



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

OCT 11 1994

The Honorable Sharon Pratt Kelly
Mayor of the District of Columbia
Office of the Mayor
One Judiciary Square
441 4th Street, NW
Washington, DC 20001

U.S. v. District of Columbia



NH-DC-001-002

Re: D.C. Village Nursing Home

Dear Mayor Kelly:

On August 20, 1990, we notified the Mayor of the District of Columbia, the Corporation Counsel for the District of Columbia, and the Administrator of D.C. Village ("DCV"), of our intention to investigate allegations of unconstitutional conditions at DCV pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. In January 1991, we completed an investigative tour of the facility with two expert consultants. On August 19, 1991, we informed the then Mayor and other District officials that we had reasonable cause to believe that persons residing in or confined to DCV were being subjected to conditions that deprived them of rights, privileges, and immunities secured by the Constitution of the United States. Youngberg v. Romeo, 457 U.S. 307 (1982).

Attorneys from the District's Office of the Corporation Counsel, and the District's Department of Human Services indicated that remedial measures would be implemented at DCV to correct any constitutional deficiencies. To ensure that the necessary remedial action had been or would be undertaken, in April 1992, we conducted a follow-up investigation at DCV with four expert consultants. Unfortunately, we found that constitutional deficiencies persisted at DCV. On October 22, 1992, we informed the Office of the Corporation Counsel that the persons residing in or confined to DCV continued to be subjected to conditions that deprived them of their constitutional rights. Again, the District's counsel indicated that steps had been or would be undertaken to correct any problems.

On April 6, 1994, we notified the Office of the Corporation Counsel of our intention to conduct a follow-up investigative tour to assess current conditions at DCV. On June 6-7, 1994, we

conducted our tour of the facility accompanied by four expert consultants: Rebecca Elon, M.D., a geriatric physician, Blaine Greenwald, M.D., a geriatric psychiatrist, Richard Amado, Ph.D., a psychologist, and Mary Ellen Anderson, R.N. Consistent with statutory requirements, we are now writing to advise you of our findings. We regret to advise you that our investigative tour revealed that the residents at DCV are continuing to be subjected to conditions that deprive them of their constitutional and statutory rights.

DCV is organized, staffed, funded and licensed as a nursing home to care for elderly persons. Nonetheless, the District has inappropriately placed at the facility a disparate group of individuals including children, persons with mental illness, and persons with developmental disabilities, including mental retardation, simply because other parts of the District's care system lack available space and services to provide necessary care. Thus, the District has asked DCV to function as an acute and chronic care psychiatric treatment facility and as a developmental center even though DCV is not equipped to provide the specialized treatment and training required for its mentally ill and mentally retarded populations.

As a result, DCV is not meeting the needs of its residents. In addition to providing inadequate care and services to its mentally ill and mentally retarded residents, DCV provides inadequate medical and nursing services to all its residents. DCV is unable to provide even adequate nursing home services to its geriatric population. All this has produced a host of serious problems including needless suffering and risk of harm, an excessive number of hospitalizations, and an unusually large number of deaths due to aspiration.

The District must reorganize DCV to permit the facility to fulfill its lawful purpose, i.e., to provide nursing home and related services to the elderly. The District should place all children and individuals with mental illness or mental retardation in appropriate community based facilities and programs. Were these residents to be appropriately placed in care facilities designed and staffed to meet their specialized needs, the chances that they would receive appropriate training and treatment would be dramatically increased. Nonetheless, to the extent that mentally ill and mentally retarded individuals are confined at DCV, the District is required to provide them with adequate psychiatric care and/or training. Youngberg, 457 U.S. 307; Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals ("PASSAR") 42 C.F.R. § 483.100 et seq. (1994).

All residents of state operated institutional facilities, including nursing homes, have a fundamental Fourteenth Amendment due process right to adequate food, clothing, shelter, medical

care, reasonably safe conditions, and training. Youngberg, 457 U.S. 307. As such, this right entitles residents to such care and training as to protect each residents' liberty interests and permit each resident an opportunity to function as independently as is reasonably possible. Individuals with disabilities have a right to programs to teach adaptive behaviors, self-help skills, communication, social skills, and skills necessary to enhance independence. See, e.g., United States v. Tennessee, No. 92-2062, slip. op. (W.D. Tenn. Feb. 17, 1994); Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D.N.C. 1988). See also 42 C.F.R. § 483.440 (Each institutionalized client is entitled to a continuous and aggressive active treatment program that is directed towards the "acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible.").

The facts disclosed during the course of our investigation supporting our findings of unlawful and unconstitutional conditions at DCV are set forth below.

I. MEDICAL CARE IS INADEQUATE.

DCV is failing to ensure that DCV residents receive adequate preventive, chronic, routine, acute, and emergency medical care in accordance with generally accepted standards of care.

The most pressing medical concern at DCV is that the medical staff routinely fails to assess and respond in a timely and appropriate fashion to individuals with aspiration pneumonia or risk of aspiration, dysphagia or swallowing difficulties, and decreased oral intake. As a result of this inadequate care, many DCV residents have died. A shockingly high number of DCV residents have died due to some form of aspiration, pneumonia or feeding dysfunction. Since June 1, 1992, at a minimum, 19 individuals are listed as having died at least in part due to "aspiration"; at least 18 others have died due to some form of "pneumonia" (which could be related to aspiration). Many of these and other individuals have died in part because of a "feeding dysfunction." Many current DCV residents have been needlessly subjected to prolonged suffering and discomfort punctuated by repeated hospitalizations merely because the medical staff at DCV has been unable to adequately assess or respond to the residents' aspiration risk or dysphagia. The DCV staff has failed and is failing to determine what specialized medical services are required for these residents and to ensure that such services are timely obtained whenever necessary. The DCV primary physicians also fail to ensure adequate continuity of care for these residents with outside hospitals when hospitalized and with outside medical consultants when furnished with a specialty consult.

Generally, the medical staff at DCV is failing to provide the residents with adequate medical assessment, diagnosis, treatment and monitoring of their conditions in keeping with generally accepted standards of medical care. For example, DCV primary care physicians fail to conduct comprehensive evaluations of all residents for whom they are responsible. Even though a medical treatment plan is urgently needed for each resident, DCV fails to provide each resident with an adequate, individualized medical plan of care. Our consultants could find no integrated medical plan of care in any DCV resident's chart. The medical staff is also failing to respond to changes in an individual's medical condition in a timely and appropriate fashion. Finally, the DCV medical staff inadequately monitors the effectiveness of medications prescribed. DCV medical records lack sufficient information to justify orders for medications or changes in medication. The absence of such data undermines the ability to evaluate the efficacy of medication treatment. As a result, residents may continue to receive medications that are not effective and do not resolve their medical condition. This also unnecessarily exposes these individuals to the risks of medication side effects.

DCV is failing to provide adequate and appropriate routine, chronic, and emergency seizure management to all epileptic individuals at DCV in accordance with accepted professional standards of care. Individuals prone to seizures need regular and periodic medical review of their condition and care. However, at DCV, there is grossly deficient medical practice in this respect. DCV fails to provide individuals with epilepsy with a comprehensive neurological assessment of their condition; and there is no apparent neurology follow-up of residents with epilepsy either by a DCV physician or by an outside consultant neurologist. As a result, it is not clear whether many DCV residents still need to be taking anticonvulsant medication.

DCV fails to provide adequate staffing to meet residents' medical needs. As we first indicated to you in our 1991 findings letter, DCV does not have the expertise, and is simply not equipped to provide the specialized medical care and treatment required for its mentally ill and mentally retarded populations. To make matters worse, DCV fails to provide its medical staff with needed staff development and continuing medical educational opportunities that would help enable them to meet these needs. On our most recent visit, staff at the facility complained to us that there were endemic staff shortages at DCV. With respect to physician staffing levels, for example, Dr. Allin, a psychiatrist at DCV, has been pressed into duty as a surrogate internist because of staff shortages. Dr. Allin is trained as a psychiatrist, not as a primary care physician, so the individuals under his care are not being afforded the needed services of a general care medical doctor. In addition, there is a trend at DCV to hire contract physicians who, at least initially, will be

largely unfamiliar with the needs of the DCV residents they are to care for. This is already a problem at DCV given the large number of contract/ agency nursing staff employed at the facility. In short, the current DCV staff is quantitatively inadequate and qualitatively deficient to deal with the complex medical needs of the DCV population.

DCV violates generally accepted practice by failing to maintain adequate and appropriate medical records with proper documentation. Interdisciplinary team notes in the individual residents' charts are grossly inadequate; meaningful progress notes are either absent or inadequate as physicians do not consistently make notes in the individuals' charts when appropriate; and medical forms in the charts are not up-to-date and often have inexplicably not been updated for months or even years. In short, DCV lacks a recordkeeping system that is sufficient to provide accurate, relevant and timely information upon which professional decisions may be based regarding the necessary care for residents. As we first indicated in 1991, inadequate recordkeeping practices have compromised DCV's ability to provide adequate care to its residents.

There are many other specific deficiencies in the provision of medical care and services at DCV including the DCV medical quality assurance system. In this regard, the staff fails to ensure that ordered services are actually rendered and that ordered medications are actually given to residents.

II. NURSING CARE IS INADEQUATE.

DCV is failing to ensure that its residents receive adequate nursing care, and that DCV nurses perform their responsibilities in keeping with accepted professional standards of care by adequately identifying health care problems, notifying physicians of health care problems, monitoring and intervening to ameliorate such problems, and keeping appropriate records of residents' health care status.

One of the most urgent problems at DCV is the facility's failure to provide each individual with adequate and appropriate nutritional management in accordance with accepted standards of care. This failure has placed many DCV residents at risk of aspirating which is an extremely dangerous, potentially life-threatening situation. DCV is failing to identify, assess and diagnose each individual who has a nutritional management problem, including difficulty swallowing, chewing, or retaining, assimilating or eliminating food and/or liquids. DCV is failing to ensure that residents are not fed improperly or while improperly positioned in a wheelchair. The DCV staff does not provide adequate medical and nursing care services with respect to those individuals with dysphagia and other eating disorders. DCV has failed to develop screening indicators to identify

individuals who are aspirating, are at risk of aspirating, and/or who have symptoms of gastroesophageal reflux. DCV is failing to provide comprehensive, interdisciplinary evaluations and diagnoses for these individuals and is failing to identify medical, dietary, feeding and positioning needs of each such individual. Even for those individuals so identified, DCV fails to regularly monitor the progress of the DCV residents at risk of aspirating and to take whatever assessment, diagnostic, treatment, or supervision steps are necessary to ameliorate the individual's risk.

The nursing assessments at DCV are inadequate and are not in keeping with accepted professional practices. DCV fails to conduct adequate comprehensive nursing assessments with quarterly updates of the nursing care needs of the DCV residents. DCV also fails to develop and implement adequate and appropriate comprehensive nursing care plans to address each resident's health care needs in accordance with accepted professional practices. DCV also fails to develop and implement an appropriate nursing care plan to address any acute condition. Moreover, nursing staff should routinely monitor each individual's current condition and review treatment needs. However, DCV fails to routinely perform on-going monitoring of serious medical conditions, and to undertake such basic procedures as taking vital signs and monitoring other individualized health status information. For example, the DCV nursing staff routinely fails to monitor individual weights and respond to individual nutritional needs in a timely fashion. DCV needs an adequate quality assurance system to ensure that proper care and monitoring are being provided to the residents.

The current nursing staff is inadequate to meet the needs of the DCV residents. The clientele at DCV have very complex medical and nursing needs with many individuals having unique bathing and/or toileting needs. Consequently, a sufficient nursing presence is crucial to their adequate care. The existing nursing staff has been forced to operate in a perpetual "crisis mode." As a result, nursing and medical care have greatly suffered. Nursing ratios must be increased generally to ensure the provision of basic nursing care, adequate supervision and therapeutic interaction for each resident.

There is currently a staffing problem given the widespread and common use of agency/contract nurses at DCV. Current nursing vacancies are not being filled, and according to the DCV Director of Nursing, agency/contract nursing staff now approaches fifty percent of total shift coverage within the facility. This is an extraordinarily high use of outside nurses and it is unacceptable. Such widespread use of agency/contract nurses presents serious risks to the health and safety of the DCV residents because the individual members of the contract staff often do not even know the names and identities of the residents

to whom they are providing care and nursing services. As such, the current practice at DCV is neither clinically appropriate nor a safe means of providing nursing care to the DCV residents.

The DCV nursing staff needs to be inserviced to ensure that they have been provided with the appropriate training to care for the diverse and challenging DCV population. DCV nurses, especially the contract nurses, are in urgent need of appropriate inservice training on the specialized needs of the DCV population, especially those with mental illness and those with mental retardation.

There are other nursing deficiencies at DCV. For example, there is evidence of an excessive number of medication errors at DCV. The facility lacks adequate nursing protocols for certain problematic yet recurring conditions among the DCV residents: eating and swallowing disorders; non-ambulatory residents; residents with seizure disorders; residents with serious behavioral problems; residents with dementia and/or mental illness; residents with mental retardation; and residents prone to confusion, falling, bedwetting, etc. Nursing care rendered to immobile residents is inadequate. At DCV, they are bathed only every three days, they are provided with irregular and inadequate range of motion exercises, and they are not turned frequently enough, thus exposing them to the risk of decubiti. In addition, physical management is insufficient to meet the residents' needs.

There are also a number of basic care deficiencies at DCV. For example, the facility fails to provide adequate pest control throughout the institution. Our consultants frequently observed ants at DCV on our most recent tour. On some units, there was a foul odor akin to a urine smell. Finally, some residents expressed concerns about missing and ill-fitting clothes, as well as unappetizing foods.

III. PSYCHIATRIC CARE IS INADEQUATE.

The District is failing to provide DCV residents with adequate and appropriate psychiatric care and mental health services in accordance with accepted professional standards to residents who need such services.

DCV has an insufficient number of psychiatric staff to provide adequate care and training to meet generally accepted professional standards. In our 1991 letter, we notified you that one of the most glaring personnel deficiencies was the shortage of staff with specialized training in the care and treatment of mental illness. We indicated that the current DCV staff was inadequate to deal with the complex psychiatric and medical needs of the DCV population. Unfortunately, this is still true today. Even the staff at the facility complained to us on our most recent visit that there were endemic staff shortages at DCV and

that this directly compromised the provision of psychiatric care and treatment. A recent example of the negative impact of the staffing shortage at DCV is the recent forced closure of Unit 3B which primarily served residents with mental illness. The staff is largely unfamiliar with the residents' individual psychiatric needs. This is especially true of the contract/agency staff at DCV. Because of the unavailability of trained and supervised professional and direct care staff, DCV both overuses and dangerously misuses chemical restraints on residents.

A psychiatrist working at a facility like DCV should not be responsible for the primary medical care of any resident. However, at DCV, Dr. Allin, a psychiatrist, has recently been pressed into service as a surrogate internist because of staff shortages. As a result, there is no qualified psychiatrist working at DCV who is responsible solely for the coordination of mental health services at the facility. Ever since Dr. Allin has been saddled with inappropriate primary care responsibilities, there has been a marked decrease in the quality of psychiatric care rendered at DCV. Serving as a primary care physician has kept Dr. Allin from providing psychiatric services to any residents outside of those on his caseload, and has greatly impaired his ability to tend to the psychiatric needs of his own patients.

It is generally accepted that individuals with mental illness, like those at DCV, are to be provided with adequate psychiatric assessment, diagnosis, treatment and monitoring of their condition. Specifically, they are to be afforded an initial comprehensive psychiatric assessment, a carefully considered psychiatric differential diagnosis based on DSM-IV criteria and objective behavioral data, a psychiatric treatment plan that is integrated with the individual's medical plan of care and with the individual's behavioral treatment programming, adequate psychiatric monitoring that includes quarterly updates of the psychiatric treatment plan, and at least a monthly psychotropic drug review to monitor drug efficacy, dosing and side effects. However, DCV does not afford this to its residents.

DCV is not providing its residents with a comprehensive psychiatric assessment including adequate behavioral data and with a functional analysis of the individual's behavior where appropriate. DCV also conducts no cognitive examinations or dementia work-ups of its residents. DCV is not providing its mentally ill residents with an integrated differential diagnosis and treatment plan which is signed by the psychiatrist. It is generally accepted in the field that a proper DSM-IV diagnosis be formulated and recorded before any institutionalized resident is provided psychotropic medication. However, the DCV medical staff is not familiar with and does not appropriately employ the DSM-IV criteria or terminology in formulating psychiatric diagnoses.

Many DCV residents have been placed on psychotropic medications without adequate documentation. This violates generally accepted practice.

With respect to psychiatric treatment at DCV, there is no effort made to integrate psychiatric care for the residents in a multidisciplinary fashion. Psychiatric notes are not integrated with the individual's overall medical plan of care or with behavioral treatment programs. Our consultant could not find a single integrated medical/ psychiatric/ psychosocial plan in any DCV resident's chart. It is generally accepted that prior to prescribing psychotropic medication for individuals with behavior problems, a facility is to specify that alternative non-pharmacological treatments have been systematically attempted and that they have been ineffective. However, this is not done at DCV. As we first indicated in our 1991 letter, DCV is failing to adequately integrate the use of psychotropic medication with behavioral programming. At DCV, there is no organized use of psychotropic medication in a carefully considered plan of care, and there is no rationale provided when medication dosages are changed. There is also no consistent correlation between medication order changes and progress note documentation of such changes. All this does not comport with accepted standards in the field. As a result, integrated psychiatric treatment plans are urgently needed for the DCV residents to ensure that programming options are exhausted before medications are perhaps needlessly employed.

Psychotropic medications are often used incorrectly at DCV. For example, medication dosing does not always conform to geropsychiatric standards, dosing of antidepressants is inadequate or not properly titrated, depression is poorly documented (if at all), and there is widespread usage of PRN medication at DCV. There are also many individuals with the medication side effect of tardive dyskinesia ("TD") living at DCV. Yet, anticholinergic medications are improperly prescribed for TD, even though these agents will, in fact, worsen TD. The DCV physicians are confusing TD and extrapyramidal symptoms. This indicates a lack of basic neuro-chemical/ neuro-pharmacological understanding among medical providers at DCV and highlights the need for inservice training in psychopharmacology and geriatric psychopharmacology. Our consultant concluded that the DCV primary care doctors are not adequately trained in the field of psychiatry. ^{1/}

^{1/} DCV provides virtually no inservice training on mental health issues for its medical care staff, nursing staff or other direct care staff. As a result, psychiatric care at DCV has suffered on every level. A continuing education program in mental health issues and practices needs to be developed for the medical,

(continued...)

It is generally accepted that the monitoring of an individual's progress on a given psychiatric treatment should include the collection of appropriate objective and behavioral data so as to ensure that the individual is receiving benefit from the treatment. However, at DCV, the staff fails to collect and provide behavioral data to the physician or psychiatrist for evaluation of the particular treatment. In fact, at DCV, there is no evidence of follow-up by the psychiatrist or primary care physician regarding a resident's progress on a given psychiatric treatment.

As we first indicated in 1991, the facility's monitoring of psychoactive medications departs from accepted medical practice and fails to protect residents from serious risks of harm. Because of the dearth of behavioral and other data collected at DCV, the physician or psychiatrist is limited in his ability to determine whether a particular medication regimen has been successful or not, and whether it should be adjusted or withdrawn. This produces the risk of undue chemical restraint. Psychotropic medications used without continual justification by objective, accurate, individualized behavioral data constitute restraint for behavioral control purposes. In addition, necessary evaluations of medications are not made at DCV, nor is there evidence of attempts at "drug holidays" or at gradual reduction after extended usage at the same dosage. Once DCV achieves stabilization of acute behavioral symptoms through medication, the staff no longer provides dynamic treatment; the treatment becomes static.

In addition, side effects of psychotropic medications are inadequately and improperly monitored at DCV. We first notified you in 1991 that DCV residents are not adequately monitored for drug side effects. For example, there currently is no regular review of prescribed psychotropic medications to integrate side effects with symptoms; DCV does not take postural blood pressure ratings on residents; and our consultant found that AIMS scores in residents' charts appeared to be perfunctory and did not correlate with his own observations.

IV. PSYCHOLOGICAL SERVICES ARE INADEQUATE.

The District is failing to provide the residents of DCV with that level of minimally adequate individualized behavioral programming to ensure and protect the DCV residents' liberty interests in personal safety and freedom from undue or unreasonable restraint.

1/((...continued)
psychiatric, nursing and other staff. In addition, the pharmacy department should be inserviced on geriatric psychopharmacology.

Individuals living in an institution like DCV must be protected from physical injury and psychological harm stemming from behavior problems. An individualized behavioral treatment program, devised and implemented according to currently accepted professional standards, can reduce and eliminate these maladaptive behaviors. However, the behavioral treatment programs currently utilized at DCV substantially depart from accepted professional standards. DCV fails to provide an adequate array of comprehensive individualized training programs developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, unreasonable use of bodily restraints, prevent regression, and facilitate the growth, development, and independence of every DCV resident. Our consultant psychologist found that DCV residents are being subjected to harm and unreasonable risk of injury due to major deficiencies in the assessment of residents and in the development, implementation and monitoring of resident behavioral programs. As a result, the District is failing to provide reasonably safe conditions and to ensure the reasonable safety and personal security of the DCV residents.

All behavioral programs must be based upon an adequate assessment of resident need, including the need to develop programs to address maladaptive behaviors. DCV residents have evidenced quite a range of maladaptive behaviors, including self-injurious behavior, pica, including ingesting feces and drinking from the toilet, and aggression. At every stage of the assessment, analysis and treatment of an individual's behavioral problems, DCV is failing to meet accepted professional practices. The inadequacies in the development and implementation of behavioral programs at DCV have deprived the residents of effective treatment for their maladaptive behaviors and violated their rights.

Residents demonstrating self-injurious, physically abusive or other destructive behaviors are not being provided appropriate training to reduce or eliminate such behaviors. The limited behavior programs that are provided are not data based and thereby fail to meet professional standards. DCV lacks a facility-wide behavioral observation system that is used by all staff. Absent appropriate data, DCV staff cannot evaluate whether behavior programs are effective.

The District is engaging in the use of chemical restraints by failing to ensure that psychotropic medications are prescribed and administered to DCV residents in keeping with accepted professional standards, and are not used in lieu of treatment, or for the convenience of staff. For those dually diagnosed individuals who need both behavioral programming and medication for their mental illness, it is extremely important that the two treatments are integrated properly. Accurate and reliable

behavioral data is particularly important when behavioral programs are combined with pharmacological treatment. In addition, written programs must show that the psychologist and physician have discussed the probable consequences of the combined treatments. However, at DCV, the level of integration of behavioral and pharmacological interventions is minimal. DCV fails to provide adequate behavioral programming for residents taking psychotropic medication. The programming that does exist, moreover, is not integrated with the use of psychotropic medication.

For those individuals on psychotropic medication, it is generally accepted that the treatment monitoring process is to involve continual reevaluation of the individual's existing behavior management program to determine whether it is appropriate and effective and whether the programs or interventions need to be developed or modified to address the resident's target behaviors so as to reduce or eliminate the need for psychotropic medication. However, DCV employs inadequate procedures for monitoring the effectiveness of behavioral programs and/or medications prescribed.

The District is failing to ensure that DCV residents are free from undue or unreasonable restraint. DCV fails to provide professionally developed individualized training programs that are sufficient to ensure that residents are not subjected to unwarranted and unreasonable restraints. For example, instead of programming, DCV routinely uses mitts to control the maladaptive behaviors of certain residents. The DCV staff consistently fails to identify and eliminate circumstances which provoke problematic behaviors in residents, particularly those who are mentally retarded. As a result, the staff intervention invariably focuses on restraint to control maladaptive or aggressive behavior, without resort to other recognized therapy methods. Physical and chemical restraints are both overused and dangerously misused by DCV staff on residents because of the lack of essential training programs.

Not all residents with behavior problems are being provided with a comprehensive interdisciplinary evaluation to determine the individual's need for training. As mentioned, there is no adequate behavior data collection system in place at DCV. For individuals with problem behaviors, DCV is failing to provide them with adequate functional analyses.

The District is also failing to provide DCV residents with that level of individualized training necessary to enhance functioning, and facilitate growth, development, and independence. In the absence of such programs, residents do not develop the skills necessary to exercise any degree of independence and they remain totally dependent on staff to meet all their needs.

DCV residents' functional capabilities are deteriorating because of inadequate interaction, stimulation and treatment. Our consultants observed that the residents typically sit around all day with nothing to do. Often this occurs while individual staff are in the room watching television. As a result, training programs at DCV are not implemented, revised or updated. In talking with staff on the units, it was not clear at all to our consultant that the residents who were supposed to be getting programming were actually getting it. Individual staff on the units were, for the most part, completely unfamiliar with the individuals' programming needs. In fact, the programming books that they are to use are located at a location far from the actual living units. Further, the training programs as written, focus on activities for the staff to do for the resident instead of for the resident to complete him or herself. This does not comport with generally accepted practices. The communication programs in place at DCV are inadequate in that they do not teach the residents to express their needs and wants. Activity programs and level of staff interaction are not adequate to even ensure maintenance of existing functional levels. Currently, activities of daily living and assistance with eating are considered activity therapy and are used to justify very limited provision of occupational and physical therapy.

We noticed a recurring problem at DCV in that there was a shortage or absence of needed adaptive equipment. For example, the speech therapist regularly noted that adaptive spoons or adaptive cups were not available for use with the residents. Even though this occurred repeatedly, DCV took no steps to remedy or even reference the problem in a quarterly or monthly review.

As we indicated in 1991, inadequate recordkeeping practices have compromised DCV's ability to provide behavioral treatment and training to its residents. DCV lacks a recordkeeping system sufficient to provide accurate, relevant and timely behavioral data upon which professional decisions may be based regarding the programming for its residents. The absence of such data undermines the ability to assess an individual's progress on a given treatment plan and the interaction of drugs and behavioral intervention.

DCV does not provide adequate psychology service hours to its residents. As we indicated in 1991, the most glaring personnel deficiency is the shortage of staff with specialized training. The current DCV staff is inadequate to deal with the complex psychiatric and psychological needs of the DCV population. Physical and chemical restraints are both overused and dangerously misused by DCV staff on residents because of the unavailability of trained and supervised professional and direct care staff.

V. FEDERAL STATUTORY VIOLATIONS

Based upon our tours, we believe that the District is not in full compliance with a number of federal statutes and regulations. For example, the District is not meeting the PASSAR requirements pursuant to 42 C.F.R. § 483.100 et seq. (1994). For those mentally retarded and mentally ill individuals confined at DCV, the District must provide them with adequate and appropriate specialized services. For those with mental illness, this includes, for example, the continuous and aggressive implementation of an individualized plan of care that, among other things, works toward reducing the resident's behavioral symptoms and improving his or her level of independent functioning. For those individuals with mental retardation, it entails, for example, the aggressive and consistent implementation of a program that works to enable the individual to acquire behaviors necessary for the individual to function with as much self-determination and independence as possible. However, the District fails to adequately provide and implement these services for its mentally ill and mentally retarded residents confined at DCV.

The District is also failing to meet the requirements of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., and the regulations promulgated pursuant thereto; and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 et seq., and the regulations promulgated pursuant thereto with respect to many individuals, especially children and other individuals whose primary diagnosis is mental disability -- individuals with mental illness or developmental disabilities. DCV is an isolated, self-contained environment which necessarily separates its residents with disabilities from the rest of society. As a result, the facility fails to provide its residents treatment in an environment that permits contacts with society and its mainstream social institutions, demands independent functioning and permits the exercise of judgment and contact with family members. The District must provide its residents with disabilities an opportunity to participate in or benefit from aids, benefits and services equal to that afforded to others outside the institution; more specifically, to those provided to other individuals with disabilities in the District's well established community-based programs. The residents are entitled to aids, benefits and services that are as effective in affording them the equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as those served in community-based programs. By confining residents with disabilities at DCV, the District is failing to provide such services in the least separate, most integrated setting as required by the ADA and Section 504.

Further, we are concerned that the District may not be providing its school-aged residents with an appropriate education in accordance with the requirements of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq. The DCV children are not being served in the least restrictive environment. Confined at the facility, they are necessarily denied adequate involvement and interaction with other school-aged children contrary to the IDEA.

In addition to the above statutory and regulatory violations, we note the many historical violations, cited by the Health Care Financing Administration, of the Medical Assistance Program (Medicaid) established under Title XIX of the Social Security Act, 42 U.S.C. § 1396r et seq., and the regulations promulgated pursuant thereto, and of the Health Insurance Program for the Aged and Disabled (Medicare) established under Title XVIII of the Social Security Act, 42 U.S.C. § 1395i et seq., and the regulations promulgated pursuant thereto.

VI. MINIMAL REMEDIAL MEASURES

In addition to the remedial measures specified in our letter dated August 19, 1991, the following additional measures, at a minimum, need to be implemented at DCV in order to protect the rights of residents and other individuals with disabilities currently confined there.

1. Facility Reorganization

a. Steps must be taken to ensure that the facility is operated as a nursing home consistent with currently accepted professional standards of care by, inter alia, placing all inappropriately placed individuals, i.e., children and other individuals with a primary diagnosis of mental illness or mental retardation, in appropriate community based programs and facilities. Priority in placement should be given to children. No further children shall be admitted to the facility. All services developed to serve these individuals will be provided in the least separate or most integrated setting.

b. All residents of DCV with mental disabilities should be professionally evaluated to determine the residential, day program, medical and other services needed to serve them in the community. Such programs should be established within a reasonable period of time and the residents placed in them. All placements should be monitored consistent with professionally based quality assurance standards and no person shall be placed in any program which cannot fully meet their needs.

c. All school-aged children should be evaluated to determine their individual needs with respect to educational services, related services and auxiliary aids to permit them to

be placed and receive appropriate educational services in the least restrictive environment.

d. To the extent that children and other individuals with disabilities remain at DCV for any period of time, services must be enhanced to meet their specialized needs, including requirements for adequate treatment and training.

2. Medical Care

The District shall ensure that DCV residents receive adequate preventive, chronic, routine, acute, and emergency medical care in accordance with generally accepted standards of care. To this end, DCV primary care physicians shall:

a. Conduct comprehensive evaluations of all residents for whom they are responsible;

b. Determine what specialized medical services are required for the residents for whom they are responsible and ensure that such services are timely obtained whenever necessary to evaluate or treat the individual's medical problems;

c. Ensure that each individual has an integrated medical plan of care to address any chronic medical problem;

d. Ensure that each individual's medical status and progress in response to the individual's medical plan of care is fully and adequately reviewed.

DCV shall provide adequate medical care for those individuals at risk of aspirating. To this end, DCV shall:

a. Identify individuals who are at risk of aspirating;

b. Take any appropriate medical steps to ameliorate the individual's aspiration risk and develop and implement an individualized feeding and positioning plan for each individual identified as at risk of serious illness, injury, or death due to aspiration;

c. Develop and implement a system to regularly monitor the progress of the DCV residents who are at risk of aspirating to ensure that the staff is continually taking whatever assessment, diagnostic, supervision and treatment steps are necessary to ameliorate the individual's risk.

The District shall provide adequate and appropriate routine, chronic, and emergency seizure management to all individuals with epilepsy at DCV in accordance with accepted professional standards of care.

3. Nursing Care

The District shall ensure that residents receive adequate nursing care, and that DCV nurses perform their responsibilities in keeping with accepted professional standards of care by adequately identifying health care problems, notifying physicians of health care problems, monitoring and intervening to ameliorate such problems, and keeping appropriate records of residents' health care status. To this end, DCV nurses shall:

- a. Conduct adequate, comprehensive assessments;
- b. Develop and implement adequate and appropriate comprehensive nursing care plans to address each resident's health care needs;
- c. Routinely perform on-going monitoring of serious medical conditions, including such basic procedures as taking vital signs and measuring weights;
- d. Develop and implement a system for recording important information about a resident's status to monitor changes;
- e. Ensure that all DCV residents receive adequate and appropriate food, shelter, and clothing.

The District shall provide each individual at DCV with adequate and appropriate nutritional management in accordance with accepted standards of care. To this end, DCV shall:

- a. Identify each individual who has a nutritional management problem, including dysphagia, difficulty swallowing, chewing, or retaining, food and/or liquids;
- b. Have an interdisciplinary team of oral motor specialists comprehensively assess each such individual to identify the causes for the nutritional management problems;
- c. Take necessary medical steps to ameliorate the problem;
- d. Develop and implement a system to regularly monitor the progress of the DCV residents with nutritional management difficulties to ensure that staff is continually taking whatever assessment, diagnostic, supervision and treatment steps are necessary to ameliorate the individual's difficulties.

The District shall provide each individual at DCV with adequate and appropriate physical management in accordance with accepted standards of care.

4. Psychiatric Care

The District shall provide adequate and appropriate routine and emergency psychiatric and mental health services in accordance with accepted professional standards to residents who need such services. Psychotropic medication shall only be used in accordance with accepted professional standards and shall not be used as punishment, in lieu of a training program, for behavior control, in lieu of a psychiatric or neuropsychiatric diagnosis, or for the convenience of staff. DCV shall:

a. Conduct a comprehensive assessment of each DCV resident receiving psychotropic medication;

b. Develop an overall treatment plan for each resident with a diagnosis of mental illness with a description of clear, objective and measurable short-term, intermediate and long range goals and objectives for each resident including time frames for the achievement of each, and provide on-going monitoring of the treatment;

c. Document that, prior to using the psychotropic medication for behavior modification, other, less restrictive techniques have been systematically tried as part of a training program and have been demonstrated to be ineffective.

DCV must develop and implement an adequate system for detecting, reporting, and responding to any drug-induced side effects of psychotropic medication.

5. Psychological Services

The District shall provide an adequate array of comprehensive individualized training programs at DCV developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, unreasonable use of bodily restraints, prevent regression, and facilitate the growth, development, and independence of every DCV resident. To this end, DCV shall:

a. Conduct a comprehensive interdisciplinary evaluation of each DCV resident with special needs to determine the individual's need for training;

b. Develop and implement a professionally based, individually appropriate data collection system to measure relevant information about maladaptive behaviors and the conditions under which they occur, including, where appropriate, the frequency, intensity, and duration of the behaviors;

c. Have a qualified professional develop and implement a professionally based, individualized training program for each

resident and provide each individual with an adequate number of hours of training.

The District shall ensure that bodily restraints, including emergency restraints and time out, are used only pursuant to accepted professional standards and that they are never used as punishment, in lieu of training programs, or for the convenience of staff.

6. Recordkeeping and Staffing

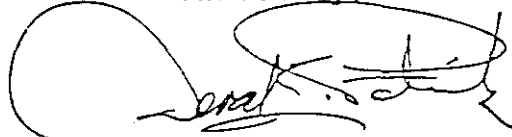
The District shall establish and maintain an adequate record for each individual that comports with accepted professional standards that shall include current information with respect to his/her care, medical treatment, and training and shall require staff to utilize such records in making care, medical treatment and training decisions.

The District shall ensure that a sufficient number of professional and non-professional staff are employed to fully meet the needs of the DCV residents.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution or otherwise to protect the rights of its residents 49 days after appropriate officials have been advised of the relevant violations of law. 42 U.S.C. § 1997b(a)(1). Therefore, we anticipate hearing from you as soon as possible but no later than 49 days after the date of this letter with any response you may have taken or intend to take to implement each of the remedies described above. If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unconstitutional and unlawful conditions we have identified. In your response, please address your willingness to enter into a judicially enforceable agreement to memorialize any agreement we may subsequently reach regarding this matter.

We look forward to working with you to resolve this matter in a reasonable and practical manner. If you or your staff has any questions, please feel free to contact Richard Farano at 202-307-3116, or David Deutsch at 202-514-6270.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Melvin Bolden, Esq.
Assistant Deputy Corporation Counsel
Office of the Corporation Counsel
Government of the District of Columbia

T. Britt Reynolds, Esq.
General Counsel
Department of Human Services
Government of the District of Columbia

Ms. Alberta Brasfield
Executive Director
D.C. Village Nursing Home

The Honorable Eric H. Holder, Jr.
United States Attorney
District of Columbia