**U.S. Department of Justice**

Civil Rights Division

*Assistant Attorney General*

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

July 14, 2004

The Honorable Sue Newton
County Judge
Baxter County Courthouse
1 East Seventh Street
Mountain Home, Arkansas 72653

Re: Baxter Manor Nursing Home

Dear Judge Newton:

On March 17, 2004, we notified you that we were initiating an investigation of conditions at the Baxter Manor Nursing Home ("Baxter Manor"), pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. Our investigation included an April 2004 tour of the facility with an expert consultant in nursing, review of policies, procedures and records, and interviews of staff and residents. We focused our inquiry on: use of restraints, protection from harm, restorative care, medical care, environment, and the provision of services to residents in the most integrated setting appropriate to their individualized needs. We held an exit interview on the last day of our tour in which we conveyed our preliminary findings to the Facility Administrator 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.

At the outset, we wish to acknowledge, and express our appreciation for, the cooperation and assistance provided to us, particularly by the Facility Administrator and staff. Further, we wish to note that it is apparent that many Baxter Manor staff members are dedicated individuals who are genuinely concerned for the well-being of persons in their care. We hope to work with your office and Baxter Manor staff in the same cooperative manner in the future.

## I. INTRODUCTION

Baxter Manor, a skilled nursing facility owned and operated by Baxter County, Arkansas, has a bed capacity of 81

beds; at the time of our tour, Baxter Manor's census was 40 residents. During our investigation, we evaluated whether residents of Baxter Manor have been afforded their constitutional and federal statutory rights. In undertaking any CRIPA investigation of a facility, our directive is to probe for the presence of a pattern or practice of "egregious or flagrant conditions which deprive [the residents of such facility] of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm." 42 U.S.C. § 1997a(a). It is well established under both the Constitution and federal law that residents of public nursing facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure not only their safety and freedom from unreasonable restraint, but also to prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); see also Heidemann v. Rother, 84 F.3d 1021 (8th Cir. 1996). Similar protections are accorded by federal statute. See Title XIX of the Social Security Act, 42 U.S.C. §§ 1396r, 1395hh; 42 C.F.R. Part 483 (Medicare and Medicaid Program Provisions). The County is also obligated to provide services in the most integrated setting appropriate to individual residents' needs. See Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.

## II. FINDINGS

As a nursing home, Baxter Manor 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). While many elements of care at Baxter Manor meet federal requirements, we identified several critical areas that do not. Baxter Manor does not provide levels of care consistent with federal law in the areas of: 1) restraint practices, 2) assessment and resident care, 3) physical environment, and 4) mealtime practices. Additionally, Baxter Manor's practices do not comply with the Americans with Disabilities Act.

### A. Improper Restraint Practices

Nursing home residents have the "right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms." 42 C.F.R. § 483.13(a). Similarly, generally accepted professional standards require that nursing home staff conduct assessments of risk factors for harm and

consider alternatives to restraints as part of the care planning process. Moreover, generally accepted professional practices dictate that restraints may only be used when it is clinically justified. Such justifications include situations where restraint is necessary: (i) to facilitate appropriately the provision of medical care; (ii) to control a resident's unanticipated violent or aggressive behavior that places either the resident or others in imminent danger; or (iii) as a last resort to provide safety when all other less restrictive methods have been attempted and failed.

Improper use of restraints can have disastrous consequences, including loss of function, depression, falls and injuries, loss of dignity, weight loss, pressure sores, serious injury, and even death. It was, therefore, a great cause of concern to us when we observed a significant number of residents with restraints whose medical charts in no way justified their use. If it is to adhere to well-established professional practices, Baxter Manor must conduct assessments of residents' fall risk factors and develop individualized care plans as alternatives to restraints. The facility also should continually reassess its use of restraints and attempt to eliminate or reduce them where appropriate. Finally, residents should be educated about the potential adverse effects of restraints, and staff should be trained on rights retained by residents subjected to restraints. See 42 C.F.R. §§ 483.10(b)(4), 483.20(k)(2).

Although Baxter Manor's written policies regarding mechanical restraint usage generally conform to federal regulatory requirements, actual practices do not consistently adhere to policy. Instead, mechanical and chemical restraints are utilized at Baxter Manor in ways that are a substantial departure from generally accepted professional standards.

**1. Use of Chemical Restraints**

Thirty-five percent of all Baxter Manor residents are currently on psychotropic medications. While use of such medications may be appropriate, their use must be clinically justified and the diagnostic basis for such use documented and routinely re-evaluated in a clinically appropriate manner. See id. § 483.25(1). Otherwise, the improper use of psychotropic drugs is a chemical restraint. Residents in a geriatric facility are especially vulnerable to harm associated with improper chemical restraints, such as a loss of cognitive and physical function and other medical complications.

Baxter Manor's use of psychotropics is a gross departure

from federal law. Baxter Manor's medical director stated that he was not aware of specific federal regulations that govern the use of medications in a nursing home. See id. § 483.25(l)(2). Baxter Manor has no protocol for anti-psychotic medication utilization. Many of the residents were prescribed psychotropic medications for ambiguous reasons such as "resisting care," "behaviors," or "calling out." Their charts did not adequately identify the target symptoms or the behaviors which might warrant the use of such medications.

Facility staff do not adequately consider psycho-social interventions, activities, and environmental manipulation as alternatives to chemical restraints. Most egregiously, drug levels are maintained without adequate clinical justification for maintaining such drug levels. See id. § 483.25(1). We learned that attending physicians at Baxter Manor have been ignoring, without any clear clinical justification, recommendations by the facility's own pharmaceutical consultant to reduce dosages of medications.

Many of the residents who were prescribed psychotropic medications appeared to be sedated during our inspection. One resident had lost both mobility and continence since being placed on psychotropic medications. Another resident had lost the ability to ambulate. The serious harm suffered by these residents may have been needlessly caused by the unchecked use of psychotropic medication.

**2. Mechanical Restraints**

Mechanical restraints utilized at Baxter Manor include: full siderails on beds, lap buddies, and geri-chairs with attached trays.[1] Until shortly before our inspection, the facility was also using vest and mitten restraints. We found Baxter Manor's use of mechanical restraints substantially departs from generally accepted professional standards. The facility's practices regarding siderails especially illustrate problems with the use of mechanical restraints.

When siderails are used without appropriate justification to prevent residents from getting out of their beds, the siderails may become a type of improper mechanical restraint, and their use places residents at risk of injury from falls, loss of function, and other health conditions. Use of siderails by cognitively

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[1] A geri-chair is a padded recliner with a strap that prevents the resident from rising out of the chair.

impaired persons increases the likelihood that they may be injured with the rails if they try to exit their beds. Residents may become entangled in their siderails, or get caught between the rail and mattress, headboard, or footboard, and risk a variety of serious injuries including: asphyxiation by having their heads or necks caught in the rails, fractures from falls, and bruises or soft tissue injuries from attempting to go over, around, or through the rails.

We found that over a third of the residents living in Baxter Manor have full siderails. Documentation to support the use of siderails was uniformly lacking. Staff told us that siderails are used to prevent residents from getting out of bed and to prevent them from falling. In actuality, as noted above, use of full length siderails is contraindicated for both of these purposes. Siderails are not effective in preventing falls, and may increase the risk of serious injuries when their use limits resident mobility. Many of the Baxter Manor residents with orders for siderails had impaired cognition and decreased physical strength. Residents with such risk factors are often unable to summon staff if they need help after getting entangled in their restraints. Thus, it is imperative that the care team carefully weigh all relevant clinical factors before permitting use of restraints including siderails. Periodic re-evaluations are also necessary to ensure that less restrictive, and often less harmful, approaches are considered.

The risks associated with siderails and Baxter Manor's deficient practices in this regard are illustrated by two incidents involving residents, B.R. and T.W.[2] Although B.R. had been placed in a bed with full siderails, B.R. was observed on the floor next to her bed after an apparent fall. After her fall, staff added an intervention to B.R.'s care plan, which basically consisted of encouraging the resident to call for help before trying to leave her bed. Yet, such an intervention would be of doubtful utility because B.R. had exhibited symptoms of a confused mental state. Alternatives to the restraints, such as using lowered beds or placing fall mats besides the bed, should have been considered thoroughly by her care team. In a separate incident, T.W. was found with an unexplained skin tear on her arm. Staff failed to evaluate adequately whether the siderails may have caused or contributed to the injury.

Even as facility staff rely on siderails or other mechanical

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[2] The resident names in this letter are pseudonyms. We will furnish an index to the County's counsel.

restraints to ostensibly help the residents, they do not mitigate adequately the harm from such restraints by providing appropriate care, exercises, and other interventions.

We found serious deficiencies with the care provided to residents to prevent the loss of mobility, incontinence, contractures (painful distortion or deformity of muscle or scar tissue), and loss of strength associated with the use of restraints.

For example, staff ordered full siderails and a lap buddy to prevent J.W. from falling, but J.W. was not given range of motion exercises to his lower extremities as ordered by the physician. J.W. eventually developed contractures, resulting in loss of mobility as well as causing pain.

We also found significant deficiencies with the daily monitoring of residents in restraints. We observed residents who were not released from restraints and assisted to exercise or toileting as required. Residents were left in restraints for several hours without timely and necessary monitoring. We observed residents left immobile in their beds, siderails up, without proper positioning, subjecting them to an increased risk of contractures, choking, and other serious harm.

**B. Assessment and Care Planning**

Under federal law, Baxter Manor must provide medical, nursing, and restorative care that allows residents to "attain or maintain the highest practicable physical, mental, and psychosocial well-being." 42 U.S.C. § 1396r(b)(4)(A). Federal law further requires a system of assessment and care planning designed to meet the resident's individual medical, mental health, communication, and psycho-social needs. 42 C.F.R. §§ 483.20, 483.25. Residents also should be assessed for and provided with therapeutic activities designed to ensure their physical, mental, and psychosocial well-being. See id. § 483.15. These activities should be designed to ensure that their abilities do not decline unless such decline is clinically unavoidable. See id. § 483.25. Baxter Manor deviates substantially from these standards of care.

**1. Assessing and addressing resident restorative, rehabilitative, and medical care needs**

We found serious problems with Baxter Manor's policies and practices regarding assessment and treatment of resident rehabilitative, restorative, and medical needs.

The assessment process and care plans themselves often did not meet generally accepted professional standards. Physicians and care teams do not operate under clinical practice guidelines and fail to address factors associated with loss of resident function. For instance, we observed that Baxter Manor staff inconsistently provide shoes to many residents who become pre-disposed to "foot drop," a preventable and painful, deforming condition where the foot ends up permanently extended forward. More generally, we found residents developed contractures without adequate assessments by medical staff as the residents' condition declined. When residents injure themselves, staff fail to assess adequately why the injuries occurred, or what steps could be taken to prevent such injuries, short of the adoption of more restrictive interventions, such as restraints.

Even when care teams complete assessments and develop care plans to address resident's medical needs, our chart audit revealed problems with the staff's implementation of those care plans. For instance, we found that the facility does not provide adequate restorative and rehabilitative care even when residents, with restorative care plans, develop contractures and loss of function. This problem arises in part because the activities and programs available at Baxter Manor are too limited to address the needs of many of the facility's residents. Staff provide therapeutic activities mainly for higher functioning residents, frequently ignoring residents with cognitive loss or other functional impairments. Baxter Manor also lacks a system for obtaining appropriate equipment (e.g., special seating to assist with positioning) required by geriatric residents. Moreover, the facility lacks systems to ensure implementation of restorative care programs when they are developed. Instead of being able to participate in facility programs, many residents with impairments are left restrained in wheelchairs or under chemical sedation for long periods of time without adequate clinical justification.

### 2. Staff training and education on the care of geriatric residents

Baxter Manor lacks basic training and educational systems to ensure adequate care. The Medical Director was not familiar with federal nursing home regulations and many facility policies. He apparently plays only a minimal role in policy development and quality assurance. This creates a leadership void that is not (and should not be) filled by other administrators or personnel. Other facility staff also lack training and education regarding geriatric care issues. Few, if any, of the direct care staff receive training on restorative care practices. Many of the

attending physicians are unaware of federal regulations regarding the use of psychotropic medications in a geriatric facility. Some direct care staff appeared untrained on care plan information relating to individual residents. The Social Activities Director, who plays a central role in planning for resident discharge, has had little or no training in discharge planning.

**C. Mealtime Practices**

When providing residents with meals, Baxter Manor staff fail to maintain and promote resident function as required by generally accepted professional standards. See id. §§ 483.15, 483.25, 483.35. In fact, Baxter Manor's mealtime practices are so deficient that they actually expose residents to an avoidable risk of serious harm. For many of the residents, meals are served at small "feeder tables," semi-circular tables where the staff stands on one side and feeds food to a group of residents on the other side, one resident at a time. We did not observe physical and verbal cues to encourage residents to feed themselves. These practices require residents to hyper-extend their necks to eat, increasing their risk of choking. Many poorly positioned residents sat in wheelchairs at the tables, often still restrained. Such practices prevented residents from obtaining sufficient access to the table and food, and predisposed the residents to choking, general discomfort, and aspiration pneumonia.

**D. Discharge Planning and Most Integrated Setting**

Baxter Manor does not comply with federal law regarding discharge planning and placement. See ADA, 42 U.S.C. § 12132. More specifically, under the ADA, qualified residents should be treated in the most integrated setting appropriate to their individual needs. A most integrated setting is one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. § 35, App. A at 543 (2004). The ADA's integration requirement includes an obligation to provide treatment in a community setting as appropriate. Olmstead, 527 U.S. at 581, 597, 600. This obligation arises when treatment professionals conclude that community-based treatment is appropriate, the affected individual does not oppose community-based treatment, and the placement can be reasonably accommodated, taking into account the resources available and the needs of others with disabilities. Id. at 602, 607. In accordance with generally accepted professional standards, Baxter Manor staff should assess residents for discharge potential, identify barriers to discharge, and address

such barriers through care planning and periodic re-assessments. Baxter Manor's discharge planning process does not, however, comply with these generally accepted professional standards.

First, Baxter Manor does not adequately evaluate or assess residents for their discharge potential and barriers to discharge. The facility's staff does not assess adequately such placement factors as a resident's functional status, medical acuity, support requirements, and individual placement preferences. We observed at least five residents requiring little or no staff assistance with daily living activities. These residents clearly warranted evaluation for potential discharge to a more integrated environment. The resident charts, however, uniformly failed to evidence that such assessments had been made.

Second, Baxter Manor does not adequately consider discharge planning issues as part of the interdisciplinary care and treatment process. The facility has no effective process for discharge planning, and resident care teams are not educated on discharge planning methodologies. Notably, most of the facility's residents are not involved in therapeutic activities that might improve their functioning and increase their options for placement in the most integrated setting. The activities and treatment programs that exist do not address the individualized needs of residents with cognitive impairment, physical challenges, and sensory loss. Activity plans do not address behavioral issues that often arise with residents who have dementia. As a result, Baxter Manor not only fails to provide the most integrated placement settings for residents, the facility actually engages in practices that may increase resident isolation and cause further loss of function, thereby diminishing the possibility of placement in the most integrated setting.

## III. MINIMUM REMEDIAL MEASURES

In order to remedy the cited deficiencies and to protect the constitutional and federal statutory rights of Baxter Manor residents, Baxter Manor should implement promptly the following measures.

### A. Restraints

1. Comply with federal regulations that prohibit the use of inappropriate mechanical and chemical restraints. Ensure that the Medical Director and other medical staff are trained on the generally accepted professional standards, including federal regulations, pertaining to the use of

restraints in a nursing home. Develop and implement an interdisciplinary approach to restraint reduction that considers alternative to restraints, requires timely evaluation of restraint orders, and ensures careful monitoring of restraint use.

2. Prioritize the assessment of residents who are at a high risk of injury due to full-length siderails. Provide, as appropriate, low beds, fall mats, and positioning devices in lieu of full-length siderails.

3. Develop a protocol for psychotropic drug use which includes comprehensive assessment and timely re-assessment of such use. Develop and implement alternative, non-pharmaceutical, approaches to addressing problematic resident behavior, as appropriate. Train staff on appropriate medication practices and monitoring in a nursing home setting.

4. Address the root causes of falls and other injuries to minimize their occurrence and provide appropriate individualized intervention.

**B. Assessment and Care**

1. Develop and implement an interdisciplinary approach to assessment and care planning that incorporates restorative and rehabilitative care needs.

2. Develop and implement restorative care plans that include measurable goals and timely re-evaluations.

3. Provide meaningful therapeutic activities, restorative care, and psychosocial supports when warranted.

4. Ensure that residents are wearing the proper footwear.

5. Train the Medical Director, physicians, nurses, and other appropriate facility staff on geriatric care standards and processes. Ensure that nursing assistants are included in care planning and trained on the implementation of activities and care plans.

**C. Mealtime practices**

1. Conduct evaluations of resident mealtime practices and posturing and implement, as appropriate, care plans to ensure safe eating practices.

2. Ensure that residents are provided with appropriate tables, equipment, and devices necessary for safe eating.

**D. Discharge planning and most integrated setting**

1. Incorporate discharge planning into each resident's periodic interdisciplinary assessment and care process.

2. Train appropriate staff on discharge planning and the requirements of the Americans with Disabilities Act.

3. Ensure that care teams evaluate whether community-based treatment is appropriate for residents based on their individual circumstances, determine whether the affected individuals oppose such community-based treatment, and provide such placement if it can be reasonably accommodated.

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We hope to continue to work with the Baxter County in an amicable and cooperative fashion to resolve our outstanding concerns regarding Baxter County Nursing Home.

We will be sending our consultant's evaluation of the facility under separate cover. Although the consultant's evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, her observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

In the entirely 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 Baxter Manor residents, 49 days after the receipt of this letter. 42 U.S.C. § 1997b(a)(1). We would, however, prefer to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. Accordingly, we will contact Baxter Manor officials soon to discuss this matter in more detail. If you have any questions about this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ R. Alexander Acosta

R. Alexander Acosta
Assistant Attorney General

cc: Ronald Kincade, Esq.
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