U.S. Departmen . Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

90702

SEP 12 1988

Honorable Garrey Carruthers
Governor
State of New Mexico
State Capitol Building
Santa Fe, New Mexico 87504

Re: Notice of Findings Regarding the Los Lunas Hospital and Training School, 42 U.S.C. Section 1997b(a)(1)

Dear Governor Carruthers:

On January 21, 1987, we informed you that, pursuant to the Civil Rights of Institutionalized Person Act (CRIPA), 42 U.S.C. Section 1997, we were commencing an investigation into conditions at the Los Lunas Hospital and Training School (Los Lunas) in Los Lunas, New Mexico. As contemplated by the statute, we are writing to inform you of the findings of our investigation and of the remedial measures required to remedy the unconstitutional conditions at Los Lunas.

During our investigation of Los Lunas, Special Litigation Section attorneys conducted tours of Los Lunas with three private consultants. Our consultants examined resident records, interviewed the facility superintendent and numerous staff members and spoke with residents. We also reviewed numerous documents provided by the facility, concerning a wide range of procedures and activities. During our investigation we were treated graciously by Los Lunas staff and attorneys from the Health and Environment Department and from the Attorney General's Office.

Our extensive investigation reveals that conditions exist at Los Lunas which deprive residents of their constitutional rights. Institutionalized mentally retarded persons have a constitutional right to adequate medical care and such training as an appropriate professional would consider reasonable to ensure their freedom from undue risks to personal safety and unreasonable bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

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Set out below are our findings and recommendations. The unconstitutional conditions revealed by our investigation include Los Lunas' failure to provide minimally adequate training programs sufficient to ensure residents are free from undue bodily and chemical restraints, failure to provide minimally adequate medical staff and medical care and failure to provide minimally adequate resident supervision to protect residents from unreasonable risks to their health and safety.

INADEQUATE TRAINING PROGRAMS

Los Lunas fails to provide professionally designed and implemented training programs sufficient to ensure that residents are not subjected to unreasonable bodily restraints. Following a careful review, our consultant psychologist concluded that Los Lunas staff are using physical restraints, isolation and punishment (e.g., forced inhalation of ammonia) to control the behavior of residents in lieu of necessary training programs.

Los Lunas staff do not identify and eliminate circumstances which provoke problem behaviors in residents. Staff intervene only after the onset of a maladaptive episode by restraining the resident. Our consultant noted that certain procedures used in restraining residents are substantial departures from accepted professional practice. Specifically, the use of "papoose boards" as restraint devices are commonplace at Los Lunas; straightjackets and ammonia inhalants are used as a consequence for antisocial behavior. Restrained individuals are in some cases isolated in a room with a closed door out of sight of staff. This practice, absent adequate surveillance, places severely handicapped residents at great risk of injury and is not professionally justifiable.

Further, the use of restraint on individual residents is continued for unacceptable periods of time without any monitoring of the restraint. The lack of appropriate monitoring is the result of insufficient tracking and recordkeeping procedures. Los Lunas lacks an effective system to evaluate the use of restraints, the need for, or the need to, modify a training program.

Finally, Los Lunas lacks a data gathering system necessary to provide information upon which professional decisions can be based regarding all aspects of training for residents who require training programs.

INADEQUATE MEDICAL STAFFING

Los Lunas does not have adequate nursing, physical therapy or occupational therapy staff to adequately meet the needs of Los Lunas residents or to provide sufficient supervision of residents to ensure their safety.

The number of nursing staff at Los Lunas is inadequate to meet the heavy demands placed upon them. For example, there is only one nurse on the night shift responsible for providing nursing coverage for 18 cottages. This nursing coverage is unacceptable for the type of resident population at Los Lunas. Having only one nurse at night exposes residents to unreasonable risks to their health and safety because the signs of incipient illness which may not be noticed by non-nursing staff and hence may not be reported to a physician in a timely fashion.

Partially as a result of the lack of adequate staff, the safety and security of residents has not always been maintained. The most flagrant case is that of a woman who was raped, developed peritonitis and died. Improved resident supervision may have prevented both the abuse and the subsequent delay in recognizing the developing peritonitis.

Patient safety is also compromised by staffing patterns which expose residents to unreasonable risks. For example, during a visit to Bashein Cottage prior to breakfast, our consultants observed 32 wheelchair bound, profoundly retarded, multiply-handicapped residents lined up in two groups of 16 in the hallway outside the eating area without any staff member in visual contact. Given the constant risk of seizures and other problems generated by medical conditions exhibited by these residents, such a practice places clients at an extreme risk to their health and safety. Again, the need for improved resident superversion is heightened by the large number of multiply-handicapped and physically and medically fragile residents at Los Lunas.

The physical therapy and occupational therapy staffs at Los Lunas consist of one person each. These individuals are unable to meet the health related needs of residents. Physical therapy is necessary at Los Lunas, especially in light of the large number of body deformities present among the resident population, in order to prevent muscular or skeletal breakdown. Occupational therapy is necessary to assist residents with eating disorders. The two individuals currently assigned to physical and occupational therapy duties are spending the majority of their time on wheelchair maintenance rather than resident care.

Finally, the ability of Los Lunas to deliver adequate medical care to its residents is hindered by inadequate recordkeeping practices at the facility. A resident's diagnosis and reasons why certain procedures and medications are proscribed are seldom written into a resident's record. When changes are made, there is little indication in the record as to the reasons for such a change. The medical section of a resident's record should reflect this information. Without such information, professional medical decisions can not be made.

INADEQUATE PSYCHIATRIC CARE

The administration of psychotropic medications at Los Lunas is not sufficiently monitored to protect resident from serious risks to their health from the overuse of these medications. Numerous residents of Los Lunas have received neuroleptic or psychotropic medications, for years in some instances, absent adequate monitoring.

In addition, while dosages are often increased in an attempt to control maladaptive behaviors, there are often no similar attempts to decrease medications nor is there a demonstration in the record to support the increased dosages. Further, the records lacked evidence that such drugs are used in conjunction with a training program.

MINIMALLY NECESSARY REMEDIES

The administration and staff at Los Lunas appear committed to providing residents with appropriate care, however the unique population of Los Lunas, combined with deficiencies in behavior management, medical staffing and psychiatric practices have resulted in the creation of an environment which is violative of the constitutional rights of Los Lunas residents. The above-noted conditions and deficiencies are both egregious and flagrant and are pursuant to a pattern or practice which is causing Los Lunas residents grievous harm.

To rectify the deficiencies at Los Lunas and ensure that constitutionally adequate conditions are maintained thereafter, the following measures, at a minimum, must be undertaken. The State is free, of course, to implement measures beyond those listed below.

1) Design and implement training programs in order to eliminate the use of undue bodily and chemical restraints. Such procedures must include improvements in the current tracking and recordkeeping systems to monitor the effectiveness of behavior management programs and allow programs to be re-evaluated, as appropriate.

2) Increase nursing staff in order to provide adequate resident supervision and detect illness among the resident population.

3) Increase physical and occupational therapy staff to ensure that residents are not at risk from muscular or skeletal breakdown or eating disorders, and associated risks to their health and safety.

4) Develop and implement side-effect monitoring procedures for residents on neuroleptic and psychotropic medication to eliminate undue risks of harm due to medication side effects.

We are willing to make our experts available to the State of New Mexico to provide technical assistance in remedying the deficiencies we have identified. Information about federal financial assistance which may be available to assist with the remediation process can be obtained through the United States Department of Health and Human Services Regional Office and through the United States Department of Education by contacting the individuals listed in the attached information guide.

Our attorneys will be contacting counsel for the State of New Mexico shortly to arrange a meeting to discuss this matter in greater detail. To date, we have been able to conduct this investigation in the spirit of cooperation intended by the Civil Rights of Institutionalized Persons Act, and look forward to continuing to work in the same manner with state officials in that spirit toward an amicable resolution of this matter.

Sincerely,

Wm. Bradford Reynolds
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Civil Rights Division

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