute care hospital for evaluation and possible admission." Similarly, the advance directives section of Ethel P.'s chart was blank, although she was listed as "full code," evidencing Ethel P.'s desire to

receive all appropriate lifesaving efforts in the event of a medical emergency. Victor N.'s chart contained blank (unfilled) immunization forms, which placed him at a high risk of harm in potentially contracting preventable diseases if in fact he did not receive proper immunization. Victor N.'s chart also contained blank CPR and health care maintenance forms.

B. PSYCHIATRIC CARE

As part of its obligation to provide residents with adequate health care, Bordeaux should provide its residents with adequate psychiatric services. See 42 U.S.C. § 1396r(b)(4)(A). Bordeaux, however, does not provide psychiatric consultations to residents consistently or sufficiently to address their needs adequately. For example, as of June 12, 2003, the last psychiatry consult for William C., a resident with schizophrenia, was dated April 1, 2002. Similarly, Tina M., a resident with arteriosclerotic dementia with depression, as of June 12, 2003, had last received a psychiatry consult on January 1, 2002. Tina M. also was taking Zyprexia and Zoloft, two powerful psychtropic medications. The Bordeaux administration recognizes that they lack sufficient psychiatric staff to meet residents' needs. Accordingly, Bordeaux is in the process of transitioning to a more intensive model for psychiatric and psychological services, and has recently contracted with Paradigm Behavioral Health Service to address this area. We are optimistic that once the new system is in place, residents will have adequate psychiatric services.

C. RESTORATIVE CARE

Federal law provides that nursing homes must maximize residents' mobility, range of motion, and function. See 42 C.F.R. § 483.25(e). To meet this standard, the facility must devise restorative care plans that cover areas such as care planning, continence treatment and services, and prevention of contractures.

1. Care Planning

To provide adequate care, facilities like Bordeaux must assess each resident's needs and preferences, develop an individualized care plan based on this assessment, and effectively and accurately implement the care plan. 42 C.F.R. § 483.20. The assessment process must include consideration of the resident's physical condition and emotional status. Id. Residents must be assessed on an ongoing basis for changes in health and functioning. In addition, when a resident experiences

a significant event that impacts his or her health or functioning, the resident must be reassessed. Id. This assessment must be used to develop a care plan that addresses all of the needs of the resident. Id. Because the problems of the elderly are complex, the combined skills of all disciplines are necessary to meet the comprehensive needs of residents. An interdisciplinary team must collaborate and develop measurable goals and approaches consistent with generally accepted professional standards of care.

A resident in a nursing home is entitled to freedom from "any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." 42 C.F.R. § 483.13(a). Restraint usage in nursing homes is not generally associated with a decrease in falls or injuries; instead, restraint usage actually increases the potential for fall-related injuries. Additionally, a resident's ability to ambulate should not be diminished "unless circumstances of the individual's condition demonstrate that diminution was unavoidable." 42 C.F.R. § 483.25(a)(1)(ii). Accordingly, residents should be free from unnecessary restraints and should be provided with appropriate assistance to optimize safe mobility.

Commendably, Bordeaux has made significant progress in reducing the use of restraints and in increasing the use of alternatives to restraints to promote mobility. Bordeaux uses side rails and geri chairs appropriately, and minimally uses highly restrictive devices, and only when clinically justified. However, our review of a significant number of care plans indicates that Bordeaux does not individualize the care plans appropriately to meet the needs of each resident. For example, some care plans lacked the development of a continence program when the need for such a program was clinically evident, and others lacked incorporation of specific precautions or monitoring requirements when the need was clinically evident. Bordeaux also fails to revise the care plans following changes in a resident's condition, such as after a fall or the development of a pressure ulcer. Such revisions are necessary to identify and implement appropriate nursing interventions to prevent resident injury or complications.

2. Continence

Residents with urinary incontinence require "appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible." 42 C.F.R. § 483.25(d)(2). Ineffective control of bladder continence can

result in slip and fall injuries, urinary tract infections (UTI), sepsis (bloodstream infection), urosepsis (bloodstream infection from a UTI), and skin irritation, including excoriation (abrasion) and worsening pressure ulcers. An adequate continence program reduces these risks. Generally accepted professional practices that address incontinence include scheduled toileting, prompted toileting, or habit training.

Although Bordeaux has a high number of residents who are incontinent, almost no residents participate in a program to reduce incontinence and restore normal bladder function. Current practices at Bordeaux consist of toileting some residents every two hours, but even this program is not implemented consistently. Bordeaux does not monitor and document residents' voiding patterns upon admission in order to develop appropriate schedules. Toileting schedules for functionally incontinent residents that incorporate the generally accepted professional practices of scheduled cuing and appropriate assistance from staff would reduce the risk of urinary tract infections and help restore normal bladder function.

3. Contractures

Bordeaux must ensure that residents maintain their range of motion unless unavoidable, 42 C.F.R. § 483.25(e)(1), and must ensure that residents with limited ranges of motion receive "appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion." 42 C.F.R. § 483.25(e)(2). Although less than five percent of Bordeaux residents exhibited a decline in range of motion during the time period of March 2003 through May 2003, numerous residents are at risk of decline in mobility and function because they are not provided with adequate range of motion exercises. Bordeaux's care in this regard does not appear to be in violation of federal law, however, we raise this as an area of concern. These residents are also at risk of contractures, or a tightening of the muscles primarily in the hands, arms, legs, and feet, which can lead to deformities. Staff perform range of motion exercises five to seven times per week to prevent contractures. However, residents who are wheelchair- or bed-bound and thus are particularly at risk for the development of contractures require consistent range of motion exercises at a minimum of one time per day, seven days per week on an ongoing basis to prevent painful and debilitating contractures. In addition, residents who have already developed contractures need range of motion exercises at a minimum of two times per day, seven days per week in order to prevent or minimize deformity, prevent further contractures, and minimize pain. Such services are not provided as frequently as

needed at Bordeaux.

D. WOUND CARE

Wounds in nursing homes may include skin tears, pressure ulcers, surgical wounds, and wounds related to vascular disease. Pressure sores in particular are universally accepted indicators of the quality of skin care. Although nursing home residents may be at risk of developing pressure sores or ulcers, most pressure ulcers can and should be prevented. See 42 C.F.R. § 483.25(c). We commend Bordeaux's staff on its wound care practices. At the time of our review, Bordeaux had a very low incidence of pressure sores that were developed in-house. However, we note that Bordeaux residents are at risk for developing pressure sores because nursing assistants are not promptly reporting areas of skin redness or breakdown to the charge nurse. Such early detection and treatment can prevent the progression of the pressure sore and related complications. Bordeaux should also ensure, consistent with generally accepted professional practice, that all staff providing direct care to residents are trained on the proper use of standard precautions, hand washing, and proper aeseptic or sterile technique to prevent the spread of infection. Bordeaux staff otherwise properly implement pressure ulcer prevention practices and treat wound infections in an appropriate and timely manner. The facility's standard use of pressure-relieving mattresses for each resident is noteworthy.

E. NUTRITIONAL MANAGEMENT

Bordeaux is required to "provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident." 42 C.F.R. § 483.35. Meals also must be provided to residents in a form that meets their needs. 42 C.F.R. § 483.35(d)(3). The dietary services currently provided at Bordeaux are inadequate and substantially depart from generally accepted standards of care for residents in long-term care facilities. Bordeaux fails to assess and manage residents' needs for therapeutic and texture modified diets properly, fails to ensure the nutritional integrity of residents' regular and therapeutic diets, fails to conduct adequate standard nutritional assessments of residents, and fails to provide proper mealtime assistance to its residents.

1. Therapeutic and Texture Modified Diets

Therapeutic diets must be prescribed by the attending physician, 42 C.F.R. § 483.35(e), and are generally based upon regular diets that are modified to meet a resident's medical or

health needs. For example, a resident with hypertension or renal disease may need a diet with less sodium, or a resident with heart disease may need a diet with less fat or cholesterol. Bordeaux offers a variety of therapeutic and texture modified diets. However, Bordeaux does not analyze the nutritional content or adequacy of either the regular or the therapeutic diets. Residents' medical charts contained no evidence that therapeutic diets had been reviewed for efficacy to ensure that the diet was meeting the resident's needs, or that dietary changes were implemented as a result of any nutritional assessment.

Generally accepted professional standards require registered dieticians to analyze the nutritive value of the foods provided at Bordeaux to ensure that residents receive the therapeutic modifications prescribed by physicians. Without such analyses, it is impossible to determine whether residents are receiving therapeutic meals that they do not need, whether residents who need therapeutic meals are properly receiving them, or whether residents are receiving appropriate therapeutic modifications to their prescribed diets. Furthermore, although generally accepted professional standards require that therapeutic diets be prescribed by a physician with input from the registered dietician, see 42 C.F.R. § 483.35(e), Bordeaux's registered dietitian is allowed to modify the calorie content of the diet unilaterally, without consulting a physician.

Food must be provided to residents in the appropriate form. 42 C.F.R. § 483.35(d)(3). Residents without teeth or with chewing or swallowing difficulties such as dysphagia may require a texture modified diet, such as "pureed," "chopped," or "thickened liquids." These diets should be modified to address the residents' increased risk of choking or aspiration and aspiration-related illnesses and death. Bordeaux does not have any method in place to determine when texture modified diets should be provided, nor does it have a procedure by which residents receiving texture modified diets are evaluated to ensure the continued efficacy of the diets. Additionally, dietary staff is not provided with guidelines for the amount of liquid needed to produce various consistencies.

During our observations of meals, we noted that some residents do not receive the appropriate texture modified diets. For example, resident Floyd C. was prescribed a soft textured diet with chopped meats and raw vegetables but he refused to eat the vegetables because he reported that they stuck to his gums and caused him to cough and choke. Staff acknowledged that he refuses raw vegetables, that he usually eats cooked vegetables,

and that this had been an ongoing problem for the past two months. Staff recognized that the texture of this diet was not effective for this resident, yet no changes had been made. The resident's medical chart did not have any documentation to indicate that a follow-up assessment was required or performed, nor did nutrition entries reflect any concern with the existing diet.

Bordeaux also does not properly use thickening agents. Thickening agents are used to thicken fluids which can be difficult for certain residents to control during swallowing and increase the risk of choking, aspiration, and aspiration pneumonia. These risks are particularly prevalent in people who have had strokes or who have other medical conditions, including dysphagia and Alzheimer's disease. In more than a third of the cases we observed, the thickening agent was used incorrectly in that only half of the proper amount of thickener was used. Additionally, the thickener was rarely properly dissolved, leading to uneven thickness of the liquid. Uneven and improper thickness of liquids places residents at unnecessary risk for choking or aspiration or aspiration-related illness.

2. Nutrition and Hydration

Bordeaux has not developed a mechanism to ensure that it provides nourishing, well-balanced meals to its residents as required by federal law. 42 C.F.R. § 483.35. In particular, Bordeaux fails to analyze its regular diets for nutritional adequacy and fails to evaluate the nutritional status of its residents consistently.

a. Analysis of Nutritional Adequacy

The menu for Bordeaux is prepared by its registered dieticians and based on the Food Guide Pyramid. However, a qualified registered dietician does not review the dietary allowances at least annually as required by generally accepted professional practices to ensure that the diets meet current nationally recommended allowances for basic nutrition. In addition, neither the regular nor the therapeutic meals are analyzed for nutritional adequacy. Proper nutritional assessment is crucial to identify and prevent instances of malnutrition. Because meals are not analyzed for nutritional adequacy, residents may receive too much or too few nutrients. For example, we observed that two residents, Minnie H. and Isabel A., each of whom are prescribed three ounces of protein for a meal,

received approximately ten and 12 ounces of protein during one meal – triple and quadruple their prescribed quantities. While adequate protein is essential in the elderly, providing such high protein diets to these two residents placed them at further risk for osteoporosis and dehydration.[4]

b. Standard Nutritional Assessment

Bordeaux does not conduct adequate standard nutritional assessments of its residents. Evaluating the nutritional status of a resident allows for early intervention in the prevention and treatment of malnutrition or poor nourishment. Without comprehensive nutritional assessments, residents risk complications such as deteriorated oral motor skills, acute weight loss, choking, aspiration and aspiration-related illnesses, and chronic constipation. Bordeaux has appropriate nutritional assessment procedures in place; however, these procedures are not followed consistently and often the data that is collected is incomplete or untimely. For example, for a number of residents, borderline abnormal lab values indicating potential malnutrition risk were regularly unaddressed.

Similarly, Bordeaux does not routinely follow a clinical protocol to identify residents who are at risk for malnutrition, although it does have an appropriate protocol. Without an adequate nutritional assessment, proper nutrition therapy and preventive nutrition intervention cannot be provided. Most residents should be assessed nutritionally within 72 hours of admission, and medically frail residents should be evaluated immediately upon admission. Federal regulations require the nutritional assessment to be part of each resident's care plan and to be updated as necessary to address changes in a resident's nutritional status. 42 C.F.R. § 483.20(b)(1)(xi). Bordeaux also fails to assess residents for drug-nutrient interactions, which can affect nutrient absorption and place residents at risk of harm for significant problems such as the reduction of bone density, anorexia, and weight loss.

Bordeaux also fails to monitor and address residents' constipation properly. If left untreated, constipation can lead to fecal impaction, which can cause anorexia, confusion,

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[4] Diets high in protein can increase ketone production, leading to excessive urination and ultimately causing dehydration. Excessive amounts of protein in the diet can also strip protein from the bones, causing or exacerbating osteoporosis.

increased risk of dehydration, and diminution of nutritional status. Although Bordeaux maintains bowel movement charts for its residents, these charts are inconsistent and incomplete, and a number of residents appear to receive inadequate intervention to address constipation.

c. Hydration

Dehydration is a serious risk in long-term care hospitals and in the elderly, and can result in the development of urinary tract infections, bowel obstructions, delirium, cardiovascular symptoms, and even death. Commendably, Bordeaux has a well-developed written hydration protocol, clearly written markers to ensure adequate hydration, alerts to indicate poor fluid intake in residents' records, and hydration carts on each housing unit. One procedure requires staff to place a paper fish on the doors of those residents who are at risk of dehydration. Although most of the other hydration protocols appear to be followed, two nursing staff members stated that they did not know the meaning of the fish symbols. While this is not a violation of federal law, we suggest that all nursing and health care staff be properly trained in and aware of the facility's hydration protocols in order for them to be effective.

3. Mealtime Assistance

Bordeaux fails to ensure that staff safely and properly assist residents during mealtimes. Generally accepted professional practices require that food be served in a manner that is supportive of the resident's needs, and, if necessary, that food service and/or support staff assist residents at mealtime. Many residents at Bordeaux depend, either totally or partially, on staff to assist them during mealtimes. A significant number of residents have notations on their food trays that state "swallowing precautions" or "observe swallowing precautions." These residents typically suffer from dysphagia and/or other swallowing disorders which can result in choking, aspiration, aspiration pneumonia, hypoxia (lack of oxygen), and even death. Malnutrition or dehydration could result if residents are not swallowing properly due to unmanaged swallowing disorders. Incorrect mealtime assistance also can result in nasal regurgitation, aspiration pneumonia, chronic respiratory infection and weight loss, and ultimately can cause the resident's death.

Staff do not have the appropriate skills to assist in the safe feeding of residents with swallowing disorders. Although Bordeaux posts some information regarding the residents' specific

swallowing needs and individualized mealtime assistance instructions in their rooms, this information does not follow them to the dining room and therefore is not available to staff during mealtimes. Moreover, the information posted in residents' rooms is incomplete in that critical factors, including positioning, distress cues, and feeding techniques, are not included. Several staff members who are assigned to assist residents during mealtimes reported that they had not received training regarding the feeding of residents, including residents with swallowing precautions. Other staff members reported that they were not trained to work with the specific resident with whom they were working.

Bordeaux does not provide consistently sufficient staff during mealtimes. Although we observed that some meals had an adequate staff to resident ratio, at other meals residents were left completely unattended. As a result, many residents attempted to feed themselves with their fingers or drank without assistance, resulting in choking and coughing. For example, we observed that one resident, Larry B., ate unattended and choked as he stuffed cornbread into his mouth. When staff finally assisted him, however, he was able to slow his pace and eat his meal without difficulty.

In addition to proper supervision, residents at Bordeaux need proper positioning while eating. Proper seated positioning is necessary to prevent choking or aspiration and aspiration-related illness. We observed several residents who were not properly positioned during mealtimes. These residents slid downward in their chairs, and one resident almost fell out of her chair. Residents who were fed in bed were similarly poorly positioned. For example, a staff person fed a bedridden resident by tilting the resident's head back. This was a highly dangerous position for the resident, and as a result, this resident was observed to choke, cough, and gurgle excessively.

Bordeaux must provide adaptive eating devices to residents who need them. 42 C.F.R. § 483.35(g). Adaptive utensils provide residents with the opportunity to be involved with mealtime activities, promote gross and fine motor skills, and allow residents the dignity of self-feeding. Adaptive utensils also allow for the maximum amount of food intake by reducing spillage. Bordeaux does not assess residents routinely for the use of adaptive eating utensils, does not provide adaptive eating utensils consistently when they are indicated, and does not provide proper guidance when adaptive utensils are used. During mealtime observations, we saw a number of residents who could have benefitted from adaptive eating utensils, but instead either

fed themselves with their fingers or did not eat at all as they waited for staff assistance. Conversely, a number of other residents who had access to such utensils were not given the opportunity to use them and instead were completely assisted by staff.

Although not a violation of federal law, we note that the mealtime environment at Bordeaux was observed to be overstimulating to residents. At times, music blared so loudly that residents and staff had to shout to be heard. Such overstimulation is problematic for residents with impaired memory, Parkinson's disease, or poor attention span. The overstimulation can cause disinterest in eating which could result in malnutrition and can increase the risk of choking.

4. Food Preparation, Service, and Storage

The Bordeaux food service department generally provides adequate and appropriate service in the areas of food temperature, food preparation, food storage, sanitation, personal hygiene, and cleanliness of the kitchen. However, during one breakfast we observed that eight out of ten residents were served juice and milk that were frozen and thus they were unable to drink them. Some residents reported that they occasionally receive frozen juice or milk for breakfast. Both milk and juice provide many essential nutrients, but no adjustments to the residents' diets were made to make up for this deficiency.

The kitchen staff also did not use gloves consistently during meal preparation, and, more importantly, no employee was observed washing their hands between food-related activities and non-food-related activities. Generally accepted professional standards require that kitchen staff wash their hands as they move from one task to the next. Sanitary standards must be stringently adhered to at all times during food preparation for individuals with weakened immune systems and the elderly. Accordingly, it is essential that staff follow appropriate sanitary procedures with an emphasis on hand washing and using gloves appropriately and consistently.

F. INCIDENT MANAGEMENT AND QUALITY ASSURANCE

It is generally accepted professional practice in facilities like Bordeaux to have a quality assurance program that: actively collects data relating to the quality of services; assesses these data for trends; initiates inquiries regarding problematic trends and possible deficiencies; identifies corrective action; and monitors to ensure that appropriate remedies are achieved. See

42 C.F.R. § 483.75(o). Generally accepted professional standards of care require a facility to identify and document incidents in order to prevent recurrence of an incident, to prevent injury to residents, and to achieve improved safety for all residents. Additionally, recommendations to prevent recurrences should be incorporated into a resident's care plan to ensure uniform implementation and to improve resident safety.

Falls occur with greater frequency in the elderly and are associated with increased mortality, morbidity, and disability. However, falls and resulting injuries are not inevitable. Bordeaux is required to provide an environment that is "as free of accident hazards as is possible," and must ensure that its residents receive "adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(1), (2). Because falls can result in fractures, head injuries, or other serious injury, facilities should endeavor to identify fall risks and work to reduce those risks. The primary goal of a fall prevention program is to minimize the number of falls resulting in serious injury.

Bordeaux fails to analyze adequately data related to injuries, falls, and other resident incidents. Although staff complete incident reports for incidents involving falls or allegations of abuse or neglect, these reports are incomplete in that they do not include recommendations to prevent the incident from recurring to the resident. Failure to conduct such activity places residents at risk for avoidable loss of health and diminution of function. Preventive measures and post-fall reassessments also should be documented in a resident's care plan. Post-fall assessments should address the root causes of falls, such as incontinence, medications, medical problems, functional decline, seating, and/or presence of illness. Because Bordeaux does not adequately follow these practices, its fall interventions are not adequate. For example, Alice N., an 82-year-old resident with dementia, had repeated falls, yet the only post-fall intervention was the use of a call light, which is clinically inappropriate and ineffective for a memory-impaired resident. Similarly, Frank Y., another resident with dementia, suffered two falls within six months. His care plan was inadequate and generalized, and also required him to use a call light. To minimize the risk of falls appropriately, these residents require more effective devices, such as alarms or call lights affixed to the resident's clothing.

G. RESIDENT RIGHTS

Nursing home residents have the right to a dignified

existence and to self-determination. 42 C.F.R. § 483.10. Residents also have the right to be involved in the development, evaluation, and revision of their care plans. Id.

Advance directives provide a way for residents to communicate their medical decisions, and to face end-of-life issues with dignity. A resident's right to accept or refuse medical care is a long-standing tenet of ethical medical practice and is a widely accepted standard of professional care. Without attention to advanced directives, patients could be subjected to unwanted, unwarranted, unnecessary, and harmful medical interventions. Alternatively, without clearly documented advance care planning, residents may not receive medical interventions that are reasonable and requested, thereby denying them necessary medical care.

Bordeaux does not meet these standards for ensuring advance care planning. In general, the policies and procedures regarding advanced care planning are haphazard, and at times contradictory and inconsistent. No policy exists to ensure that residents have their advance directives placed in their charts, and Bordeaux staff were unclear as to who was responsible for ensuring that patients' living wills are placed in their charts. In addition, even when advance care directives are in the charts, they are often contradictory or not followed. For example, a speech therapist recommended tube feeding for Camille H., despite contrary instructions in her durable power of attorney. A form in Betty C.'s chart stated that she had no will or durable power of attorney, but the documents that follow the form were her will and durable power of attorney. Finally, Margaret M. was sent to the hospital despite a care plan that included the instructions "do not hospitalize."

H. MOST INTEGRATED SETTING

The Americans with Disabilities Act requires Bordeaux periodically to assess residents to determine whether their continued stay at the facility, rather than in more integrated settings, is appropriate. See 28 C.F.R. § 35.130(d)(public entities must provide services in the most integrated setting appropriate to the needs of the individual); Olmstead v. L.C., 527 U.S. 581, 602 (1999)(public entity is required to provide community-based treatment when the entity's treatment professionals have determined that community placement is appropriate, the affected person does not oppose such treatment, and the placement can be reasonably accommodated). Such assessments include an evaluation of the supports and services each resident would need to transition to a more integrated

setting, and an evaluation of the barriers to such a discharge. Bordeaux did identify two recent success stories in which residents Ralph T. and Albert E. were successfully discharged to community settings with appropriate supports and services. However, as noted above, there was a general lack of individualized care planning in the facility, and, as part of this failure, Bordeaux's treatment professionals fail to assess periodically whether community-based treatment is appropriate for its residents, thereby improperly constraining residents who may be served in a more integrated setting.

III. MINIMUM REMEDIAL MEASURES

In order to remedy these deficiencies and to protect the constitutional and federal statutory rights of Bordeaux residents, Bordeaux should implement promptly, at a minimum, the following measures.

A. GENERAL MEDICAL CARE

Bordeaux residents should be promptly assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care, including with sufficient documentation to withstand clinical scrutiny.

Every Bordeaux resident should receive prescription medications only after first having been thoroughly evaluated/worked up and diagnosed according to generally accepted standards of care, including with sufficient documentation to withstand clinical scrutiny, and each medication similarly should be clinically justified as an appropriate treatment for the diagnosed medical condition for which it is prescribed. More particularly, Bordeaux should:

1. Develop policies and procedures and conduct chart reviews to ensure that:

    a. Residents have a clinically justifiable, current diagnosis for each medication that each resident receives;

    b. All medications are prescribed at optimum therapeutic levels; and

    c. All medications are monitored for side effects and continued appropriateness.

2. Ensure that attending physicians evaluate residents on an individual basis to determine the frequency of medically necessary visits. Attending physicians should then see residents as often as medically necessary.
3. Develop and implement a utilization review process to review the frequency of physician visits.

4. Ensure that nurse practitioners properly utilize their protocols and that nurse practitioners perform their roles as defined in their operations manual to include collaborating with the attending physician and delivering medical care according to designed protocols.

5. Ensure that, consistent with federal regulations, medical notes and documentation are accurate, current, complete, and organized in a manner allowing relevant information to be quickly identified.

B. PSYCHIATRIC CARE

Bordeaux should ensure that the psychiatric care provided to its residents is adequate.

C. RESTORATIVE CARE

Bordeaux should ensure that each resident has an adequate restorative care program in place to maximize each resident's mobility, range of motion, and function. Specifically, Bordeaux should:

6. Individualize all resident care plans to meet specific resident needs, and revise care plans following any significant change in a resident's condition in a timely manner.

7. Develop and implement a continence program for each resident clinically in need of such a program and consistent with generally accepted professional standards of care.

D. WOUND CARE

Bordeaux should ensure that wounds are properly detected. In particular, Bordeaux should:

8. Require nursing assistants to report any areas of skin redness or breakdown to the charge nurse promptly.

9. Ensure that all direct care staff follow proper hand washing procedures, standard safety precautions, and aseptic or sterile techniques.

E. NUTRITIONAL MANAGEMENT

Bordeaux should ensure that it provides its residents with a nourishing, palatable, well-balanced diet that meets the needs of each resident. More particularly, Bordeaux should:

10. Develop and implement diet policies that provide practical guidelines for the facility's population. Diet policies should address the purpose, use, modification, preparation, and adequacy of all diets, including regular diets, therapeutic diets, texture-modified diets, and diets including the use of thickening agents.

11. Analyze the nutritional content of all meals to ensure nutritional adequacy and nutritive value. Develop a protocol to clarify that physicians are responsible for prescribing or changing residents' therapeutic diets.

12. Develop and implement a protocol for the use of texture modified diets, including initial evaluation as well as reevaluation of the use of a texture modified diet for individual residents.

13. Develop and implement a comprehensive nutritional assessment for each resident which incorporates an evaluation of oral motor ability, feeding skills, and biochemical and clinical markers. This comprehensive nutritional assessment should be conducted within 72 hours of admission, or immediately upon admission for medically frail residents. The assessment should be part of each resident's care plan and should be updated as necessary to address changes in a resident's nutritional status, and should address drug-nutrient interactions.

14. Develop and implement an appropriate form for tracking and monitoring toileting patterns and train staff on its use.

15. Devise and implement protocols regarding the prevention and management of dysphagia. At a minimum, the protocol should provide instruction regarding: (a) methods to encourage safe consumption of food and liquids, (b) guidance on symptoms to identify residents who are experiencing problems with oral motor difficulties, (c) the use of thickening

agents, and (d) the recognition of feeding cues.

16. Provide competency-based training for staff to ensure safe mealtime assistance for residents with swallowing disorders and ensure periodic monitoring of staff. Ensure that residents' specific swallowing needs and individualized mealtime assistance instructions are available to staff who provide mealtime assistance.

17. Develop and implement a protocol to ensure adequate mealtime staffing, ensure that staff are properly trained on the feeding of individual residents, and address appropriate positioning before, during, and after mealtimes for residents who are assisted with meals in their wheelchairs or beds.

18. Evaluate residents to determine if they would benefit from the use of adaptive eating devices when clinically justified. Residents who use adaptive devices should receive periodic evaluations to monitor the continued efficacy of these utensils.

19. Ensure that kitchen staff follow appropriate sanitary procedures with an emphasis on hand washing and using gloves appropriately and consistently.

F. INCIDENT MANAGEMENT AND QUALITY ASSURANCE

Incidents involving injury and unusual incidents should be reliably and accurately reported and investigated, with appropriate follow up. In particular, Bordeaux should:

20. Require Incident Report forms to include an area for recommendations to prevent recurrence, and ensure that the recommendations are transferred to the residents' care plans for implementation.

21. Consistently implement individualized care plans for fall prevention and restraint reduction. Reassess and revise fall prevention and restraint reduction care plans as needed.

22. Assess the need for personal, bed, and chair alarms, especially for memory-impaired residents, and use when appropriate to prevent and reduce the incidence of falls.

G. RESIDENT RIGHTS

23. Bordeaux should develop and implement a policy and procedure to document advance care directives systematically such that a resident's decision to withhold or withdraw life-saving medical interventions is clearly evident from the resident's records. The advance care policy and procedure should include provisions for internal audits.

H. MOST INTEGRATED SETTING

24. Bordeaux should ensure that treatment professionals periodically and reliably assess residents to determine whether community placement is appropriate for any of them. If treatment in a more integrated setting is determined to be appropriate, then such treatment should be provided, if the affected person does not oppose such treatment and the placement can be reasonably accommodated.

* * * *

We hope to continue to work with the Metropolitan Government in an amicable and cooperative fashion to resolve our outstanding concerns regarding Bordeaux.

We will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses, and recommendations provide further elaboration of the relevant concerns and offer practical assistance in addressing them.

In the unexpected event that the parties 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 to otherwise protect the rights of Bordeaux residents, 49 days after the receipt of this letter. 42 U.S.C. § 1997b(a)(1). Accordingly, we will contact Metropolitan Government officials soon to discuss in more detail the measures that the Metropolitan Government must take to address the deficiencies identified herein.

Sincerely,

/s/ R. Alexander Acosta

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