U.S. Department of Justice

Civil Rights Division

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

NOV 19, 1997

Honorable Robert Casey
Governor
Commonwealth of Pennsylvania
Governor's Executive Office
Room 225
Main Capitol Building
Harrisburg, Pennsylvania 17120

Re: Notice of Findings Regarding the Ebensburg Center, 42 U.S.C. Section 1997b(a)(1)

Dear Governor Casey:

On August 8, 1986, we notified you that, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. Section 1997, we were commencing an investigation into conditions at the Ebensburg Center in Ebensburg, Pennsylvania. As contemplated by the statute, 42 U.S.C. Section 1997b, we are writing to inform you of the findings of our investigation and the minimum measures required to remedy the unconstitutional conditions at the Ebensburg Center identified by our investigation.

As part of our investigation, Special Litigation Section attorneys conducted tours of Ebensburg with three private consultants. Our consultants examined resident records, interviewed the facility director 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.

Our extensive investigation reveals that conditions exist at Ebensburg 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 safety and freedom from undue bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

Set out below are our findings and recommendations. We will discuss only those conditions which we believe are violative of constitutional rights. Those unconstitutional conditions include Ebensburg's failure to provide minimally adequate training

sufficient to protect residents from unreasonable risks to their health and safety and from undue bodily restraints and the facility's failure to provide minimally adequate medical care.

INADEQUATE TRAINING AND UNDUE PHYSICAL RESTRAINT

Ebensburg Center fails to provide its residents with adequate training programs and, as a result, systematically overuses, and misuses, physical restraints.

a. Absence of Training Programs. Professionally designed and implemented training programs for mentally retarded individuals with self-injurious or aggressive behaviors are an important means of eliminating or reducing those behaviors. The Supreme Court in Youngberg specifically held that mentally retarded individuals are constitutionally entitled to such training as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily restraint. Ebensburg fails to provide such training, and residents suffer physical injuries and undue bodily restraint as a result.

Our psychologist consultant's review of resident charts revealed that physical restraints are used excessively. Our consultant attributed the undue use of restraint, in part, to the absence of adequate behavior management procedures. Adequate training for residents is also critical to prevent undue use of chemical restraint. At the time of our psychopharmacologist's tour almost one-half of Ebensburg's residents received psychotropic medication. While our expert noted that efforts are underway to reduce drug usage, the success of such efforts depends on much greater attempts to develop appropriate behavior training programs and integrate psychotropic medication use with such programs.

When training programs are written for Ebensburg residents, many are so deficient as to fall below the level of any acceptable professional standard. For effective behavior management to take place, Ebensburg must properly assess the needs of residents, develop appropriate training programs, and insure that such programs are implemented by professionals who are competent and qualified to do so.

b. Use of Restraints. As noted above, physical restraints are used at Ebensburg in lieu of minimally adequate training programs. In addition, they are used for the convenience of staff and as punishment. Our expert concluded that there is a systematic overuse, and misuse, of physical restraints at the facility.

Our review of resident records found numerous cases in which residents had standing orders for restraints irrespective of need. These orders are clear evidence that restraints are not

being used for particular residents for specific reasons and are being used randomly by staff absent any justification. Such use represents a substantial departure from accepted professional judgment.

In sum, the undue use of bodily restraint at Ebensburg is consistent with an insufficient and improperly trained staff and the lack of appropriately implemented behavior management procedures. The presence of these factors has forced the Ebensburg staff into an over reliance on physical restraint.

c. Resident Safety. As a result of Ebensburg's failure to provide minimally adequate training programs, residents at the facility are not being provided with a reasonably safe environment. Our review of resident records noted a high rate of maladaptive and self-injurious behavior resulting in a high injury rate among the resident population. Without professionally designed training programs and a sufficient number of trained staff to implement those programs, Ebensburg residents will continue to suffer otherwise preventable harm.

MEDICAL CARE

a. Nursing Services. Ebensburg residents are also put at unnecessary risk of harm due to the lack of a sufficient number of adequately trained nursing staff members. The existing nursing staff is poorly organized and lacks the coordination and communication with other staff essential to the exercise of professional judgment regarding residents' medical and nursing care. Health care plans are not individualized to identify and provide for each resident's needs. Clinical supervision of nurses is almost non-existent and nurses, in turn, do not supervise direct care staff responsible for basic health care surveillance. Our nursing consultant concluded that the lines of authority, responsibility and accountability for nursing are so unclear and fragmented as to seriously compromise the continuity of care provided.

b. Infection Control. Aside from staffing, measures are not in place to either prevent, identify, or control infections acquired at Ebensburg or brought into the facility from the community. Even basic elements of an infection control program are not in place and a system for reporting, evaluating, and maintaining records of infections among patients and staff does not exist. Such procedures are especially necessary, because of the numerous potentially infectious injuries residents receive from bites, scratches, falls and various forms of self-injurious behaviors existing at Ebensburg.

c. Physical Management of Severely Handicapped Residents. A review of the physical therapy staff and services available at Ebensburg shows that residents are not receiving adequate

physical therapy services. Such therapy is essential given the large number of physical deformities and mobility problems among the resident population. Ebensburg does not employ a sufficient number of physical therapists and therapy aids to ensure that residents are not suffering skeletal or muscular breakdown from the lack of such therapy. Essential adaptive equipment, such as wheelchairs, is often broken or ill-fitted, thus causing new physical problems or exacerbating old ones.

INSUFFICIENT NUMBER OF QUALIFIED STAFF

Ebensburg is currently understaffed at both the direct care and professional levels. Moreover, staff are not fully qualified to assume all their job responsibilities and are poorly supervised. An insufficient number of qualified staff at the Center contributes to, and exacerbates, the deficiencies in care previously mentioned.

a. Professional Staff. By far the most serious shortage of staff at Ebensberg Center is in the nursing department. Physical disabilities, mobility and visual handicaps, diseases, complex medical conditions, digestive problems, and age-related needs are common among Ebensburg residents. Frequent accidents and other incidents often resulting in injury from scratches, bites, cuts, bruises, and fractures, and the accompanying risk of infections posed by open wounds, add to the demands on nursing staff. At present, there are too few nurses to provide needed services. The number of nurses actually on duty during a one week period reviewed by our nursing expert fell well below the facility's own minimum staffing levels. The six nursing supervisors spend at least one third of their time on administrative duties; there is no nursing supervision on the evening or night shifts. The administration of medications facility-wide alone requires Ebensburg nurses to prepare, dispense, and document administration of 2411 regularly scheduled individual doses of medication. These duties leave no nurse to appropriately respond to emergencies and accidents, and perform treatments direct care staff cannot provide. It is crucial that Ebensburg Center increase its nursing staff if residents are not to remain at risk to their health and safety.

There are also too few physical therapists and therapy aids to serve the many Ebensburg residents with severe physical disabilities. Our expert criticized both the evaluation process for determining who is in need of physical therapy to prevent body deformities, contractures, and other physical problems, and the ability of the existing physical therapy staff to provide such services to those residents the facility identifies as in need. Residents in need of these health related services are placed at undue risk of contractures, bodily deformity, and other serious threats to their physical health.

2. Ebensburg must hire and deploy a sufficient number of adequately trained direct care and other professional staff to provide residents with the training described in the preceding paragraph.

3. Ebensburg must hire and deploy a sufficient number of adequately trained nursing staff members to prevent residents from being placed at undue risks to their health and safety.

4. Ebensburg must establish an effective infection control program that will ensure continual prevention, identification and response to infections.

5. Ebensburg must hire and deploy a sufficient number of adequately trained physical therapists and physical therapy aids to ensure that residents are not at an undue risk from skeletal or muscular breakdown or the development of other physical conditions posing serious risks to their physical health.

We are willing to make our experts available to the Commonwealth of Pennsylvania 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 Department of Public Welfare shortly to arrange for 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 with state officials in that spirit toward an amicable resolution of this matter.

Sincerely,

Wm. Bradford Reynolds
Assistant Attorney General
Civil Rights Division

cc: Leroy S. Zimmerman, Esquire
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