Memorandum

LK:AEP:RJF:TED:ph
DJ 168-33-106

Subject	Date
Recommendation to Investigate Pinecrest Developmental Center Pineville, Louisiana	SEP 19 1994

To Deval L. Patrick
Assistant Attorney General
Civil Rights Division

From Arthur E. Peabody, Jr.
Chief
Special Litigation Section

INTRODUCTION

We recommend that the Department initiate an investigation into the conditions of confinement at the Pinecrest Developmental Center ("Pinecrest") in Pineville, Louisiana, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. Pinecrest is the largest state-operated institution for the developmentally disabled in Louisiana.[1]/

Residents of state operated facilities for the developmentally disabled and mentally retarded have a fundamental Fourteenth Amendment due process right to reasonable safety, adequate medical care and training. Youngberg v. Romeo, 457 U.S. 307 (1982). Such training must be sufficient to protect each resident's liberty interests and permit each resident an opportunity to function as independently as their individual handicapping conditions permit. See, e.g., Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D.N.C. 1988); United States v. Tennessee, No. 92-2062, slip op. at 12 (W.D. Tenn. Feb. 17, 1994); Halderman v. Pennhurst State School & Hospital, No. 74-1345, slip op. (E.D. Pa. March 29, 1994). See also 42 C.F.R. § 483.440.

Information we have obtained indicates that residents of Pinecrest are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights.

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[1]/ In the near future, we intend to expand our investigation in Louisiana to include other large state-run facilities for the developmentally disabled, most notably Hammond Developmental Center, the second largest such institution in the state. We have already learned, for example, that the adequacy of active treatment at Hammond is suspect and that there may be an unduly low number of staff physicians working there calling into question the adequacy of medical coverage.

Alleged unconstitutional conditions include abuse and neglect of residents, inadequate medical and psychiatric care, and failure to provide residents with adequate training. Such deficiencies subject residents at Pinecrest to unreasonable risks to their personal safety and violate their constitutional rights. In addition, Pinecrest is a large and isolated institution which unduly segregates its residents from the rest of society solely on the basis of their disabilities. As a result, the facility is failing to provide services to its residents in the least separate, most integrated setting as required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq.

POSSIBLE VIOLATIONS

A. The State of Louisiana Fails to Provide Pinecrest Residents with Services in the Least Separate, Most Integrated Setting.

An isolated, self-contained, institutional environment which separates residents from the rest of society on the basis of their disabilities, necessarily subjects these individuals to conditions which are violative of the ADA and Section 504. Nonetheless, Louisiana continues to house an inordinately large number of its disabled population in large congregate facilities. In fact, Louisiana has the third largest institutionalized developmentally disabled population in the United States.[2]/ We have targeted Pinecrest Developmental Center because it is by far the largest such institution in the state, currently housing over 1350 individuals with developmental disabilities. This is nearly as many residents as live in all the other such Louisiana state facilities combined.[3]/

Even though Louisiana has an extremely large developmentally disabled population, the state ranks at or near the bottom of national rankings in terms of expenditures for community services.[4]/ Contrary to national trends, the number of

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[2]/ Developmental Disabilities Study (Draft) (Louisiana Advocacy Center for the Elderly), March 21, 1994, at 4.

[3]/ The census in each of the nine Louisiana state facilities for the developmentally disabled breaks down as follows: Pinecrest 1,364; Hammond 500; Metropolitan 348; Northwest 265; Ruston 130; Southwest 120; Peltier-Lawless 45; Columbia 26; and Leesville 20. Telephone Interview with Lois Simpson, Director, Louisiana Advocacy Center for the Elderly (May 11, 1994).

[4]/ Developmental Disabilities Study (Draft) (Louisiana Advocacy Center for the Elderly), March 21, 1994, at 5.

developmentally disabled individuals living in Louisiana institutions has risen dramatically in recent years. For example, between 1977 and 1992, the number of Louisiana residents served in certified ICF/MR facilities grew by approximately 74 percent, while the number nationwide has decreased by 3 percent.[5]/ This increase is attributable to Louisiana's failure to sufficiently de-institutionalize developmentally disabled persons by providing supports for them within the community and expand community based services.[6]/ Louisiana has taken virtually no steps to reduce its institutionalized developmentally disabled population.[7]/ Even when Louisiana places an individual out of a facility and into the community, the state fills the vacancy in the institution with another disabled person.[8]/

Pinecrest is no exception. As is true in the rest of Louisiana, the state has failed to provide Pinecrest residents with needed placements in a community setting. Community providers report that the number of referrals received from Pinecrest has declined over the last few years.[9]/ Contrary to generally accepted thinking in the field, the mindset of the professional and administrative staff at Pinecrest is that only those with mild or moderate disabilities are suitable for placement.[10]/ As a result, many Pinecrest residents who are suitable for community placement continue to be isolated from the rest of society. Not only does the segregation violate the residents' statutory rights, the care and treatment afforded them in the institution does not rise to the level provided elsewhere in the community. According to one provider, Pinecrest residents do not receive the "same quality of care people living in the community receive."[11]/

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[5]/ Id. at 3.

[6]/ Id. at 4.

[7]/ Telephone Interview with L. Simpson.

[8]/ Id.

[9]/ Telephone Interview with Kathy Thomas, Division Director, Evergreen Presbyterian Ministry (July 24, 1994).

[10]/ Id.

[11]/ Id.

B. The State Fails to Ensure that Pinecrest Residents are Free from Abuse and Neglect.

Several residents have been the victims of recent abuse at Pinecrest. For example, in June 1994, the mother of a twenty-three year old resident began picketing in front of Pinecrest to protest the abusive treatment of her son.[12]/ A staff person had allegedly slapped and choked him.[13]/

In January 1994, the family of a male resident, R.T., removed him from Pinecrest when an investigation concluded that he had been abused by a staff member.[14]/ The investigation revealed that two months earlier, R.T. had suffered significant bruises on his upper right side, right arm, lower left side, and shoulder. R.T. had already incurred many other serious injuries during his stay at Pinecrest. In 1991 alone, R.T. suffered a fracture to his right ankle, collarbone, and humerus.[15]/ In that year he also suffered from reported rashes on his back, scrotal area, and face.[16]/ In 1992, R.T. experienced seven falls.[17]/ He also suffered from more bruises and rashes.[18]/

Pinecrest staff have also subjected residents to neglect. For example, last year, a Pinecrest aide transported a non-ambulatory resident to a local charitable hospital for a series of gastrointestinal tests.[19]/ However, upon completion of the testing, the Pinecrest staff completely neglected to pick up the resident. It was not until dinner time that the staff even

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[12]/ Id.; Telephone interview with P.Z., mother of Pinecrest resident (Aug. 9, 1994).

[13]/ Id.

[14]/ Memorandum from Travis Randles, HSW Program Office, Alexandria Health Standards, to Lily McCalister, Manager, Health Standards Section, State of Louisiana Department of Health and Hospitals (Feb. 17, 1994).

[15]/ Interdisciplinary Team Annual Report and Individual Program Plan for R.T. (May 21, 1992) at 4.

[16]/ Id. at 5.

[17]/ Interdisciplinary Team Annual Report and Individual Program Plan for R.T. (April 8, 1993) at 6.

[18]/ Id. at 5.

[19]/ Telephone Interview with P.Z.

realized the resident was missing.[20]/ By this time, the resident had "disappeared."[21]/ Even though the Pineville police conducted a search and an investigation, the resident still has not been located.[22]/ This form of gross neglect would imperil any resident's health and well-being, but it is especially true in this case where the individual suffered from seizures and had limited vision.[23]/

Finally, the mother of a male resident who has lived at Pinecrest since 1975 reported that several years ago, an aide dropped her son causing him to fall against a dresser knocking out his two front teeth.[24]/ Despite his mother's request, Pinecrest has neglected to provide this man with adequate restorative dental care. She also reported that her son, who is nonambulatory and nonverbal, regularly develops rashes.[25]/ This example of an individual with recurring rashes, and the case of R.T. who also suffered from rashes, indicate a strong likelihood that decubiti routinely develops at the facility due to staff neglect.

Traditional oversight and monitoring of such abuse and neglect is often missing at Pinecrest. Because Pinecrest is located in an isolated, rural area in central Louisiana, it has gone largely unmonitored by local advocacy groups such as Protection and Advocacy, which does not have an office in the area.[26]/ Further, parental oversight is not always present given that many parents live hundreds of miles away from the facility.[27]/

C. The State Fails to Provide Pinecrest Residents with Adequate Medical Care.

Surveyors enforcing the Title XIX regulations have repeatedly cited Pinecrest for its failure to provide adequate medical care for its residents. Specifically, Pinecrest fails to

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[20]/ Id.

[21]/ Telephone Interview with K. Thomas.

[22]/ Id.; Telephone Interview with P.Z.

[23]/ Telephone Interview with P.Z.

[24]/ Id.

[25]/ Id.

[26]/ Telephone Interview with L. Simpson.

[27]/ Id.

fully evaluate the nutritional status of tube-fed clients.[28]/ Pinecrest staff do not monitor the specific nutritional intake needs (i.e., calories, protein, fluid) of its tube-fed residents.[29]/ Pinecrest staff also fail to recommend vitamin or mineral supplements for tube-fed residents whose intakes fall substantially below the recommended daily allowances.[30]/ Obviously, this deficiency places the health and well-being of the tube-fed residents at risk.

For residents receiving dialysis, Pinecrest fails to fully coordinate their nutritional care with the dialysis center. When the dialysis center orders diet changes, adjustments of protein content, or renal shakes, the staff at Pinecrest often fail to implement these orders.[31]/ In addition, staff fail to maintain fluid intake records,[32]/ and fail to include fluid restrictions in nutritional assessments for residents with fluid limitations.[33]/ Inadequate management of nutritional status can lead to malnourishment or dehydration.

We have also received information indicating that some residents are being harmed at mealtimes by inappropriate feeding techniques.[34]/ For example, the surveyors cited Pinecrest for administering tube feedings to residents lying in bed.[35]/ This is usually a very dangerous practice placing the residents at great risk of aspirating.

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[28]/ Health Care Financing Administration ("HCFA") Statement of Deficiencies and Plan of Correction (March 25, 1994) at 7.

[29]/ Id.

[30]/ Id. at 7-8.

[31]/ Id. at 8; see also HCFA Statement of Deficiencies and Plan of Correction (March 20, 1992) at 16.

[32]/ HCFA Statement of Deficiencies and Plan of Correction (March 25, 1994) at 8.

[33]/ HCFA Statement of Deficiencies and Plan of Correction (March 20, 1992) at 16.

[34]/ HCFA Statement of Deficiencies and Plan of Correction (March 25, 1991) at 1.

[35]/ Id.

When R.T. was at Pinecrest, he would occasionally gag when being spoon fed at the evening meal.[36]/ The attendant would then completely discontinue feeding him.[37]/ A repeated pattern of this form of staff response to a client's meal refusal could lead to significant weight loss. In fact, at the time of his discharge in 1994, R.T. was over twenty-six pounds below his recommended body weight.[38]/ He also suffered from frequent episodes of constipation.[39]/

Community providers also report that many residents leave Pinecrest with serious medical conditions that went undiagnosed during their stay. Several residents were released from Pinecrest carrying the Hepatitis B virus.[40]/ Another former resident was subsequently diagnosed as a "brittle diabetic."[41]/

In addition, Pinecrest has failed to provide its residents with adequate physical therapy. A significant number of residents who live in the medical unit suffer from severe contractures.[42]/ One resident has been diagnosed with a condition which will eventually result in his hip detaching from its socket. He needs intensive physical therapy but is not receiving it at Pinecrest.[43]/ The physical therapist at Pinecrest reportedly told the resident's parents that she did not have the time to provide the therapy required because of insufficient staff.[44]/

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[36]/ Interdisciplinary Team Annual Report and Individual Program Plan for R.T. (April 8, 1993) at 7.

[37]/ Id.

[38]/ Id.

[39]/ Id. at 5.

[40]/ Telephone interview with K. Thomas; see also HCFA Statement of Deficiencies and Plan of Correction (March 20, 1992) at 12; HCFA Statement of Deficiencies and Plan of Correction (March 15, 1993) at 2-3 (citing Pinecrest for deficiencies in its infection control plan).

[41]/ Telephone Interview K. Thomas.

[42]/ Id.

[43]/ Telephone Interview with P.Z.

[44]/ Id.

D. The State Fails to Ensure Appropriate Use of Psychotropic Medication at Pinecrest.

The manner in which Pinecrest administers psychotropic medication is seriously deficient. Pinecrest staff routinely administer psychotropic medication to residents with maladaptive behaviors before the staff develops and implements an individualized behavioral program for the person.[45]/ We have reason to believe that, contrary to generally accepted standards in the field, it is quite common for residents to receive psychotropic medication without first being provided with an individualized behavior program.[46]/

In addition, the surveyors have cited Pinecrest for failing to ensure that psychotropic medications used to control inappropriate behaviors are used only after determining that the harmful effects of behavior clearly outweigh the potential harmful side effects of the drugs.[47]/ For example, Pinecrest gave one resident Ativan for three days in the absence of any documentation of a behavioral problem before or during the administration of this drug.[48]/ As a result, surveyors called the drug's administration "an unnecessary" chemical restraint.[49]/

Further, Pinecrest has administered psychotropic medication without obtaining informed consents from legal guardians, or review and approval by the human rights committee or interdisciplinary team.[50]/

E. The State Fails to Provide Adequate Programming to Pinecrest Residents.

The residents at Pinecrest are also not receiving adequate training that will help to abate or eliminate their serious maladaptive behaviors. Even when residents have been provided

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[45]/ HCFA Statement of Deficiencies and Plan of Correction (March 20, 1992) at 8; Telephone Interview with K. Thomas.

[46]/ Telephone Interview with K. Thomas.

[47]/ HCFA Statement of Deficiencies and Plan of Correction (March 25, 1994) at 9.

[48]/ Id.

[49]/ Id.

[50]/ Telephone Interview with K. Thomas; HCFA Statement of Deficiencies and Plan of Correction (March 25, 1994), Attachment, "Significant Findings."

residents. For example, when R.T. entered the facility at the age of eleven, he was able to walk unassisted.[59]/ He left Pinecrest at the age of 23 confined to a wheelchair.[60]/

Pinecrest has also failed to document the accomplishment of objectives specified in individual client programs in measurable terms.[61]/ Surveyors found that staff members scored objectives inaccurately, subjectively, or from memory.[62]/ Staff members also fail to progress the accomplishment of objectives in a timely manner.[63]/ As a result, many residents continue to be trained on objectives that have been met.[64]/

CONCLUSION

The information gathered thus far indicates that the inadequate conditions at Pinecrest deprive residents of their constitutional and statutory rights. We therefore recommend that an investigation of Pinecrest be instituted under our CRIPA authority. Funds are available to conduct this investigation.

Approved: 

Disapproved: _____

Comments:

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[59]/ "Summary to Staff" on R.T. prepared by Dr. L.J. Credeur (February 15, 1980).

[60]/ "Discharge Summary" on R.T. prepared by Mary DeKeyzer, Social Service Coordinator, Louisiana OMR/DD (January 13, 1994).

[61]/ HCFA Statement of Deficiencies and Plans of Correction (March 20, 1992) at 6.

[62]/ Id.

[63]/ HCFA Statement of Deficiencies and Plan of Correction (March 25, 1994) at 3.

[64]/ Id.; HCFA Statement of Deficiencies and Plan of Correction (March 20, 1992) at 4.

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

OCT 12 1994

The Honorable Edwin W. Edwards
Governor of Louisiana
State Capitol
P.O. Box 94004
Baton Rouge, LA 70804-9004

Re: Investigation of Pinecrest Developmental Center in Pineville, Louisiana

Dear Governor Edwards:

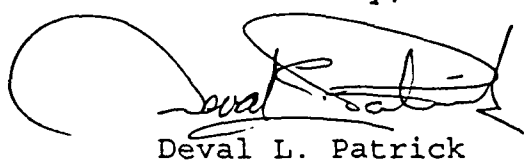
I am writing to inform you of our intention to investigate conditions at Pinecrest Developmental Center ("Pinecrest") in Pineville, Louisiana. This investigation is conducted pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq.

The purpose of the investigation will be to determine whether conditions at Pinecrest violate the residents' federal constitutional and statutory rights. We will be looking at, among other things, resident safety, the adequacy of medical care, training, staffing, the use of psychotropic medication, and issues involving community placement. The initiation of this investigation does not indicate a prejudgment on our part that federal rights have been violated. Additionally, if any violations are found, we intend to confer with you and your staff concerning any appropriate corrective action.

We would like to initiate this investigation as soon as possible. In that regard, attorneys from my office will contact your staff within the next week to arrange a tour of Pinecrest by our consultants and Civil Rights Division personnel. The attorneys responsible for this matter are Tawana Davis, (202) 514-6534, and Richard Farano, (202) 307-3116.

Thank you for your cooperation.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: The Honorable Richard P. Ieyoub
Attorney General
State of Louisiana

The Honorable Rose V. Forrest
Secretary
Health and Hospitals Department

Mr. Edwin Wright
Administrator
Pinecrest Developmental Center

Michael D. Skinner, Esquire
United States Attorney
Western District of Louisiana

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

OCT 12 1994

The Honorable Richard Riley
Secretary
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, D.C. 20202-0100

Re: Investigation of Pinecrest Developmental Center
Pineville, Louisiana

Dear Secretary Riley:

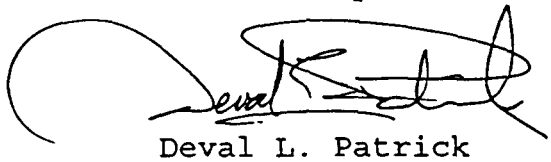
I wish to advise you, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997h, of our intent to investigate Pinecrest Developmental Center ("Pinecrest") in Pineville, Louisiana.

We have received information that calls into question the constitutionality of the conditions at Pinecrest. If you have received any complaints regarding this facility, please advise us. As well, if this facility is serving children and information is available regarding compliance with the Individuals with Disabilities Education Act, we would appreciate receiving such information.

We will cooperate fully with your Department in this matter and will consult with you regarding the status of our investigation. The attorneys assigned to handle this investigation are Tawana Davis, (202) 514-6534, and Richard Farano, (202) 307-3116.

Thank you for your assistance.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Ms. Judith E. Heumann
Assistant Secretary
Office of Special Education and
Rehabilitative Services

Mr. Tom Hehir
Director
Office of Special Education Programs

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

OCT 12 1994

The Honorable Donna E. Shalala
Secretary
U.S. Department of Health
and Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201

Re: Investigation of Pinecrest Developmental Center
Pineville, Louisiana

Dear Madam Secretary:

I wish to advise you, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997h, of our intent to investigate Pinecrest Developmental Center ("Pinecrest") in Pineville, Louisiana.

We have received information that calls into question the constitutionality of the conditions at Pinecrest. If you have received any complaints regarding this facility or have any other information you believe would be helpful in the conduct of this investigation, please advise us. We understand that this facility is fully certified for participation in the Medicaid program.

We will cooperate fully with your Department in this matter and will consult with you regarding the status of our investigation. The attorneys assigned to handle this investigation are Tawana Davis, (202) 514-6534, and Richard Farano, (202) 307-3116.

Thank you for your assistance.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Harriet Raab, Esquire
General Counsel

Bruce C. Vladeck, Ph.D.
Administrator
Health Care Financing Administration

Mr. Anthony J. Tirone
Director
Office of Survey & Certification
Health Standards Quality Bureau