U.S. Department of Justice

Civil Rights Division

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

February 6, 1992

REGISTERED MAIL
RETURN RECEIPT REQUESTED

The Honorable Booth Gardner
Governor of the State of Washington
Legislative Building
Olympia, Washington 98504

Re: Notice of Findings Regarding the Fircrest Residential Habilitation Center, Pursuant to 42 U.S.C. Section 1997b

Dear Governor Gardner:

I am writing in reference to our investigation of the Fircrest Residential Habilitation Center ("Fircrest") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. §§ 1997 et seq. Consistent with the requirements of CRIPA, the purpose of this letter is to advise you of the conditions at Fircrest that deprive residents of federally protected rights, the supporting facts, and to recommend necessary remedial measures.

Conditions at Fircrest

Our investigation uncovered flagrant or egregious conditions resulting in violations of the constitutional and federal statutory rights of Fircrest's residents. The following conditions, alone or in combination, were found to violate the constitutional or federal statutory rights of Fircrest residents:

1. Pervasively unsafe environment;

2. Neglect of residents;

3. Inadequate medical care;

4. Lack of sufficient numbers of and sufficiently trained direct care and professional staff;

5. Overuse and misuse of physical restraints;

6. Lack of training programs for residents;

7. Discrimination against residents based upon the severity of their handicaps, a violation of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; and

8. Lack of professionally based educational evaluations and placements consistent with such evaluations required by the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400 et seq.

These conditions or practices threaten the health and safety of Fircrest residents, deprive them of adequate medical care, and subject them to a broad array of unprofessional practices as well as to unreasonable bodily restraint in violation of their federally protected rights. Youngberg v. Romeo, 457 U.S. 307 (1982). Each of the conditions or practices identified above represents a substantial departure from generally accepted professional judgment or is inconsistent with commonly accepted medical standards.

Fircrest's practices also violate federal statutes applicable to the facility. Section 504 of the Rehabilitation Act proscribes discrimination against handicapped individuals on the basis of the severity of their handicapping condition. Under Section 504, handicapped individuals must be provided the opportunity to participate in alternate community based programs and facilities made available to their less handicapped peers, provided that reasonable accommodation can be made. Where, as here, reasonable accommodation in alternate community programs can be made, the failure to serve severely and profoundly handicapped residents in such programs runs afoul of the nondiscrimination mandate of Section 504 and its implementing regulations. Likewise, the failure to consider severely handicapped Fircrest residents for alternate programs, when other, less handicapped former residents of Fircrest have been so considered by means of a professional evaluation, constitutes a violation of Section 504.

Fircrest's practices also contravene the IDEA, which, mandates that, except in unusual circumstances, school-aged handicapped children be educated in public school settings in the community. Under the statute and its implementing regulations, severity of handicap is an unlawful criterion upon which to base exclusion from public school settings. Observation of the children in Fircrest's institutional school suggests that their physical handicaps or behavior problems are considered a barrier to their enrollment in public schools. The facility's failure to professionally evaluate such residents for placement in community school programs and the failure to place them in such programs, absent exceptional circumstances, clearly violates the IDEA.

The facts supporting our findings regarding these constitutional and statutory violations are set forth in the Attachment accompanying this letter.

Minimal Remedial Measures

The conditions described in the Attachment reflect systemic deficiencies in the care and treatment service delivery system at Fircrest. In legal terms, these flagrant or egregious conditions deprive Fircrest residents of their constitutional and federal statutory rights. Immediate relief is required. In our view, the following measures must be taken to remedy the deficiencies described above:

1. Immediate steps must be taken to provide increased safety for residents and eliminate the high rate of injury at the facility. Such steps should include increased supervision of residents by direct care staff; enhanced training for such staff to teach them skills necessary to both supervise and intervene with residents, as appropriate; and the development of a comprehensive system to monitor injuries, ascertain the cause, and institute necessary remedial action. If 1:1 staffing is required for certain residents exhibiting very dangerous behaviors, it should be provided.

2. All residents must be evaluated by a professionally constituted inter-disciplinary team to determine their individual needs for care, treatment, and training. Based upon such evaluations, professionals must develop for each resident an individualized training program sufficient to ensure their personal safety, reduce or eliminate the use of physical and chemical restraints, and prevent regression. Such programs should include behavior modification programs, training in the development of self care skills, and such other programs a professional deems reasonable to address resident needs. Priority in evaluation and development of individualized training programs should be given to those residents exhibiting the most dangerous behaviors.

3. Policies and practices regarding the use of restraint require substantial modification. Fircrest may not use mechanical, physical, or chemical restraints as a substitute for training programs, as punishment, or for the convenience of staff. Restraint techniques currently in use that are inconsistent with currently accepted professional standards should be promptly eliminated.

4. Medical care must be significantly improved. Acute and emergency care practices require increased involvement of physicians; monitoring of acute conditions as well as documentation of such require improvement; the policy and

practice of using prn orders requires careful review to ensure that the practice adheres to currently accepted professional standards; deficiencies in seizure management must be eliminated; unprofessional medication practices must be eliminated; antiquated policies and practices in nursing services require substantial revision and updating; specialty medical services, including psychiatry, neurology, and occupational and physical therapy, likewise require enhancement.

5. Immediate steps are required to ensure compliance with the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973. These steps include professional evaluation of school-aged residents and the provision of educational services consistent with the purpose and plain meaning of the statute, i.e., the provision of educational services for such children in community settings, except in appropriate circumstances, as well as a change in any state policy or practice that results in the exclusion of severely or profoundly retarded residents at Fircrest from state supported or operated community based mental retardation programs and facilities; such residents should be evaluated to determine their appropriate placement and should be placed consistent with such determinations within a reasonable period of time.

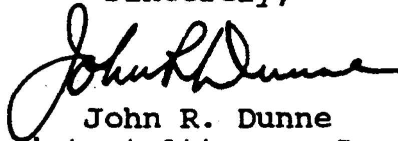
6. Enhanced professional resources are required at Fircrest. In addition to the medical specialty resources identified above, additional trained and qualified psychologists are needed to conduct the evaluations identified as necessary as well as to develop and ensure the consistent implementation of appropriate training programs.

To resolve these issues and to remedy the identified violations in a mutually agreeable manner, we propose to meet with appropriate State officials in the near future to commence the negotiation of a consent decree or other agreement enforceable in the appropriate federal district court, which would set forth the precise remedial measures agreed upon and other reporting and monitoring requirements. We also suggest that you contact appropriate Federal officials of the Department of Health and Human Services and Department of Education to ensure the maximal use of federal financial assistance, resources which might be used to address these deficiencies.

The Department stands ready to provide additional information and guidance in the hope that a prompt and mutually agreeable resolution of this matter can ultimately be reached. If prior to a meeting, you or any members of your staff have any questions, please contact Arthur E. Peabody, Jr., Chief, Special Litigation Section, for assistance.

In closing, let me thank you for the cooperation extended to us thus far by Washington State officials, who have at all times been responsive and helpful. I remain confident that we can resolve this matter amicably.

Sincerely,



John R. Dunne
Assistant Attorney General
Civil Rights Division

cc: Honorable Kenneth O. Eikenberry
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State of Washington

Mr. Richard J. Thompson
Secretary
Department of Social and Health Services
State of Washington

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Fircrest Residential Habilitation Center

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ATTACHMENT

Facts Supporting Findings of
Constitutional and Statutory Violations

The Department's investigation of the Fircrest Residential Habilitation Center, initiated on January 9, 1991, consisted of: 1) tours of the facility by four consultants to the Department, namely, a physician, a psychologist, and two registered nurses; 2) examination of facility records, including various incident reports and other records involving residents as well as administrative rules and other policies; and 3) numerous interviews with Fircrest staff.

The facts supporting the Department's findings are set forth below.

I. Pervasively Unsafe Environment

Our consultants' opinions, based upon their careful and thorough review of Fircrest, paint a profoundly disturbing portrait of conditions to which residents at Fircrest are subjected on a daily basis. Observations made by these consultants during their tours of various living units and program areas indicate that residents are left in abject idleness for protracted periods of time. Due to the lack of human interaction and care, residents have developed significant stereotypic, maladaptive or anti-social behaviors. These inappropriate behaviors range from headbanging, eating foreign objects and pulling hair, to waving arms, flicking fingers and other self-stimulatory activities. Due to the lack of care, attention and programmed activities, many of these residents' behaviors have regressed to a primitive state. It was not an infrequent occurrence for residents to be found lying on the floor or asleep on sofas or in chairs during the daytime. Yet other residents have developed overtly dangerous behaviors threatening the safety of other residents. Still others have totally withdrawn and are oblivious to any activity around them. These behaviors are generally avoidable or correctable when adequate training is provided.

The review of these consultants also indicates that residents suffer needless serious injuries -- many of unknown origin, i.e., residents were not properly supervised so that no one observed the injury. In 1990, for example, the last full year for which we have complete data, our review of Fircrest's own records reveals that there were 4,930 incidents at the facility -- an alarming incident rate of over 90%. On the average there were 410 incidents per month for some 440 residents. We further note that the number of moderate incidents or those resulting in a significant injury or threat to another individual nearly doubled in 1990, rising from 1210 such incidents in 1989 to 2313 in 1990.

These statistics became all too real in the observations made by our consultants during their tours. Numerous residents were seen with fresh wounds and lacerations, including shaved spots on heads revealing stitches and healing injuries; red marks and significant bruises; multiple scabs and scars, and large bandages or casts. Indeed, in some living units, it was not uncommon for a significant number of residents to exhibit some sign of present or recent significant physical injury.

II. Neglect of Residents

The level of care afforded to Fircrest residents in certain areas is so deficient as to constitute active neglect of the serious needs of residents. Significantly, our consultants observed numerous situations where staff failed to intervene to care for residents in direct need of attention. Our consultants observed residents engaged in self-injurious behavior, having seizures, masturbating in open view -- all without staff intervention of any kind. Further, there were instances where residents were left completely unattended and staff entered the room only after our consultant had entered the area. Moreover, a review of records revealed additional situations where staff apparently failed to act where circumstances warranted action. For example, records indicate that residents have been injured while left in bathrooms unattended. Residents have been discovered with foreign objects lodged in their noses and other orifices. Such objects have also been discovered following emesis or during surgical procedures. One resident was found with strings hanging out of his rectum, yet he received only what our physician consultant characterized as "delayed" medical attention. At least one restraint helmet had what appeared to be blood on the inside of the ear areas. In a particularly disturbing incident, one resident was found dead in the day room of a living unit; the resident had been dead for up to three hours before her body was discovered by staff.

Physically handicapped residents of Fircrest are exposed to especially dangerous conditions. Due to improper positioning and feeding techniques, residents have lost mobility, suffered contractures and aspirated and are subjected to continuing risk of further aspiration. Our consultant in physical management was distressed about both the positions in which residents were fed -- positions which jeopardize their health -- and the rapidity with which they were fed. The consultant observed residents being fed their entire meals in periods of time as short as five minutes. These practices are so deficient that they not only constitute neglect of residents, but subject residents to unnecessary danger.

III. Inadequate Medical Care

Medical care at Fircrest is inadequate. Our physician consultant identified numerous cases which he characterized as lacking sufficient physician involvement. Such cases range from seizure management to identification of a common ear infection. Specifically, he found physician involvement in the monitoring and early detection of acute medical problems to be inadequate. He identified a significant number of cases where residents with physical illnesses were not given proper medical care before they became acutely ill. Indeed, our nursing consultant found one such case where the resident subsequently died. Although we were encouraged to learn at the time of our tour that the facility was developing a record review system to assist in identifying serious illnesses, the system had not yet been fully implemented.

Seizure management was also found to be deficient. Deficiencies ranged from inadequate evaluations -- including the failure to involve a consultant neurologist when appropriate -- to inadequate charting of both the occurrence of seizures and the response of residents to treatment as a means of affording adequate seizure management.

Psychiatric consultations for residents receiving psychotropic medication are largely unavailable; screening for tardive dyskinesia, a severe side effect from psychotropic medications, is not performed; and staff have not been trained to evaluate the side effects of the powerful, mind-altering drugs used at the facility.

Finally, our physician consultant criticized the practice of "telephone" medicine or the use of prn ("pro re nata," or as needed) orders for medication. Such orders, as utilized at Fircrest, permit nurses to make medication decisions for which they are not properly trained and exacerbate the non-involvement of physicians in the medical care delivery system at Fircrest.

The lack of adequate physician involvement in the delivery of medical care to Fircrest's residents has placed great stress on nurses at Fircrest. As a result of staffing shortages and the use of antiquated nursing policies, nursing care has been seriously compromised. Our nursing consultant found nursing policies to represent substantial departures from generally accepted practice in at least five different areas. These areas include physical assessments, identification of acute illness, hydration practices, administration of medication and use of prn orders, and evaluation of the effects of medication prescribed for residents. Those nurses on duty striving to provide adequate care have not been sufficiently trained to provide services to individuals at Fircrest who present specialized needs.

Fircrest fails to provide its physically handicapped residents appropriate, professionally designed adaptive equipment, placing these residents at risk of physical deterioration and harm. Additionally, Fircrest fails to properly position handicapped residents or to use safe, professionally designed feeding programs.

IV. Lack of Sufficient Numbers of and Sufficiently Trained Direct Care and Professional Staff

Our consultants were unanimous in their view that Fircrest lacks the professional resources to provide adequate care to its residents, most of whom are severely or profoundly retarded and have associated medical problems or physical handicaps.

Although many living units appeared to have adequate coverage of direct care staff, especially during the daytime, such staff has not been adequately trained to perform their assigned functions. As referenced above, in critical areas, such staff is simply ill-equipped to care for residents. Many are required to start work without adequate training. Nearly all are not supervised by personnel who can both provide them with necessary assistance and ensure that they perform their assigned duties. Professional staff in most categories is so overburdened that they cannot even begin to do those tasks necessary to provide appropriate care and safe conditions for residents.

Staffing shortages are especially acute in the areas of psychiatry, neurology, nursing and occupational and physical therapy. Our nursing consultant was critical of the inability of the nursing staff to consistently perform routine nursing functions due to both inadequate numbers and questions of competence. Further, the needs of Fircrest's 140 physically handicapped residents simply cannot be met by the one physical therapist and three aides currently on staff. Indeed, the lack of appropriately trained staff is so severe at Fircrest that the staff must spend most of its time seeking to control residents and even to contain them rather than meeting their needs. The professional expertise available is so meager that -- as one consultant explained -- residents are left essentially to "fend" for themselves.

V. Overuse and Misuse of Physical Restraints

Our psychologist consultant noted with disapproval the broad array of physical restraint techniques commonly utilized at Fircrest. These techniques include strait jackets with four-point restraints; chairs with waist, arm, chest, and ankle restraints that completely immobilize residents; pica masks or helmets with face masks; wrist to wrist and ankle to ankle restraints; and staff incapacitating residents by holding them down involuntarily on the floor or elsewhere for a period of

"enforced relaxation." While at the time of our tours, Fircrest was unable to provide a complete list of all residents upon whom these and other restraints have been imposed in recent months, it is clear from our review that the use of such restraints to control behavior represents common practice at the facility. Indeed, the use of such techniques is so pervasive for behavior control purposes that our consultant concluded that such devices are used as punishment, for the convenience of staff and in lieu of training programs, all of which are professionally and constitutionally unjustifiable.

Significantly, residents have been injured in physical restraints. These injuries include fractures, lacerations, bruises, and other "unexplained" injuries. These injuries appeared repeatedly in our review of incident reports. Moreover, such reports were verified by the observations made by our consultant psychologist during his tour. Further, in a disturbing incident, our consultant observed the use of "required relaxation," or the practice of several staff holding a resident face-down on the floor against her will.

As referenced above, the use of prn orders results in the chemical restraint of residents who -- like others who are subjected to physical restraint -- should be provided with professionally developed training programs to reduce maladaptive or anti-social behaviors and taught positive replacement behaviors. The use of chemical restraints at Fircrest is likewise without professional justification.

VI. Lack of Training Programs

Fircrest fails to provide residents with professionally developed and implemented training programs. Programs for residents exhibiting the most serious maladaptive and other anti-social behaviors are seriously deficient. To the extent they exist at all, they are not consistently implemented. Moreover, direct care staff have not been trained in appropriate methods of implementation.

Much of the anti-social, maladaptive behavior, injuries and use of restraints is attributable, in significant part, to the lack of such training programs. Residents who have failed to receive adequate care over a protracted period of time have developed inappropriate behaviors. Staff ill trained to develop and implement training programs resort to control devices to subdue the residents, i.e., physical and chemical restraint. Behaviors deteriorate and accidents and injuries accelerate. With the escalating tensions produced by the behavior problems exhibited by the residents, the use and the severity or degree of restrictiveness of restraint likewise increases. Absent the development and implementation of professionally based training programs, the cycle of harm and restraint will continue.

VII. Discrimination Against Residents

State officials have chosen to confine at Fircrest severely or profoundly retarded persons with behavior problems or associated physical handicaps. Records reviewed indicate that such persons have not been adequately evaluated by an appropriate professional for participation in alternate state operated or funded programs, including community based mental retardation services, or have not been recommended for such placements because institutional officials believe present services cannot meet their needs.

VIII. Lack of Professionally Based Educational Evaluations and Placements Consistent with Such Evaluations

In reviewing the educational program offered at the Maxim School, located on the grounds of Fircrest and administered by the Shorecrest School District, our psychologist consultant found the quality of the educational programs afforded to residents to be adequate. However, the school-aged children enrolled in the program did not have adequate professionally based evaluations to determine whether, consistent with the requirements of the Individuals with Disabilities Education Act ("IDEA"), placement in the institutional school represented placement "in the least restrictive alternative."