October 21, 2002

Mr. Kenneth Brady
County Commissioner
Banks County
144 Yonah-Homer Road
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Mr. Harold Fletcher
Chairman
Jackson County Board of Commissioners
67 Athens Street
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The Honorable Charles Hardy
Mayor
City of Commerce
1642 South Broad Street
Commerce, Georgia 30529

Re: Investigation of Banks-Jackson-Commerce Medical Center and Nursing Home

Dear Gentlemen:

On June 20, 2001, we notified you that we were investigating conditions at the Banks-Jackson-Commerce Nursing Home and Medical Center ("BJC") in Commerce, Georgia, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. BJC, a public nursing home located in Commerce, Georgia, is operated by the Banks-Jackson-Commerce Hospital Authority on behalf of Banks County, Jackson County and the City of Commerce, Georgia. BJC is a component of the Banks-Jackson-Commerce Medical Center and Nursing Home. Our investigation is limited to the nursing home units of the facility. The nursing home cares for approximately 160 residents, the majority of whom are elderly. The nursing home is composed of five "units," two of which primarily house residents with dementia.

We conducted our investigation by reviewing facility records, including residents' medical charts and other documents relating to the care and treatment of BJC residents; interviewing administrators, staff and residents; and conducting on-site

reviews of the facility on September 6-8, and December 12-13, 2001, with expert consultants in addition to the Department of Justice ("DOJ") staff. During the course of the investigation, we were treated courteously by BJC administration and staff and we appreciate the cooperation extended to us, including the assistance of attorneys from Alston and Bird, LLP.

We have completed our review and, consistent with CRIPA's statutory requirements, we are writing to inform you of our findings. Based on our investigation, we conclude that conditions at BJC violate residents' constitutional and federal statutory rights. These violations include: failure to protect residents from harm; inadequate nutritional and hydration services; failure to provide adequate skin care to prevent pressure sores; failure to provide adequate restorative care, including continence, and physical and occupational therapy services; improper restraint usage, particularly the use of bedrails; inappropriate use of psychotropic medications; and failure to serve residents in the most integrated setting appropriate to their needs.

We set forth below the facts supporting our findings of unconstitutional and unlawful conditions and practices at BJC and the minimum measures that are necessary to remedy these deficiencies.

I. BJC IS FAILING TO ENSURE THE SAFETY OF ITS RESIDENTS

Individuals residing in publicly-operated nursing homes, such as BJC, have the constitutional right to live in reasonably safe conditions and to be provided the essentials of basic care. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). Federal statutes governing the operation of nursing homes 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. § 1351i-3; and their implementing regulations, 42 U.S.C. § 483 Subpart B. However, BJC is failing to ensure that residents are kept free from harm or unnecessary risk of harm.

A. Lack of Investigation of Injuries

During our review of facility documents, we came across several serious incidents where a resident had an injury and the cause was unknown. BJC did not conduct adequate investigations

of these events to determine how they occurred and the measures needed to prevent their recurrence or future injuries. For example, in March 2001, a resident was noted to have sustained large bruises to the right shoulder and rib cage from trauma that was unobserved. A BJC nurses' note to the State regulatory agency about the event stated that the bruising was the result of the resident's anemia. The resident, however, was not anemic at the time of the incident.

Moreover, BJC's Medical Director, or someone with similar authority, does not receive or review adequately incident reports. Thus, the Medical Director is not in a position to fulfill his responsibility to assure the health, safety and welfare of residents. 42 C.F.R. § 483.40.

B. Lack of Adequate Fall Prevention Program

BJC is not providing residents with a reasonable level of safety, by failing to protect residents adequately from the risk of falling. Falls, and the injuries that can result from falls, particularly fractures, pose a serious risk to elderly persons.

According to data provided by BJC for the six-month period of January through June, 2001, there was an average of over 26 falls per month at the nursing home. For a facility the size of BJC, this is an unduly high number. Even though the facility performs fall risk assessments on residents upon admission, these assessments are not updated after a resident suffers a fall. Nor are the assessments updated upon a significant change in a resident's condition, as required by the standards of care, see e.g., 42 C.F.R. 483.20(b)(4). Additionally, the preventative measures the nursing home does take are mostly ineffective. Our review revealed that for residents who repeatedly fell, the preventative interventions following a fall would often be limited to "encourage resident to call for assistance" or "monitor" the resident. Restraints, such as a "lap buddy" on a wheelchair (a device that fits like a tray over the arms of a wheelchair and prevents a person from standing up from the wheelchair), were too often the primary intervention for fall prevention.

For example, resident, H.U., fell 15 times in less than a three-month period during 2001. BJC's primary response to this resident's falling was to restrain the resident in a Geri-chair at a nurse's station, with a lap belt, or by sitting the resident in a straight chair in the lounge without adequate consideration

of less-restrictive but safe, fall prevention measures. In a ten-week period in 2001, resident, B.T., fell 19 times. Recommendations to prevent future falls, "monitor," "place in Geri-chair," "add table top to Geri-chair," were minimal and ineffective.

Resident M.H. fell on August 27, 2001, resulting in significant bruising to the forehead. According to BJC documentation, staff were alerted to the resident's room when they heard the resident yelling. Upon entering the room, staff found the resident lying on the floor with a large contusion to the forehead. The resident stated she had slipped on urine on the floor. The resident had no care plan in place for falls. An adequate investigation as to how the fall occurred was not done. There was no further information, as even required by BJC's own incident reporting procedures, to identify factors to prevent future falls.

A review of facility documents showed that toileting and residents' transferring in and out of bed are the most frequent circumstances for resident falls. Such occurences, coupled with the high number of falls, indicate that BJC does not have sufficient bowel and bladder training programs in place for residents; resident rooms are not safely maintained (i.e., clean, dry, and uncluttered); and staff are not adequately monitoring residents. Even though BJC had conducted in-service education for its staff on fall prevention, our review of records, documents, and interviews with staff revealed that staff were not sufficiently educated nor consistently implementing recommendations to reduce the incidence of falls and the injuries associated with falling.

Further, during our review of facility incident reports we noted numerous instances where residents were injured when staff were assisting them in and out of bed or in and out of a wheelchair. There is either not enough staff to perform such transfers safely or the staff in place has not been trained adequately in the proper techniques of transferring residents.

Our investigation has revealed that residents of the nursing home have suffered harm because of the facility's failure to provide adequate supervision of residents. On numerous occasions, incident reports describe residents as being "found" by staff or other residents after suffering injuries from falling out of their beds or wheelchairs. For example, shortly before our arrival at BJC in September, 2001, a resident in a wheelchair

was seriously injured when she was allowed to wheel herself unsupervised out the front door of the facility, crashed into a sidewalk curb, overturned, and fell from her wheelchair.

II. BJC FAILS TO PROVIDE ITS RESIDENTS WITH ADEQUATE NURSING AND MEDICAL CARE.

Residents of publicly operated nursing homes, such as BJC, have a constitutional right to adequate health care. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982); see also 42 U.S.C. § 1396r(b)(4)(A); 42 U.S.C. § 1395i-3(b)(4)(A)(facility must provide for medical, nursing, and specialized rehabilitative services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"). As set forth below, BJC is failing to provide its residents with adequate health care services, including nursing, medical and restorative care.

A. Inadequate Medical and Nursing Care

The medical staff at BJC is not monitoring the health status of nursing home residents adequately and is failing to ensure that residents receive the level of medical care to which they are entitled.

Our review of the files of current and former BJC residents, revealed several deficiencies. Many progress notes appeared to be "rubber stamped." Further, progress notes would often bear little or no relationship to the actual condition of the resident. For example, in May, 2001, a resident was admitted to BJC's acute care hospital with acute pulmonary edema, yet subsequent progress notes by the physician assistant states that the resident had "no serious problems" during this time. Subsequent notes continued to document inadequately the residents' health status. Two months later, the resident was again admitted to the hospital with acute pulmonary edema.

BJC residents are not provided with adequate, individualized care plans that address their needs. Care plans are not individualized as initially written; nor are they updated upon a significant change in a resident's condition as required by federal regulations and the standard of care. In addition, care plans lacked sufficient detail to properly direct nursing staff in rendering resident care. Thus, nursing-related interventions often were not timely implemented by nursing staff or evaluated adequately. For example, as noted below, while BJC generally

provides adequate treatment for pressure sores, proper planning for skin care, and the interventions that result therefrom, would prevent the initial occurrence of most pressures sores. The lack of effective care planning directly results in many of the deficiencies in care occurring at BJC.

B. Restorative Care

Restorative nursing care is designed to promote resident independence in areas such as feeding, bathing, toileting, continence, and moving and positioning. Restorative nursing is essential in order for residents to attain and maintain their highest practicable physical, mental, and psychological well-being as required by federal regulations. See 42 C.F.R. § 483.25.

BJC does not have an adequate restorative care program. Due in part to the lack of nursing and therapy department staff, BJC does not adequately prevent contractures (i.e., permanent muscular contraction) that could be prevented with adequate restorative services. See 42 C.F.R. § 483.25(e). There is only one staff member dedicated to restorative nursing care. Even though BJC's physical or occupational therapy staff might recommend therapies to prevent contractures, such as range of motion interventions, there is not enough staff to implement these recommendations and as a result, BJC residents have developed otherwise avoidable contractures. The lack of an adequate restorative care program also negatively impacts on BJC's ability to prevent pressure sores.

BJC is also not making an adequate effort to restore residents to continence. See 42 C.F.R. § 483.25(d)(2). Despite almost two-thirds of BJC's residents being reported as incontinent of bladder and over half being incontinent of bowel, it was reported to us by BJC staff that only those residents able to report to staff their need for toileting were placed on bowel or bladder training. The absence of sufficiently intense continence programs for residents is a serious failing at BJC, especially when combined with the absence of adequate restorative care. This failing may also be partly responsible for the undue prevalence of urine odors we noted as we toured BJC.

C. Inadequate Pressure Sore Prevention and Care

BJC is failing to ensure that residents do not develop clinically avoidable pressure sores, as federal regulations

require. See 42 C.F.R. §483.25(c)(1-2). While BJC generally provides adequate treatment for pressures sores once they occur, there is an absence of individualized programs designed to prevent pressure sores. Of the 22 residents who had pressure sores at the time of our visit, 16 of those residents developed their pressure sores while at BJC. The facility fails to ensure that residents who need turning and positioning to prevent pressures sores are turned and repositioned as needed.

Further, we noted certain conditions and practices that are likely to lead to the development of skin breakdown or to prevent timely healing of skin sores. For example, one BJC resident had to be admitted to a hospital with an infected bilateral hip pressure sore. A review of this resident's chart revealed that, when staff positioned the resident, the staff would use a technique called "log-rolling" that can actually cause further shearing of the wound and reduce blood supply to the underlying tissues of the wound.

We also noted instances where the bedding on residents' mattresses would be wrinkled in such a way as to form areas of undue pressure on residents' skin, thereby increasing the likelihood of pressure sore development.

BJC's failure to provide adequate care for pressure sores is exacerbated by the fact that BJC does not maintain consistent records for monitoring pressure sores. For example, for one resident, notes stated that a pressure sore was "healing." When our physician observed the resident, however, the sore did not appear to be healing but was instead still very active and appeared to be causing significant pain to the resident.

A major reason for many of the deficiencies cited above lies with the fact that the BJC nursing staff is not performing in a manner consistent with current standards of practice. Nursing staff have not been educated adequately in key areas of nursing practices, such as physical assessment, care plan development, implementation of interventions and monitoring of resident outcomes.

A further factor that has negatively impacted resident care was the nursing home's over-reliance on the use of temporary or "agency" staff. Such staff are often unfamiliar with the individual needs of residents. During our December, 2001 visit to BJC we were informed that the nursing home had decreased its reliance on agency personnel. Further efforts to stabilize the

nursing staff would be helpful.

Exacerbating the above-cited problems is the fact that the nursing department at BJC does not have adequate quality assurance mechanisms in place. Adequate quality assurance functions, performed by appropriately educated staff, would significantly aide BJC staff in identifying and correcting quality of care issues. Many negative outcomes suffered by BJC residents could be ameliorated if such mechanisms were in place to address issues before they became serious problems for the residents.

III. BJC'S RESTRAINT PRACTICES VIOLATE PROFESSIONAL STANDARDS OF CARE

Nursing home residents have constitutional and federal statutory rights to be free from restraints imposed for the convenience of staff or without medical justification. Youngberg v. Romeo, 457 U.S. 307 (1982); 42 U.S.C. § 1396r(c)(1)(A)(ii). Professional standards of practice and federal regulations require facilities to demonstrate a specific medical symptom that requires the use of restraints, rather than imposing them for discipline or convenience. 42 C.F.R. § 483.13(a). BJC uses restraints on its residents in violation of these standards and in ways that threaten the health and safety of residents.

BJC uses bedrail restraints without adequate medical justification. During our September visit to BJC, we toured the nursing home units late at night and noticed a high percentage of residents in their beds with the bedrails in the up position. Moreover, we noted instances in which, in response to a resident's behavior, BJC staff would put the resident into bed and raise the bedrails.

BJC's use of bedrails as restraints is not in keeping with federal regulations. 42 C.F.R. § 483.13(a). Risks associated with bedrail use in nursing homes include the increased likelihood of harm and injury when residents attempt to exit their beds over the bedrails, causing skin tears and falls. Prolonged bedrail use, and the loss of mobility that results from such use, can have negative, long-term effects on residents such an increased muscle and skeletal weakness. Moreover, bedrails should not be used for the convenience of staff.

BJC also fails to consider adequate alternatives to restraints, especially when the restraint, usually bedrails, were used by the facility ostensibly as a positioning "enabler."

Positioning devices, such as foam wedges, that can be used in the place of bedrails, often were not used or were used inappropriately.

IV. BJC IS FAILING TO PROVIDE ITS RESIDENTS WITH ADEQUATE NUTRITIONAL AND HYDRATION SERVICES

Nursing homes such as BJC are required by federal regulation to provide residents with adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 C.F.R. § 483.25(i-j). BJC is failing to ensure that residents receive adequate nutritional services.

During our visit to BJC, we watched several mealtimes on various units, observing the quality and quantity of the food that was served. We noted that, while adequate portions of food were being served, residents often ate very little of what was presented to them and no alternatives or substitutes were offered. A primary cause for this failing is that BJC does not have a sufficient number of adequately educated staff to assist residents with eating and drinking. One daughter of a BJC resident told us she pays an individual to come into the nursing home to make sure her mother gets fed adequately.

BJC's failure to provide adequate hydration and monitoring of residents' hydration status creates numerous health risks for residents, and is having serious consequences. A review of records concerning residents who died or were admitted to the emergency room during 2001 revealed that numerous residents were hospitalized for conditions related to lack of adequate hydration. Hospitalizations included almost 50 residents suffering from urinary tract infections, as well as admissions for treatment of dehydration, urosepsis and fecal impaction. The occurrence of such illnesses indicate inadequate fluid intake by residents.

V. PSYCHIATRIC, PSYCHOLOGICAL AND PSYCHO-SOCIAL SERVICES AT BJC VIOLATE PROFESSIONAL STANDARDS

BJC fails to provide adequate psychiatric services, particularly with regard to the oversight of psychotropic medication, and to provide residents with adequate psychological services and other activities to maintain residents' mental well-being.

Federal regulations require nursing home residents to be

free from unnecessary anti-psychotic medication. 42 C.F.R. § 483.25(l)(1). An unnecessary medication is any medication that is: excessive in dose; excessive in duration; without adequate monitoring or indication for use; in the presence of adverse consequences, indicating that the medication should be reduced or discontinued; or without specific target symptoms. Id. Federal law also requires that residents receive gradual dose reductions and unless contraindicated, behavioral interventions aimed at reducing medication use. 42 C.F.R. § 483.25(l)(2)(ii). Our review of psychiatric medication practices at BJC saw many of these mandates being violated.

For example, we noted several cases in which long-acting benzodiazepines, notably Diazapam (Valium), were prescribed on both a regular basis and on a PRN ("as needed") basis. As we examined them, these combinations were being used in excess of professional standards. We came across one resident who had been prescribed two doses of Valium a day continuously for almost six years. These medications were often given to residents, not to address a psychiatric need, but rather for "agitation." When used in such a manner, these medications amount to an improper chemical restraint.

Further, we also identified occasions where other sedatives were used on a regular basis for weeks or months at a time. For example, we noted one resident had been prescribed Ambien (a medication with strong sedating effects) for more than two consecutive years and another who had Ambien prescribed for almost as long. In both cases, there were duplicate orders with overlapping starting and ending dates.

We also noted several instances of the inappropriate use of Amitriptyline (Elavil), a psychotropic medication with potentially serious side effects, including over-sedation, which can be particularly troublesome for the elderly. We found residents who had been on this medication for months at a time, and even years at a time, including one resident who had this medication prescribed for over seven years. We also found instances of residents who had been on Thioridazine (Mellaril), another heavily-sedating anti-psychotic medication for undue lengths of time including one resident who had been taking the medication for two years and another for three. Thioridazine has been reported in studies as having a significant incidence of sudden death associated with its use and is a poor choice for use in the elderly.

Exacerbating these problems is the fact that there is insufficient psychiatric consultation and oversight of medication use at BJC. A local psychiatrist visits BJC, but only on a quarterly basis. He does not have regular contact with the medical staff. Further, BJC medical staff infrequently request a psychiatric consultation for a resident when such a consultation is indicated.

BJC also fails to provide adequate care for the psychological and psycho-social needs of its residents with depression. Approximately 60 residents at BJC have a diagnosis of depression, yet the facility fails to provide group or individual counseling, or other activities designed to treat depression.

Further, federal regulations recognize the critical importance that activities and mental stimulation play in maintaining good psychological health among nursing home residents. See, e.g., 42 C.F.R. § 483.15(f)(a)("facility must provide for an ongoing program of activities designed to meet... the interests and the physical, mental, and psychosocial well-being of each resident"). BJC fails to provide an adequate range and schedule of activities necessary to meet the needs of its residents. For example, when we reviewed the activity schedules of residents, we noticed that there would often be gaps of several days without any scheduled activity.

VI. FAILURE TO PROVIDE SERVICES IN THE MOST INTEGRATED SETTING APPROPRIATE TO RESIDENTS' NEEDS

Finally, based on our tours of the facility and our review of residents' records, it appeared that some BJC residents could be served more appropriately in community-based placements. Failure to serve those residents in the most integrated setting appropriate to their needs is a violation of Title II of the Americans with Disabilities Act of 1990. See 42 C.F.R. § 35.139(J)(public entities must provide services in the most integrated setting appropriate to the needs of the individual).

VII. MINIMAL REMEDIAL MEASURES

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

1. Provide a safe environment for its residents. BJC must

institute policies, procedures and practices to investigate adequately, and follow-up on, instances of potential resident abuse, neglect and/or mistreatment, including injuries resulting from unknown causes. As an element of these practices, the BJC Medical Director should review all incident reports and initiate any appropriate administrative or clinical action. BJC must follow state and federal regulations on reporting injuries and incidents to state authorities.

2. Provide each resident with adequate medical and nursing care, including appropriate and on-going assessments, individualized care plans, and health care interventions to protect the resident's health and safety. To accomplish this, BJC should:

a. Ensure that each resident's health status is adequately monitored and reviewed, and that changes in a resident's health status are addressed in a timely manner.

b. Ensure that all BJC nursing staff members are adequately trained in current standards of practice and that policies are updated and the staff is trained on those policies.

c. Provide effective preventive systems for pressure sores and provide adequate care for residents with pressure sores.

d. Design and implement appropriate interventions to prevent falls once a resident is assessed at being at risk for a fall, and re-evaluate those interventions as necessary.

e. Up-grade and expand restorative care services in order to allow residents to attain and maintain their highest practicable level of functioning. At a minimum, this would include:

i. Providing bowel and bladder training for all incontinent residents who could reasonably benefit from such training.

ii. Providing adequate range of motion exercises for all residents at risk for contractures.

iii. Providing proper therapeutic devices and positioning for residents with contractures in accordance with professional judgment.

f. Employ and deploy a sufficient number of consistent nursing staff to provide adequate supervision, routine care, preventative care, and treatment to each BJC resident.

3. Maintain a clean and reasonably odor-free environment.

4. Ensure that BJC uses bodily restraints, specifically bedrails, only pursuant to accepted professional standards and federal law and that restraints are never used for the convenience of staff. Prior to restraint application, residents must receive a comprehensive assessment of the appropriateness of the restraint. Residents with bedrails in place must be monitored adequately to ensure the bedrails pose no undue risks to the residents' safety. The facility should ensure that staff monitor restraint use in accordance with professional standards of practice and federal law, and re-evaluate the continued use of restraints on a timely, periodic basis.

5. Provide adequate nutritional management services, including:

a. conducting adequate nutritional assessments of individual residents' specific nutritional needs;

b. ensuring that residents receive appropriate diets;

c. monitoring resident's nutritional status, weight and food intake;

d. ensuring that residents who need assistance in eating are assisted by adequately trained staff; and

e. providing residents with adequate amounts of fluids to ensure proper hydration.

6. Provide sufficient, meaningful activities for all residents and make efforts to get residents involved in activities, including counseling for residents who require psycho-social services to address issues such as depression or other psychiatric disorders.

7. Psychopharmacological practices must comport with generally accepted professional standards. All use of drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Medications should be prescribed based on clinical need.

8. Psychopharmacological practices, including the use of antipsychotics, medication combinations, PRN orders and the prescription of benzodiazepines, must be revised to comport with accepted professional standards.

9. Provide adequate and appropriate psychiatric and mental health services in accordance with generally accepted professional standards.

10. Improve the education program at BJC for medical and nursing staff in the evaluation, diagnosis and treatment for residents with psychiatric and/or behavioral problems.

11. Implement adequate quality assurance mechanisms that are capable of identifying and remedying resident quality of care deficiencies.

12. BJC, the Hospital Authority, the Counties of Banks and Jackson, and the City of Commerce should explore options for identifying and placing those residents who could be served appropriately in community settings into such settings.

Under separate cover, we will send your counsel our expert consultants' reports. Although the expert consultants' reports and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you, and we have every confidence that we will be able to do so.

We look forward to meeting with you and BJC staff to develop solutions to the noted deficiencies. The attorneys assigned to this matter will be contacting counsel representing BJC in the

near future to discuss this matter in further detail.

Sincerely,

/s/ Ralph F. Boyd, Jr.

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