EXHIBITS

Exhibit 1	a.	Declaration of Ellen Anderson, B.S.N., M.A., J.D. Curriculum Vitae of Ellen Anderson
	b.	Declaration of Saundra Baugh
	c.	Declaration of Charles Burgess
	d.	Declaration of Robert Dorr
	e.	Declaration of Linda K. Duval, R.N.
	f.	Declaration of Rebecca Elon, M.D., M.P.H. Curriculum Vitae of Rebecca Elon
	g.	Declaration of Curmet Forte
	h.	Declaration of Blaine S. Greenwald Curriculum Vitae of Blaine Greenwald
	i.	Declaration of M. Anne Hart
	j.	Declaration of Charlease Hatchett
	k.	Declaration of Andrew Hawkins
	l.	Declaration of Joseph Haynes
	m.	Declaration of Maria Laurence
	n.	Supplemental Declaration of Maria Laurence Letter from Karen Clay to Frances Bowie
	o.	Declaration of Ronald L. Messenheimer
	p.	Declaration of John Mogenson
	q.	Declaration of Maria Morton
	r.	Declaration of Jack H. Robinson
	s.	Declaration of Alan I. Roomberg
	t.	Declaration of Lamont Royster
	u.	Declaration of Ted Schimpff
	v.	Declaration of Laura Scott
	w.	Declaration of Willie Veasey
	x.	Declaration of Marco Waters
	y.	Declaration of Pernell J. Williams
Exhibit 2		Past Amounts Due DCV Vendors

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	
	)	

DECLARATION OF ELLEN ANDERSON, B.S.N., M.A., J.D.

I, Ellen Anderson, B.S.N., M.A., J.D., the United States' nursing consultant in this case, pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), do hereby declare:

1. I am a registered nurse with twenty-three years of experience in the health care field. My experience and background encompass serving as a nurse clinician, a clinical and staff nurse, to serving as the deputy director for the State of Maryland's Department of Health and Hygiene, Mental Hygiene Administration. In that capacity I was responsible for the programmatic management of over 110 community-based programs and the fourteen facilities administered by the Mental Hygiene Administration. More recently, I served as the senior administrator responsible for the direction and operation of the University of Maryland, School of Medicine, Departments of Anesthesiology and Psychiatry. I have also served as a faculty

associate to the University of Maryland, School of Medicine. Most recently, I have served as a consultant evaluating nursing and health care and working with state and local governments and private corporations regarding health care delivery systems for thousands of patients.

2. To acquaint the Court with my specific qualifications, I provide a copy of my curriculum vitae, which is attached to my Declaration, which contains further details about my experience and qualifications.

3. I have served as an expert consultant in cases involving professional nursing standards for long-term care. I have worked with the United States Department of Justice since 1989 in the Department's investigation and enforcement activities under the Civil Rights of Institutionalized Persons Act ("CRIPA"). In this capacity, I have been involved with CRIPA investigations in several states including New York, Maine, Virginia, Massachusetts, California and the one CRIPA investigation in the District of Columbia.

INVOLVEMENT WITH THIS CASE AND FAMILIARITY WITH D.C. VILLAGE NURSING HOME

4. In April 1994, I was asked by the Department of Justice to serve as an expert consultant to assess the care and treatment of residents at the D.C. Village Nursing Home in Washington, D.C. I first toured D.C. Village on June 6-7, 1994. Prior to the tour, I reviewed numerous documents provided by D.C. Village, including policies and procedures of the facility, internal

reports and summaries, consultations and treatment protocols, staffing patterns and sign-in sheets, incident reports and hospitalization records. During the investigative tour, I observed, among other things, routine nursing and health care, routine management, training and treatment of residents on their living units, as well as meal times on the living units. In addition, I reviewed numerous records, including medical records, Interdisciplinary Team ("IDT") notes, nurse progress notes and assessments, physician notes, and hospitalization records. I also interviewed residents and multiple staff members. In addition, I observed the care and treatment of decubitus ulcers.

5. My review of the care and treatment of D.C. Village residents in 1994 revealed a number of critical deficiencies. The nursing care and related treatment provided to the residents was significantly below accepted professional standards. Of most immediate concern was the facility's failure to provide each resident with adequate and appropriate nutritional management in accordance with accepted standards of care.

6. In addition, I found inadequate nursing care and treatment for the care, prevention and treatment of decubitus pressure ulcers and an excessive number of medication errors.

7. I also found that the nursing staff complement, comprised of almost 50% temporary contract nurses, failed to meet the needs of the D.C. Village residents. Nursing staff was being forced to function in a perpetual "crisis mode." As a result,

residents were placed at risk of harm due to the resulting inadequate nursing and medical care.

8. I re-toured D.C. Village on May 25-26, 1995 and again on May 30, 1995. Again, I observed the routine medical and clinical care, management and treatment of residents and spoke with a number of staff. I conducted interviews with direct care staff, various Registered Nurses ("RN"s) and Licensed Practical Nurses ("LPN"s), and the newly appointed Director of Nursing. I also spoke with a number of residents. I directly observed the care and treatment of residents with decubitus pressure ulcers feeding of residents, and medication administration. During the tour, I reviewed more documents, including individual resident medical records, medication logs, nursing and physician notes and orders.

9. I found that the deficiencies I identified in the prior year had not been corrected by the District. I was especially concerned to find that in many instances conditions had deteriorated, placing residents at further increased risk of significant harm.

10. In my opinion, nursing care and treatment at D.C. Village are inadequate and pose a serious, immediate risk of harm to D.C. Village residents.

Nursing Care For Residents' Decubitus Ulcers is Inadequate

11. A major concern at D.C. Village is the high incidence of decubitus ulcers (i.e., pressure sore ulcers involving skin tissue wounds and destruction). Decubitus ulcers are routinely

classified in four stages: Stage I (superficial wound); Stage II (partial-thickness wound); Stage III (full-thickness wound and Stage IV (deep tissue destruction).

12. It is generally accepted that most incidents of decubitus ulcers are preventable and all are treatable if identified at an early stage. The key is identifying the at-risk patient and, where a risk is identified, taking appropriate preventive measures.

13. Prime candidates for pressure ulcers include the elderly, the chronically ill, the immobile, weak and debilitated individuals, nutritionally compromised individuals, residents with altered mental status or who are incontinent, and persons who have decreased sensation and accompanying paralysis. Due to the prevalence of these conditions at D.C. Village, a large segment of D.C. Village's population are prime candidates for decubitus pressure ulcers.

14. Preventive measures include repositioning patients regularly every two hours to take the pressure off any single area, introducing pressure-relieving devices, keeping the skin clear of urine and feces, assessing nutritional and fluid needs, gently cleaning and drying potential skin breakdown areas, massaging around the area with appropriate ointments to improve circulation, and recording site and treatment interventions.

15. During my investigation, I asked the charge nurse on each unit to identify residents with decubitus ulcers and the stage of their skin breakdown. Facility-wide, over 30 residents

with decubitus ulcers were identified. This means that with a total census of 279, more than 1 out of every 10 D.C. Village residents suffers from this condition that is largely preventable. Several of the residents had recurring decubiti and many had multiple decubitus ulcers.

16. In my opinion, D.C. Village residents continue to suffer unnecessary skin breakdowns that are not being assessed, evaluated and treated properly. The neglect and improper care of decubitus ulcers at D.C. Village has had dire consequences for a number of residents.

17. For example, I observed Claude B. in the surgical clinic after he had been sent there for the treatment of his decubitus ulcers. Claude has a stage IV decubitus ulcer on his right hip and a skin flap closure on his left hip. He also has two "new" stage II decubiti on his left foot which the treating physician described as resulting from Claude having been left on his left side for prolonged periods. Claude B.'s decubitus ulcer on his hip is one of the worst I have seen in my professional career. It was deep, red and raw with the skin completely eaten away. It was sickening and hard to view such sores on the body of another human being. Claude kept squirming and crying out from pain while the treating physician manipulated the skin tissue to examine the wound. Claude had to be restrained by the nurse. I have seen some pretty hideous bedsores over my 23 years of nursing practice but this particular sore was horrible and one of the worst I have ever seen. In my opinion, given the

inadequate care and treatment, further skin breakdown is imminent for Claude unless corrective action is taken immediately.

18. Claude was in the surgical unit for the treatment of two new stage II decubiti that had developed on his left foot. I watched the physician pull off the layer of skin tissue on top of the decubitus ulcers. Claude continued to cry out in pain. The skin was red, raw and bruised inside.

19. I also observed the decubiti of resident Lamont R. who is paralyzed from the neck down. Lamont has no feeling or sensation below the neck. He has a decubitus ulcer on his left ankle that he believes developed when he fell out of bed. A second decubitus ulcer on the ball of his left foot is now borderline stage III/IV. In my opinion, it looks infected. The decubitus ulcer on his foot was initially detected this past February and has not yet healed. Lamont indicates that he noticed urine flowing out of his tennis shoe. The urine had spilled out of Lamont's catheter tubing, down his pants leg and into his shoe. Upon having his shoe removed by staff, the sore was noticed. He described the sore as initially being the size of the tip of a pencil eraser. The decubitus ulcer I observed looked infected, was raw and deep and had increased to the size of a quarter.

20. Another resident, William S., has suffered from decubitus bedsores that were allowed to deteriorate resulting in the recent amputation of William's leg on April 28, 1995. William's medical record documented improper delayed notification

by nursing staff of signs of infection to the physician. The result was the amputation of William's leg that could have been avoided and prevented. William currently suffers from two decubitus ulcers. He has a large hole on his right hip that has eaten into the muscle that is reported by D.C. Village as a stage III ulcer. William also suffers from a decubitus ulcer on his right buttock that is raw, red and beginning to eat into muscle tissue. This indicates further breakdown of the skin. The wounds could easily be infected. I asked the D.C. Village nurse if a culture had been taken to see if either of the wounds were infected. The nurse informed me that none had been ordered. It is accepted nursing practice that a culture should be taken anytime a wound looks suspicious.

21. My review of William's medical record also indicated significant lapses in his care and treatment. William was 45 pounds below his ideal body weight prior to his amputation. I saw no evidence in his record that a nutritional assessment had been performed. Even now, William is still 10 pounds under his appropriate body weight. Still, no nutritional assessment has been performed. In addition, according to William's record, he failed to receive his supplemental feeding or physician-ordered water bolus (a procedure in which water is injected to insure proper hydration) the day before I commenced my tour at D.C. Village on May 24, 1995. Given his low weight, such neglect can have dire consequences unless appropriate nursing care is begun immediately.

22. Moses D. is another recent amputee, having had his right leg amputated on October 17, 1994 and his left leg on February 14, 1995. Moses currently suffers from two decubitus ulcers. I asked the charge nurse to remove Moses' dressing so that I could examine the decubitus ulcer by the base of his spine. I observed that the dressing was saturated with urine. The entire dressing, large portions of his body and the bed linens were soaked. The best way to describe what I saw was a pool of urine. Around the edges, the urine had dried, leaving huge stains. This indicates to me that Moses had been left laying in his own urine for hours without being checked. As a professional nurse, I was appalled by seeing that. A resident requiring total care who is bed-ridden should never be left for long periods of time without supervision. A bed-ridden resident should be offered a urinal regularly and checked, at a minimum, every two hours. After the charge nurse removed the dressing, I observed that Moses' urine had seeped through and was laying directly on the wound contaminating the decubitus ulcer. When I asked the charge nurse how often Moses' dressing was changed, I was informed once per day. In my opinion, this is inadequate. The wound I observed by his spine, near the tailbone, can be described as a borderline stage II/III decubitus ulcer. The entire top layer of skin was missing over the entire area. The ulcerated area was over 3 inches in diameter and the skin breakdown was complete to the muscle. I returned a second time to review Moses' care four days later on May 30, 1995, and was

utterly appalled to find almost the exact same situation. Moses was again laying in his bed with a urine soaked dressing over his decubitus ulcers. The bed was soaking wet. It appeared that Moses had been neglected again for hours.

23. My review of Moses' medical chart gives further indication of improper and inadequate care. The medication administration record ("MAR") documents that nursing staff had twice failed to provide Moses, within the prior week of my May 1995 tour, with his physician-ordered water bolus injection deemed necessary to insure adequate hydration. This failure serves to exacerbate Moses' skin breakdown as well as places him at risk of dehydration.

24. During my tour, staff and residents reported a lack of core essential supplies normally used to treat decubitus ulcers including duoderm tape, 4x4 pads and Silvadene ointment creme. One evening charge nurse reported that the shortages were as recent as the prior week. When asked about possible shortages, another nurse stated: "things have gotten better this week." The nurse indicated the belief that residents are at risk. A third nurse claimed that there had been numerous food, medication and supply shortages and that they have been short for so long, that staff have lost track of what is and is not available. Numerous other nurses and aides confided in me that supplies were an on-again/off-again proposition. A physician indicated that shortages of medications, especially antibiotics, had become

commonplace and that the physician was forced, on occasion, to substitute alternative medications.

Assessing and Monitoring the Nutritional and Feeding Needs of Residents is Inadequate

25. D.C. Village residents' nutritional needs are not being adequately monitored. For example, Houston J. had a documented weight loss of 24 pounds in less than three weeks yet no nutritional/medical assessment had been performed. Significant weight loss such as this can greatly compromise an individual's health and well-being. My review of medical records indicated that even residents identified at risk (e.g., William S. and Lamont R.) had not received nutritional assessments. Other residents, who had physician-ordered supplemental feedings (e.g., Richard G. and Catherine S.) had documented missed feedings thereby compromising their nutritional well-being. Moreover, my review of recent hospitalization records reveals four residents (Houston J., George A., Jeff C., and Thomas B.) being hospitalized between February 1995 and May 1995 with a listed diagnosis of dehydration.

26. Despite the fact that I had identified the failure to properly and adequately assess individuals at risk for swallowing problems during the prior year's tour, I observed minimal corrective action. In fact, I observed a poster in the lobby of the facility which announced that a "Dysphagia Clinic" was just being kicked off the first day of my investigative tour -- nearly a full year after my prior tour. During my investigation, I

observed a significant failure to adequately monitor residents during meal times. This failure places many D.C. Village residents at risk of aspirating which is an extremely dangerous, potentially life-threatening situation.

Risk of Medication Errors is Excessive at D.C. Village

27. During my investigative tour, I found evidence of many medication errors. On one unit, (Unit 3A), a review of the medication administration record ("MAR") and the corresponding medication blister packs revealed huge discrepancies. Medications were being documented as having been given when it was clear that they had not been administered. For that one unit, encompassing over 30 residents, the medication count was off for every single resident reviewed. While on the same unit, the record of one resident, Charles L., indicated that he was to be given a dose of Dilantin elixir (a medication to control seizures) twice a day. The record indicated that Charles had already received one dosage that day and was scheduled to receive a second dosage at 5:00 that afternoon. I asked to see the supply of the afternoon's medication. I was informed that they were out of the medication and that pharmacy would be supplying the medication later that day. Later that evening, I returned to the unit to ascertain whether the medication had indeed come in and had been administered. I was informed that the medication had not as yet arrived. However, upon reviewing the MAR, the medication had been marked as having already been administered to Charles. When confronted, the medication nurse admitted that the

record was indeed inaccurate and that the medication had not been given. This type of nursing practice grossly violates accepted nursing standards and is professionally unjustifiable.

28. On another unit, I found a discrepancy in the administration of Houston J.'s Dilantin (seizure medication between May 12, 1995 and May 25, 1995. I personally verified three missed dosages of Dilantin by counting the medications in Houston's blisterpack which revealed an excess number. In fact, the medical record indicates that the treating physician, after documenting an inappropriate blood level, was forced to order a one-time increased level dosage to compensate for the blood level.

29. Another example of the frequent medication errors is Edward S. who has an order for phenobarbital (a medication often used to control seizures). My review of the MAR indicated that Edward had not been given his anti-seizure medication twice in the prior week, on May 12 and again on May 18th.

30. I found medication errors to be a systemic, on-going problem exacerbated by a nursing staff that is understaffed, over-burdened and confronted with the prevalent use of temporary agency/contract nurses who are not adequately familiar with the needs of D.C. Village residents.

Nurse Staffing at D.C. Village is Inadequate

31. I continue to find nurse staffing at D.C. Village to be professionally unsound and dangerous. In my opinion, the

existing nurse staffing at D.C. Village continues to operate in a perpetual "crisis mode."

32. I found the problems to be exacerbated by the prevalent use of agency/contract nurses at D.C. Village. Agency/contract nursing staff remains at just under 50 percent of total shift coverage within the facility. I found such widespread use of agency/contract nurses to present serious risks to the health and safety of the D.C. residents because several individual members of the contract staff did not know the names and identities of the residents to whom they were providing care and nursing services and administering medications.

33. For example, on one unit I toured, both nurses on duty were temporary agency/contract nurses who were not able to answer basic questions about the residents without looking at the records. Specifically, neither nurse could identify the residents when asked. Neither could identify any of the residents' needs, treatment, or medication regimen. Every question was responded to with "let me look it up." This over-reliance on temporary staff is inappropriate and dangerous in a facility such as D.C. Village where continuity of care and familiarity with residents are critical to ensure adequate safety and treatment.

34. Staff must be acutely aware of residents' needs and alert and responsive to often subtle changes requiring intervention. Inadequate and inappropriate staffing has resulted in residents not receiving the care and attention they require.

35. Nursing staff, overburdened, short-staffed, and often unfamiliar with the individuals' needs have and continue to fail to meet the basic needs of D.C. Village residents. For example, bed-ridden residents are reportedly bathed only every three days at best. Moreover, as indicated earlier, bed-ridden residents are not turned on a regular basis to prevent or minimize incidents of decubitus ulcers. Due to the lack of staff, both in numbers and training, residents are often not provided with needed therapy despite orders for such in the individuals' records. For example, Byrd A. had not received her prescribed skin care regimen twice during the week prior to my tour. Dressings are changed infrequently and, as personally observed, are often urine-soaked by the time they are changed. Nursing staff routinely fail to monitor individual weights and respond to individual nutritional needs in a timely fashion.

36. During my three-day tour, I never saw a single resident being given appropriate range of motion exercises. In fact, what I did observe was residents routinely being left unattended. For example, I observed Catherine S. left in a posey vest (a restraint used to prevent falling). I was concerned whether residents were being released periodically for range of motion exercises. My review of Catherine's record was quite remarkable. The record verified that the entire evening shift the day before had gone by with no charted restraint release by staff. What was more remarkable, however, was that the night shift, which had not yet begun, had already documented in Catherine's record that she

had been periodically released from the posey vest restraint throughout the night. This is a significant departure from professional practice standards.

I declare under penalty of perjury that the foregoing is true and accurate. Signed this 14th day of June, 1995.

Mary Ellen Anderson, B.S.N., M.A.; J.D.

MARY ELLEN ANDERSON
2427 Stanwick Road
Phoenix, Maryland 21131
Telephone: (410) 628-8020

EDUCATION:

Juris Doctor, 1994
University of Maryland School of Law, Baltimore, Maryland

Coursework in Master of Administrative Science Program, The Johns Hopkins University, Baltimore, Maryland, 1976-1979

Master of Arts, Major in Psychology, 1976
Towson State University, Towson, Maryland

Bachelor of Science, Major in Nursing, 1973
University of Maryland, Baltimore, Maryland

Associate of Arts in Nursing, 1971
Essex Community College, Baltimore, Maryland

BAR ADMISSION: The Bar of Maryland, June, 1994

EMPLOYMENT:

1/94 - Present — Assistant Professor
Towson State University
Health Science Department
Towson, Maryland

Responsible for preparing technical proposals and feasibility and policy-related analyses for mental health and substance abuse managed care initiatives related to national, state and local government accounts and academic medical centers in collaboration with a national managed care organization. Provide consultation and technical assistance on health care administration and management to government agencies and private organizations. Teach graduate and undergraduate level courses on health care administration and policy and related issues.

1/92 - 12/93 Senior Administrator
University of Maryland
School of Medicine
Department of Psychiatry
Baltimore, Maryland

Responsible for direction of all administrative matters related to the Department of Psychiatry and its activities within the University of Maryland Medical Center, which encompasses the School of Medicine, the University of Maryland Medical System, and University Physicians, Inc. Responsible for the preparation and financial management of the Department's budgets from all sources, which total approximately $28.5 million annually. Managed the administrative aspects of the privatization of a State-operated clinic system, with total annualized revenues of $3.1 million. Responsible for the provision of administrative support services for approximately one hundred (100) faculty and eighty (80) trainees and for direct supervision of five (5) management staff and the oversight of approximately six hundred (600) management, technical and support staff within the Department. Manage personnel, procurement, and grant/contract management functions for research and clinical service programs within the Department. Direct planning activities and functions within the Department and participate on various institutional committees within the Medical Center.

4/91 - 7/92 Senior Administrator
University of Maryland
School of Medicine
Department of Anesthesiology
Baltimore, Maryland

Responsible for direction of all administrative matters related to the Department of Anesthesiology and its activities within the University of Maryland Medical Center, which encompasses the School of Medicine, the University of Maryland Medical System, and University Physicians, Inc. Responsible for the preparation and financial management of the Department's budgets from all sources, which total approximately $17 million annually. Responsible for the provision of administrative support services for approximately forty-two (42) faculty and thirty-four (34) trainees and for direct supervision of five (5) management staff and the oversight of approximately twenty-five (25) management, technical and support staff within the Department. Managed personnel, procurement, and grant/contract management functions within the Department. Directed planning activities and functions within the Department and participated on various institutional committees within the Medical Center.

5/88 - 4/91 — Faculty Associate
Mental Health Policy
Studies Program
University of Maryland
School of Medicine
Department of Psychiatry
Baltimore, Maryland

Responsible for preparation of short term plans related to significant departmental service expansion, both inpatient and outpatient. Conducted feasibility analyses related to capital and program expansion, including expense and revenue projections, staffing requirements, and cost containment initiatives. Prepared federal planning documents, funding proposals, and issue papers for State and local governments and private agencies. Investigated alternatives for organizing and providing mental health services to high priority populations (e.g. children, the elderly and severely mentally ill patients). Participated in evaluation of innovative service delivery systems.

7/89 - 7/90 — Director of Inpatient Services
Glass Mental Health Centers, Inc.
Baltimore, Maryland

Responsible for the management of a private psychiatric hospital for adolescent and adult patients. Supervised clinical department heads and administrative staff. Responsible for negotiating and monitoring service and space contracts. Responsible for managing transition to two hospital sites and development of an inpatient psychiatric program for adolescents during period of facility expansion from thirty-seven to eighty-five beds. Participated in Executive Committee meetings at the corporate level which determine strategic planning objectives and policy development for all operations, including outpatient, inpatient, and specialty mental health and substance abuse services.

5/86 - 5/88 — Deputy Director
Mental Hygiene Administration
Department of Health and Mental Hygiene
Baltimore, Maryland

Responsible for the budgeting process and fiscal and programmatic management for over 110 community-based programs and the fourteen facilities administered by the Mental Hygiene Administration with annual budgets exceeding $250 million and an employee base of approximately 7500 full time equivalents. Directed the planning and management

information system functions for the Administration and the development and management of special initiatives including collaborative efforts with general hospitals, long-term care facilities, State health regulatory commissions, and other State departments and agencies. Supervised personnel, procurement, and grant/contract management functions of Maryland's publicly funded mental health system. Supervised the Assistant Directors for Administration and Management, Quality Assurance, Special Projects, Planning and Management Information Systems, Regional Offices, and facility-based programs. Developed and negotiated contracts and service agreements featuring innovative financing mechanisms for service alternatives with hospitals and other health care providers. Represented the Administration and the Department before the Legislature and at public and professional meetings.

8/85 - 5/86 — Acting Director of Special Projects Office (On assignment from the Mental Hygiene Administration)
Office of Financial Planning and Management Analysis
Department of Health and Mental Hygiene
Baltimore, Maryland

Responsible for the development and operation of a newly created unit to analyze the fiscal and administrative feasibility of various management initiatives impacting on the Department of Health and Mental Hygiene, a major State Department with a budget of $1.4 billion in F.Y. 1986 and 4,000 employees. Analyzed and studied Federal funding programs and submitted recommendations for program prioritization and implementation to senior management. Supervised professional staff in analyzing utilization and fiscal data and in preparing financial impact statements and feasibility reports. Participated in focused management studies, including the reorganization of the Juvenile Services Administration, and recommended changes and improvements in operating procedures and program policies.

11/84 - 5/85 — Acting Director of Mental Health and Mental Retardation (On assignment from the Mental Hygiene Administration)
Baltimore City Health Department
Baltimore, Maryland

Directed publicly funded mental health, mental retardation, and employee assistance programs with annual budgets of $21 million. Responsible for overseeing the development and monitoring of thirty grant programs.

Supervised a staff of seven professionals. Developed policies relating to the development and provision of mental health and retardation services. Represented the Division and the Department at community, interagency and legislative meetings

5/79 - 11/84
5/85 - 8/85

Program Administrator
Mental Hygiene Administration
Department of Health and Mental Hygiene
Baltimore, Maryland

Directed fiscal and programmatic aspects of State hospital and community mental health programs in Central Maryland jurisdictions. Managed annual grant budget of $10 million. Directed regional initiatives including the development of a pilot psychiatric inpatient unit for State hospital patients in a community-based general hospital and community psychiatric rehabilitation and housing programs. Developed short-term and long range plans. Responsible for regional office coordination of State psychiatric facilities in Baltimore City with total budgets of $78 million in F.Y. 1986. Assisted these facilities in maintaining Medicare certification and gaining JCAHO accreditation and in the resolution of budgetary, personnel, and programmatic problems. Provided technical assistance to health officials and planners. Represented the Mental Hygiene Administration at community and policy development meetings involving health professionals, legislators, agency representatives, and citizen advocacy groups.

11/76 - 5/79

Nurse Clinician
Walter P. Carter Center
Department of Health and Mental Hygiene
Baltimore, Maryland

Responsible for provision of individual, group, family, and play therapy. Screened and evaluated cases. Consulted with educational, medical, and community agencies. Developed, implemented, and evaluated therapeutic programs and the in-service training program for Children's Services. Supervised staff and graduate students. Represented the Outpatient Clinic and Nursing Department in inter-Departmental meetings.

6/76 - 9/76

School Psychology Intern
Roanoke City Public Schools
Roanoke, Virginia

Responsible for psychological testing and evaluation of public school students. Consulted with parents and teachers regarding educational

remediation and psychiatric treatment recommendations. (non-salaried, degree requirement)

9/74 - 6/76 — Clinical Nurse
University of Maryland Hospital
Baltimore, Maryland

Responsible for provision of clinical care to critically ill infants, children, and adolescents in an intensive care setting in a teaching hospital. Supervised professional staff and students. Worked as part of an interdisciplinary team with medical and other clinical professionals.

8/71 - 9/74 — Staff Nurse
Greater Baltimore Medical Center
Towson, Maryland

Responsible for provision of professional nursing care to pediatric and adult patients on all tours of duty in a private community general hospital. Supervised professional and non-professional nursing personnel.

1970 - 1971 — Nursing Assistant II
Greater Baltimore Medical Center
Towson, Maryland

Responsible for provision of semi-skilled and auxiliary nursing care to pediatric adult patients.

CONSULTANT - CONTRACTS:

1994 - Present — Howard County Government
Howard County, Maryland
Core Service Agency Project

1993 - Present — Green Spring Health Services, Inc. Technical Assistance and Professional Writing related to Mental Health and Substance Abuse Services and Managed Care

1989 - Present — United States Department of Justice
Expert Witness for Civil Rights of Institutionalized Persons Act (CRIPA) Cases

	1992 - 1993	Liberty Institute of Community Psychiatry and Behavioral Sciences Baltimore, Maryland Comprehensive Mental Health Plan for Fiscal Years 1993 - 1996
	1992	Washington County Mental Health Authority Washington County, Maryland Comprehensive Mental Health Plan for Fiscal Years 1992 - 1995
	1991	The National Institute of Mental Health Program Evaluations and Site Visits of McKinney Act Mental Health Demonstration Programs for the Homeless Mentally Ill
	1989	Franklin County Mental Health Board Franklin County, Ohio Options for Development and Implementation of Legislatively Mandated Utilization Review and Quality Assurance Standards
	1989	The North Baltimore Center, Inc. Baltimore, Maryland Management and Organizational Analysis of Community Mental Health Center
	1989	Washington County Health Department Washington County, Maryland Core Service Agency Project
PROFESSIONAL AND CIVIC AFFILIATIONS:	1994 - Present	Member, The Maryland State Bar Association, Inc.
	1982 - Present	Member, Greater Baltimore Board of Realtors
	1984 - Present	Member, Credit Committee, State Employees' Credit Union
	1988 - 1990	Vice President, Hunter's Run Homeowner's Association
	1989 - 1990	Member, Board of Directors, Transitional Living Council, Inc.

1984 - 1986	Treasurer, Maryland Women's Health Coalition Chair, Fundraising Committee
1983 - 1984	Chairperson, Mental Health Coalition, Central Maryland Health Systems Agency

REFERENCES: Available upon request

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff,	)	
v.	)	Civ. No. 95-948 TFH
THE DISTRICT OF COLUMBIA, et al., Defendants.	)	DECLARATION OF SAUNDRA BAUGH

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Saundra Baugh, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") for the past fourteen years. I presently live on Unit 2B in a small room with two elderly women.

2. I am currently 42 years old. I require nursing care because at age 20, I suffered an injury that caused my spine to be partially severed, leaving me paralyzed from the waist down. The injury also left me unable to use my fingers. I am now confined to a wheelchair, and am largely dependent on staff to meet my basic care needs. I must live at DCV because I have no where else to go.

3. In recent months, basic care services for the residents have deteriorated at DCV. There have been severe shortages of food and drink, hot water, medications, and medical supplies. Ms. Brasfield, the DCV facility director, has told me that the city's budget crisis has put DCV in a "difficult situation" and has caused many of these shortages. As a result, the DCV staff

have had to do the best they can. Yet, in spite of their efforts, the residents have suffered because of the shortages.

4. Because individuals from the Department of Justice and other outside surveyors were present at the facility during the week of May 23-30, 1995, basic services to residents were enhanced and increased to make it appear to the outsiders as if there were no basic care shortages. However, this is misleading. For example, the meals served to us that week were of better quality and greater quantity than they had been for months. The facility always puts on a good show for the surveyors, yet poor services always return once the outsiders leave. I fully anticipate this happening again.

5. In 1995, food shortages have adversely affected resident care and residents' quality of life. As a substitute for meat, the staff have repeatedly served us peanut butter sandwiches for dinner and lunch. With the peanut butter, we are served only water to drink, not juice. Before the surveyors arrived last week, we had not been served salad or fresh vegetables for months. In fact, on the day the outsiders first arrived, we were given salt, pepper, sugar and juice at lunch and dinner for the first time in months.

6. Last year, meals were tolerable. This year, meals are extremely unappetizing and practically inedible. Sometimes, I can't even figure out what's been served. When a hot meal is attempted, the food is usually either undercooked or overcooked, leaving it too hard, or soggy and watery. This year, I have

often been unable to eat what's been served and am left to buy my own food.

7. It is quite often the case that staff either forget to bring me my meal tray, or they bring me a meal which I simply cannot eat. I am unable to drink milk or eat certain kinds of fish. If I eat salmon, for example, I will usually vomit. I'm pretty sure I'm allergic to such foods, but I've never been tested. Nonetheless, I'm continually served such inappropriate foods. When I alert the staff of this, they have either brought me back just a sandwich, or they have left me with nothing to eat. I have told my dietician repeatedly about my individual feeding needs, yet nothing ever seems to come of it. I know this happens to other residents as well.

8. There have been medication shortages this year that directly affect resident health and welfare. I have been left without needed medication simply because the facility did not have it. For example, a few weeks ago, the pharmacy did not have my prescribed allergy medicine for about two weeks. Because the medicine was not available, the doctor changed my prescription to an inappropriate sinus medicine until the allergy medicine was again available. During this time, I awoke most mornings congested and stopped up, unable to speak clearly for awhile. The pharmacy also recently ran out of the medication I need in order to control my muscle spasms. I was without this important medication for a few days.

9. There are also severe shortages of medical supplies. For example, I, along with many other DCV residents, suffer from bed or pressure sores called decubiti. I currently have such sores on my buttocks. In properly treating these sores in the past, DCV staff have used duoderm tape. The duoderm tape works well at protecting the sore and helping it heal faster. However, in recent months, there has been no duoderm tape available at DCV. The staff are left to improvise, treating sores with a combination of gauze, ointment and four by four's. This treatment is not sufficient. The make-shift patch used on my sores often becomes dislodged, leaving the sensitive sore exposed and subject to further irritation. Without the duoderm tape, the patch never stays in place properly. As an aside, I've learned that some are claiming that decubiti only develops at the outside hospitals and not at DCV; this is simply not true. I've been hospitalized often, and yet I've never developed decubiti anywhere but at DCV.

10. There are shortages of other needed supplies. Currently, there are few if any toothbrushes, combs, brushes, soap, lotion, paper towels, and regular sized cups made available to the residents. I have seen staff bring in soap from the outside, buying it with their own money, simply because the facility had run out. We are forced to use very small cups that simply don't hold enough liquid. I have been able to get myself over to the dentist's office to obtain a new toothbrush, but other residents who do not have that ability are left to use

their old toothbrushes for too long. In addition, blood pressure cuffs are out of date, so the nurses bring in their own for use with the residents. DCV also has a shortage of light bulbs and fluorescent lights. I noticed replacement fluorescent lights installed only upon the outside surveyors' arrival.

11. We are never guaranteed to receive adequate hot water for bathing at DCV. About a month ago, we were without hot water on my unit for an entire week. The facility had put up signs on some units warning the residents that the hot water was not available to them. During that time, it was too cold for anyone on my unit to bathe or to take a shower. I was forced to not take a shower or a bath at all that week. At other times, the water is merely warm. Sometimes, we are forced to take a sponge bath because the water is not hot enough. As an aside, I'm supposed to be bathed at least twice a week, but I'm usually only bathed once a week.

12. The lack of adequate hot water has rendered the facility unable to wash and properly sanitize dishes and eating utensils. As a result, in 1995, we have used plastic utensils and paper plates more often than we have used silverware and dishes. It is very important that silverware be available for the DCV residents. Some elderly and medically infirm individuals cannot eat or be fed properly with the plastic "sporks" used at DCV. The "spork" is a combination spoon and fork with sharp plastic prongs at the end. I've seen DCV residents poked in the mouth, tongue and chin when these "sporks" are used. I've even

heard the staff say aloud that they can't feed the residents with the plastic utensils.

13. Clothes often come back from the laundry still stained and shrunken. Towels look dirty; diapers return stained and shrunken with rusted snaps. The diapers given to me have become so shrunken, that the staff have had to double-up the width of what's left just to meet my needs. This doubling is uncomfortable and inadequate. In addition, residents' clothing is often stolen or lost when sent out to the laundry.

14. A few weeks ago, my wheelchair was in need of repair. It was taken to the repair shop for an entire week. I had had an alternate wheelchair to use for such occasions, but it was stolen a few months ago while I was at an outside hospital. Thus, while my chair was being fixed, I was left without the use of a wheelchair altogether. As a result, I was confined to bed for the whole week while I waited for my wheelchair to be returned.

15. During the time I was forced to remain in bed while my wheelchair was being repaired, the nursing and direct care staff failed to attend to my basic needs. For example, while in bed, I'm dependent on staff to help me go to the bathroom. However, during that week, staff regularly left me in bed wet with urine for 10-12 hours at a time after I had been incontinent. Needless to say, it is very uncomfortable, unhealthy and embarrassing to be left wet for such a long time. I know it can't have helped my bed sores.

16. I've noticed such neglect affecting other DCV residents. Just recently, I noticed residents with Alzheimer's disease left in fecal matter for hours simply because the staff neglected to check on them. Typically, incontinent residents are left to sit in their own feces from 1:00 in the afternoon until after 6:00 at night. This has happened quite regularly during my stay here at DCV. Nurses are supposed to be monitoring the residents, but many of them sit at the nursing station all day talking. Some take pride in their work, but others could care less.

17. The nurses do not tend to our other basic care needs. As I indicated, I am unable to use my fingers, so I can't brush my own teeth. Nonetheless, no staff person or nurse had brushed my teeth for the entire week before the outside surveyors arrived. The evening of their arrival, however, a staff person brushed my teeth. The last time my teeth had been brushed was at the dentist's office a week earlier.

18. The nurses who work at DCV on a part-time, contract basis, lack familiarity with the residents and our needs. This has a real impact on resident care. For example, I never know who's going to be here and when. Because the contract nurses are not familiar with us, they improperly treat residents' decubiti. They have improperly treated mine. Contract nurses also constantly make medication errors. I invariably have to tell the nurses what medications I take and when I take them. Often I have to correct the nurses after they hand me the wrong pills at

the wrong time. Even after I correct their mistake, if it's just a timing error, the contract nurses often encourage me to take the pills that they've given me at the time anyway. The permanent nurses regularly make mistakes as well. They often try to dispense medications by memory, which can certainly lead to errors. Both contract and permanent nurses pass out medications by hand instead of using a small paper cup as they are supposed to. They also do not wash their hands when moving from person to person providing services.

19. For nurses at DCV, paperwork is more important than the residents. Nurses often write entries in the record without interacting with or saying a word to the residents. Many times, they will write in the record that they have done something, like change a dressing for a bed sore, yet they will have not done anything at all. I typically have to ask the nurses to do things for me that are supposed to be done routinely anyway.

20. Generally, the staff treat us in a disrespectful manner. They often do not talk to us at all or if they do, they will talk to us as children. They've made degrading comments to me such as "Move, so I can get that junk off your table." In dealing with other residents, I've heard staff comment aloud, "I can't stand [resident's name]." The staff will do as little for you as possible, and they will only do something for you if they are your assigned nurse. I've asked other nurses to help me, and I've been rebuffed because the person was not assigned to me.

The staff tend to holler loudly at one another. This just adds to the stress and frustration level at the facility.

21. Staff routinely call in sick and/or take annual leave, leaving the units short staffed. I believe absenteeism may be so high because each nurse's caseload is so heavy. I would estimate that over half the time we do not have enough nurses on the unit. The nurse shortage means that they cannot attend to the needs of the full care residents. There always seems to be a shortage of nurses and staff on the weekends. Even when we do have our full complement, the nurses are invariably pulled from other units. That means they are not familiar with us or our needs.

22. I do not receive sufficient physical therapy at DCV. I had only been receiving range of motion therapy three times a week. I understand that ultrasound and massage have just been cancelled. I've lost a lot of mobility since I arrived at DCV.

23. The doctors do not come around to check up on us regularly. My doctor never comes around to see me on his own initiative; he only comes by when asked. Upon my return to DCV from a recent hospitalization, my doctor merely took my vital signs and did not talk to me or ask me about my needs or past care.

24. In my chart, it indicates that I'm currently involved in a "fall prevention" program. However, I have never been told this by staff and do not know what my program is. It also indicates that my dietician had conducted a quarterly assessment

of my nutritional needs. However, the dietician never spoke with me about my needs or desires. She simply made a record entry.

25. I have recently discovered that our personal funds accounts may be in jeopardy, or are at least tied up. We are entitled to seventy dollars a month as a "personal needs allowance." I have learned that residents' money is being tied up somehow, and that to get it in the future will require going through alot of red tape. If this is true, this will effectively keep many DCF residents, especially those who are less alert and aware from accessing their own money. The personal funds appear to be another casualty of the city's budget crisis.

I certify under penalty of perjury that the foregoing is true and correct. Executed this ____ day of June, 1995.

_____
Saundra Baugh

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF CHARLES BURGESS

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Charles Burgess, do hereby declare:

1. I am the son of Willie Burgess, who was a resident at D.C. Village ("DCV") for about three years before his death on August 20, 1994.

2. My father had Alzheimer's disease and he needed total and complete basic care services. I tried to care for him myself at my home, but after a year, I found I was ultimately unable to juggle work and meet his needs adequately. He needed 24-hour care.

3. I was very dissatisfied with the care my father received at DCV. As soon as I placed him at DCV, his health deteriorated rapidly. When I would visit him, I often found that my father had been sitting in his own feces or laying in bed full of his own feces. The smell was awful. The nursing staff had completely neglected to meet his needs. I was left to clean him up and change him myself. The staff would only act when I would complain. In fact, care always got worse the longer I stayed

away from the facility. Only when I spoke up all the time, did the staff ever act to provide anything to my father. I was told that unless I visited DCV every single day, the care would not be adequate to meet my father's needs; otherwise, he would be ignored. That was true.

4. Before my father entered DCV, he was able to walk well. However, the DCV staff stopped walking him and he gradually lost the ability to walk entirely. Eventually, he couldn't walk at all. By the time of his death, his legs were completely drawn up to his chest in a fetal position. He couldn't straighten them out any more. I attribute this deterioration solely to the neglect of the DCV staff. In fact, every single time I visited my father, he was sitting doing nothing. The staff never interacted with him.

5. At the time of his death, my father had become afflicted with severe bed sores. Before entering DCV, my father had never suffered with bed sores. The sores started appearing a few months after placement at DCV. They kept getting worse. At first, the bed sores were just large; then they became deep too. By the time he had reached the hospital just prior to his death, the hospital doctor showed me that the sores on his buttocks were so deep, he could put his hand in them. I saw these sores personally, and I can attest that the sores were humongous.

6. At DCV, my father had been left to develop deep bed sores on his back and his legs. Given the size of the leg sores and the potential for infection, it was decided that the best

course of action would be to have both his legs amputated. This was done at the hospital. Given my father's frail health, he died a few days later. The sores developed in the first place because the DCV staff had failed to keep my father walking and active and because they failed to properly turn my father while he was on the bed.

6. Whenever I visited my father, his clothes were always missing. I had bought him a lot of new clothes -- pants, shoes, socks, underwear. I spent about $500 on the clothing. However, the next time I visited, it was all gone. I never saw my father's clothing again. When I visited him, he always seemed to be dressed in a raggedy pair of pants that were two or three sizes too big for him.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 4th day of June, 1995.

Charles Burgess

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF ROBERT DORR

Pursuant to the provisions of 28 U.S.C. § 1746 and D.C. R. 106(h), I, Robert Dorr, do hereby declare:

1. I am the President of Central Armature Works, Inc.

2. Central Armature provides electrical contractor services, makes repairs and sells parts for electrical equipment.

3. In June 1994, we were called to provide an estimate for an anticipated repair of a boiler motor at the D.C. Village Nursing Home ("DCV"). A boiler motor and pump circulate hot water for use in other parts of a building. Over the course of three days, we surveyed the job and concluded that the motor in question was burned up and not able to be repaired. We provided DCV with an estimate on the cost of repairing the hot water unit, however, we did not hear back from them to repair it. Finally, in late January or early February 1995, we were called back to DCV to do the work as originally quoted. By this time, the boiler pump had become completely locked from having sat idle for so long. We repaired the boiler pump, checked it for leaks and replaced the boiler motor with a new Toshiba 15 horsepower motor.

4. On February 28, 1995, we billed the District $4,440.33 for the repair of the hot water boiler, yet to this day, we have still not been paid. If you include other unpaid invoices, the District currently owes our company almost $5,000.00 for parts and labor supplied to DCV. Specifically, the District also owes us for services we rendered in April 1995 in the amount of $165.00, and for parts supplied in May 1995 in the amount of $313.56.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 9 day of June, 1995.

Robert Dorr

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	DECLARATION OF
	)	LINDA K. DUVAL, R.N.
	)	

Pursuant to the provisions of 28 U.S.C. § 1746 and D.C. R. 106(h), I, Linda K. Duval, R.N., do hereby declare:

1. I am the Chief Operating Officer for Premier Nurse Staffing, Inc., dba SRT MedStaff ("SRT"). Generally, SRT provides supplemental nurse staffing and other health related services for hospitals, nursing homes and private individuals.

2. Pursuant to a contract with the District of Columbia, SRT has provided nurses for D.C. Village ("DCV") on an as-needed basis for the past several years.

3. As of June 1, 1995, the District owes SRT at least $251,401.89 in past due amounts for services we have rendered at DCV. Some outstanding invoices date back to 1994. I have attached a letter sent to Ms. Alberta Brasfield, the DCV Executive Director, and a computer printout detailing the monies past due.

4. Because of the District's failure to pay us, we have had to cancel all contract nursing services with DCV. We

officially stopped furnishing nurses to DCV at 11:00 p.m. on Friday, June 2, 1995.

5. Since we stopped supplying DCV with nurses, I have spoken with Mr. Vernon Hawkins, the Interim Director of the District's Department of Human Services. He said his Department was working on getting us the money we are owed, but he was not ultimately able to furnish me with a time when, in fact, we would get paid.

6. SRT pays in full the nurses who work at DCV shortly after they complete their work there. We continue to bill the District for these services, but we do not receive payment. As a result, SRT is forced to assume the financial burden of paying its employees without reimbursement from the District Government. If the District doesn't pay us, we are simply not able to continue to provide services. Our banking relationships will not finance receivables aged over ninety days. Thus, our financial situation and our banks simply will not tolerate the District's indefinite non-payment.

7. On many different occasions, I had alerted District officials that if they did not pay us, our company would be forced to terminate our services to DCV. In fact, I have spent much of my time the last three weeks simply trying to get payment from the District for services rendered at DCV. I have called everyone I know to call to try to obtain payment. In the attached letter, I have partially detailed the individuals I've spoken with in attempting to resolve this matter. Unfortunately,

some individuals would not return my calls until I left a message with the magic words that we were threatening to terminate services. Other District officials actually argued with me that we would not be paid because we were not working under a valid contract. I can attest that our company only provided services at DCV pursuant to valid and existing contracts with the District.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 9 day of June, 1995.

Linda K. Duval, R.N.

Premier Medical Services, Inc.

Premier Certified Home Health
Premier Nurse Staffing
SRT MedStaff

June 5, 1995

Ms. Alberta Brasfield, Executive Director
D.C. Village #2
D.C. Village Lane, S.W.
Washington, D.C. 20032

Dear Ms. Brasfield:

It is with much frustration and regret that Premier Nurse Staffing, Inc., dba SRT Med-Staff, discontinue providing RN's and LPN's to DC Village as contractor for contract number JA/95707 due to NON-PAYMENT of Premier's invoices for services dating back as far as 12/1/94 to present. SRT Med-Staff has been a primary provider of nurse staffing services under contracts numbered JA 93677 and JA 390704.

Listed below are the overdue invoices which have been presented for payment following each month of services:

December 1994 Services	$35,580.79
January 1995 Services	$33,563.80
February 1995 Services	$38,168.44
February 17 - May 15, 1995 Services	$27,266.51
March 17 - March 31, 1995 Services	$29,326.93
April 1 - April 19, 1995 Services	$25,034.62

May 1995 Services have been submitted for payment weekly instead of monthly over the last several weeks. Also, Mr. Tony Siler and/or myself have placed numerous phone calls to several people, including but not limited to the following individuals requesting processing and payment for Premier's services:

Ms. Gladys Fountain - LTC
Ms. Queen - LTC
Mr. Ronald Collens
Ms. Anne Wilson
Mr. Atley - several messages left - no return calls
Mr. Robert Taylor - Comptroller's Office
Ms. Delores Shephard - Comptroller's Office
Mr. George Hemmingway - Comptroller's Office
Ms. Rosa Doyle - Comptroller's Office
Ms. Eunice Weldon - Comptroller's Office

Premier Medical Services, Inc.

Premier Certified Home Health
Premier Nurse Staffing
SRT MedStaff

The current status of this receivable is unacceptable to Premier Banking relationships with $35,580.79 over 120 days aged; $69,144.59 over 90 days aged; $134,579.54 over 85 days aged.

In order for Premier to reinstate services $69,144.59 must be paid in full and remaining invoices must be paid promptly. Premier pays the nurses wages weekly. We cannot continue this relationship without timely payment of our invoices.

We look forward to your cooperation in rectifying this situation. It is our intent to continue providing the much needed nursing services required by DC Village to care for your patients as soon as payment is received.

If there is anything that we need to do to facilitate your payment please contact me at (703) 941-1001.

Sincerely,

Linda K. Duval, RN
Chief Operating Officer
Premier Nurse Staffing, Inc.
dba SRT Med-Staff

cc: Gladys Fountain

A C C O U N T S R E C E I V A B L E A G I N G R E P O R T

DIV - MA - MID ATLANTIC REGION STANDARD SERVICE DETAIL AGED AS OF 06/08/95 -151

LOCATION - 535 - SRT MID-STAFF INTL 535 PRINTED IN APPLY-TO-NO ORDER

ITEMS PAST AGING DATE NOT INCLUDED

DOC-NO	DOC-DAT	TYP	INV-NO	INV-DATE	AGE	BALANCE	AGED CUSTOMER BALANCE CURRENT	> 30	> 60	> 90	> 120
CUST NO 002558 NAME D.C. VILLAGE											
15105	04/13/95	I	015105	04/13/95	49			25,146.49			
1280	04/26/95	C	015105	04/26/95	46			33.51-			
1299	04/28/95	C	015805	04/20/95	46	35,034.02		78.35-			
15522	04/27/95	I	015822	04/27/95	39	10,497.05		10,497.05			
15904	05/04/95	I	015904	05/04/95	32	11,659.43		11,659.43			
16246	05/11/95	I	016246	05/11/95	25	14,820.14	14,820.14				
16535	05/18/95	I	016535	05/18/95	18	11,666.02	11,666.02				
16689	05/25/95	I	016689	05/25/95	11	4,874.07	4,874.07				
16890	06/01/95	I	016890	06/01/95	4	9,211.35	9,211.35				
					TOTAL	251,401.89	40,780.59	76,518.03	65,434.95	33,760.82	35,407.90
							16.02%	30.43%	26.02%	13.42%	14.08%
LOCATION	535				TOTAL	251,401.89	40,280.59	76,518.03	65,434.95	33,760.82	35,407.90
							16.02%	30.43%	26.02%	13.42%	14.08%
REGION	MA				TOTAL	251,401.89	40,280.59	76,518.03	65,434.95	33,760.82	35,407.90
							16.02%	30.43%	26.02%	13.42%	14.08%
COMPANY NAME	PMS				TOTAL	251,401.89	40,280.59	76,518.03	65,434.95	33,760.82	35,407.90
							16.02%	30.43%	26.02%	13.42%	14.08%

NUMBER OF CUSTOMERS SELECTED 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	
	)	

DECLARATION OF REBECCA D. ELON, M.D., M.P.H.

I, Rebecca D. Elon, M.D., M.P.H., the United States' geriatric/medical consultant in this case, pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), do hereby declare:

1. I am both a practicing and academic physician specializing in geriatric medicine and gerontology. My professional career has been devoted to treating elderly patients in long-term care settings as well as teaching, writing, and studying about the provision of long-term care for the geriatric population.

2. To acquaint the Court with my specific qualifications, I provide a summary of my background below. My curriculum vitae, which is attached to my Declaration, provides further details about my experiences and qualifications.

BACKGROUND, EXPERIENCE AND EDUCATION

3. Educational background: I received my medical degree from Baylor College of Medicine in 1981 and my Master's Degree in

Public Health from the University of Texas in 1991. My residency was in internal medicine and I served a fellowship specializing in geriatrics at the Baylor College of Medicine.

4. Academic experience: I am an Associate Professor of Medicine, Division of Geriatric Medicine and Gerontology, at the Johns Hopkins University School of Medicine.

5. Administrative and clinical experience: In July 1994, I was appointed and currently hold the position of Medical Director at the Johns Hopkins Geriatric Center. In this capacity, I am responsible for overseeing the medical care and treatment for the residents of the Geriatric Center, a long-term care facility affiliated with the Johns Hopkins Health System. Prior to my appointment, I served as Associate Medical Director, first at the Lorien Frankford Nursing and Rehabilitation Center (1991-1993) and more recently, at the Johns Hopkins Geriatric Center.

6. Professional Activities: I am board certified in the field of internal medicine and have a specialty certification in geriatrics. I have also been granted the status of "Fellow" by the American College of Physicians. I am an active member in the American Geriatrics Society, the American Medical Directors' Association and the Gerontological Society of America.

7. Publications: I have published extensively on a variety of topics in the field of geriatric medicine, including articles, book chapters, monographs, manuals, and other publications in respected professional journals and treatises in

the field of gerontology. Recent articles and book reviews include: The Current and Future Role of the Medical Director; Nursing Home Medicine; Abuse and Neglect of Elderly Persons Living in Nursing Homes: Prevention and Intervention, and Medical Practice in Nursing Facilities: Assessing the Impact of OBRA. In addition, I have been an invited speaker at numerous symposiums, grand rounds and annual meetings of medical associations. My publications and presentations have focused extensively on long-term care and treatment.

8. Expert Witness activities and experience in long term care related litigation: I have served as an expert consultant and witness in cases involving professional standards for long term care. I have worked for both defendants and plaintiffs and for the federal government. In addition, I have been qualified as an expert witness in court on matters involving appropriate medical care and on geriatrics and long term care. I have worked with the United States Department of Justice since 1990 in the Department's investigation and enforcement activities under the Civil Rights of Institutionalized Persons Act ("CRIPA"). In this capacity, I have been involved with CRIPA investigations in several states including New York and Virginia and the one CRIPA investigation in the District of Columbia.

INVOLVEMENT WITH THIS CASE AND FAMILIARITY WITH D.C. VILLAGE NURSING HOME

9. In April 1994, I was asked by the Department of Justice to serve as an expert consultant to assess the care and treatment

of residents at the D.C. Village Nursing Home in Washington, D.C. I first toured D.C. Village on June 6-7, 1994. Prior to the tour, I reviewed numerous documents provided by D.C. Village, including policies and procedures of the facility, internal reports and summaries, consultations, treatment protocols, and injury, hospitalization and death records. During the investigative tour, I observed, among other things, routine medical and health care, routine management, training and treatment of residents within their living units, as well as meals on the living units. In addition, I reviewed resident charts and interviewed multiple staff members.

10. My assessment of the care and treatment of D.C. Village residents in 1994 revealed a number of critical deficiencies. The medical care and related treatment provided to the residents were far below accepted professional standards. Of most immediate concern, because of the continual risk of death to the residents, were the deficiencies noted in feeding residents and care and treatment of residents with increased risk of aspiration (i.e., inhaling food or fluids into the lungs). I found that D.C. Village residents had been needlessly subjected to prolonged suffering and discomfort punctuated by repeated hospitalizations merely because the medical staff was unable to adequately assess or respond to the residents' aspiration risk or dysphagia (difficulty in swallowing). I found a shockingly high number of D.C. Village residents having died due to some form of aspiration, pneumonia or feeding dysfunction.

11. I toured D.C. Village again on Tuesday, May 30, 1995. Again, I observed the routine medical and health care, the management and treatment of residents, feeding practices at mealtimes and the care and treatment provided to residents with decubitus pressure ulcers. I reviewed individual medical records, spoke with a number of staff and residents, and reviewed the death records of a number of residents who had died during the past year.

12. I determined that the deficiencies I had identified last year had not been corrected by the District. I was distressed to find that conditions had deteriorated even further, placing residents at increased risk of significant harm.

Inadequate Care of Decubitus Ulcers Jeopardizes the Health and Lives of D.C. Village Residents

13. During my recent investigative tour, I found numerous examples of inadequate care of decubiti (pressure sore ulcers involving skin tissue wounds and destruction). D.C. Village residents continue to suffer unnecessary skin breakdowns that are not being assessed, evaluated and treated properly.

14. In order to assist the Court, I will briefly describe the various stages typically ascribed to decubitus ulcers. Decubitus ulcers are routinely classified in four stages ranging from stage I (superficial wound, reddened skin), stage II (partial-thickness wound, broken skin), stage III (full-thickness wound, damage has extended beyond superficial tissue to the deep tissues below and may involve drainage) to stage IV (deep tissue

destruction extending to the muscle or bone). Once skin is broken, infection often sets in. Extensive infection can lead to sepsis (overwhelming infection of the body) which, in turn, often leads to death especially in this population.

15. It is generally accepted that most decubitus ulcers are preventable and all are treatable if identified at an early stage. The key is identifying the at-risk patient and taking appropriate preventive measures where an incident might occur.

16. Appropriate preventive measures include repositioning patients on a regular basis, introducing pressure-relieving devices (e.g., air mattress properly inflated, gel pads, spetial beds, elbow and/or heel protectors), assessing nutritional and fluid needs, gently cleaning and drying potential areas of skin breakdown, massaging around the reddened area for at least 30 seconds and recording site and treatment interventions.

17. As a result of my investigative tour, I find a general systemic failure by D.C. Village to adequately assess residents at risk, as well as a systemic failure to take appropriate preventive measures. Moreover, the neglect and improper care of decubitus ulcers at D.C. Village has had dire consequences for a number of residents.

18. The pervasiveness and seriousness of decubitus ulcers at D.C. Village and the facility's inability to prevent and treat them are apparent from statistics provided by D.C. Village. There are at least 30 D.C. Village residents, or more than one out of every ten people who live there, who currently have

decubitus ulcers.[1] The tragic consequences of the facility's failure to prevent decubiti in the first instance and to adequately treat it once it emerges are also apparent from recent hospitalizations of D.C. Village residents for serious complications from decubiti.

19. For example, on February 16, 1995, George A. had to be hospitalized for two weeks due to dehydration and a possible infected decubitus ulcer. On March 24, 1995, Marie D. had to be hospitalized for amputation of her left leg due, reportedly, due to infected decubitus ulcers. On April 13, 1995, William S. had to be hospitalized for two weeks due to a septic right knee. On April 28, 1995, William's leg was amputated above the knee due to necrosis and gangrene. Within the past year, at least seven different D.C. Village residents (William S., Marco W., Otis S., James M., Violet F., Stanley L. and Marie D.) had to have limbs amputated.

20. The life-threatening consequences of decubitus ulcers among D.C. Village residents are equally apparent. For example, D.C. Village lists "multiple decubitus ulcers" as a cause of death for John B. on March 9, 1995. Similarly, D.C. Village identifies "multiple decubitus ulcers" as one of the causes of the May 5, 1995 death of Marie D. who, as mentioned previously,

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[1] In addition to the 30 individuals identified by D.C. Village, I personally observed at least one other resident, Lamont R., not identified by D.C. Village, who had multiple decubitus ulcers.

was hospitalized in March for amputation of her left leg due to infected decubitus ulcers.

21. Many of the recent D.C. Village hospitalizations and deaths are listed as sepsis. Sepsis is the body's response to overwhelming infection. A decubitus ulcer can and often is a major contributing factor to the resulting sepsis. In the recent two month period, alone, between March 10, 1995 and May 8, 1995, three different D.C. Village residents were hospitalized with a diagnosis of sepsis. In the two month period between March 31, 1995 and May 23, 1995, seven other D.C. Village residents were hospitalized to rule out a diagnosis of sepsis.

22. My observations and review of individual records verified the inadequate care of decubiti at D.C. Village. An example is Claude B. who I observed on the surgical unit. Claude's decubitus ulcer on his hip is dusty blue and red, with unhealthy tissue. If I were to describe the wound to a lay person, I would say it looks like old hamburger. He has a hole in his right hip that is approximately 6 centimeters. Below that opening, beneath the surface the wound extends for another ten centimeters, through the muscle and down to the bone. The entire decubitus ulcer is, in actuality, about fiffteen to eighteen centimeters. He has two other decubitus ulcers on his foot.

23. Claude was in the surgical unit for the treatment of the two decubitus ulcers on his left foot. I observed the physician pull off the dead skin revealing a stage III wound with dead tissue down to the muscle. The physician then treated the

foot ulcer with the ointment Elase. Elase, used to debride dead tissue, is rarely used on foot ulcers because of the danger of having the ointment spread to adjacent healthy tissue. The physician spread the Elase liberally beyond the necrotic/dead tissue of the ulcer onto healthy skin. If extended beyond the necrotic area, the result is that healthy adjacent tissue may be damaged, resulting in extending the decubitus ulcers. The result was that the D.C. Village "cure" could actually exacerbate the problem. Due to the inadequate care being rendered, Claude is now at high risk of having his wounds becoming infected and is in danger of potentially losing his leg unless corrective action is taken immediately.

24. I also observed the decubitus ulcers of Lamont R., who is quadriplegic, totally paralyzed from the neck down. Lamont has two decubitus ulcers on his left foot. Lamont's medical record indicates two inappropriate physician orders. First, there is a 60-day order for Elase, which is inappropriate for a foot ulcer. Second, there is an order for Intrasite on the dead tissue. Intrasite is an gel product normally used to enhance granulation tissue growth. It is totally ineffective and inappropriate to be ordered to treat necrotic/dead skin. Such orders are a significant departure from professional standards and place Lamont at risk of imminent harm. I am very concerned that the inadequate treatment has led to a progression of Lamont's wounds and predisposes him to potentially losing a limb unnecessarily.

25. Another resident that I am quite concerned about is Houston J. Houston currently has two decubitus ulcers, one on his left foot and one on his right heel. The right heel wound is a stage III decubitus ulcer that has significant dead/necrotic tissue that needs surgical attention for debridement. My review of his record shows no request for a surgical consult. The failure to properly debride such a wound of dead tissue is a departure from professional standards and places Houston at imminent risk that the wound will get larger and get infected. Potentially, Houston if not adequately treated imminently, risks a potential loss of limb, sepsis, and even possibly death.

26. Another example of the inadequate care being rendered at D.C. Village is William S. who, after suffering from decubitus bed sores that were allowed to deteriorate, had to have his leg amputated in April 1995. The amputation was a direct result of inadequate care and neglect coupled with improper delayed notification by nursing staff of signs of infection. The result was the amputation of a resident's leg that could have been prevented.

27. William's medical record reveals that on March 17, 1995, nursing staff documented that William's knee was warm to the touch and that he was running a fever. Blood tests indicated a high white blood count. The physician was not notified. Three days later, on March 20th, medical records document William's temperature at 102 degrees and an elevated pulse rate of 126. The nurse's notes indicate that William was "flushed ...

dehydrated." He was then transferred to the hospital, still not having seen a D.C. Village physician. William was diagnosed at the hospital as suffering from cellulitis with drainage of infected pus from the knee and returned to D.C. Village. On April 4, 1995, William's progress notes states "the ulcers are getting worse." He was not admitted again to the hospital until April 13th, some nine days later where his leg was amputated above the knee due to necrosis and gangrene.

28. I personally observed William's current care and treatment during my tour. William currently suffers from two stage III/IV decubitus ulcers on his hip and buttock. I found him lying on an air mattress that was improperly inflated, thus offering no pressure relief. The ulcer on his hip was oozing green pus. In my opinion, this indicates that the wound is likely to be infected. The ulcer on his hip was a hole in the skin approximately 4 x 6 centimeters in size. The wound was red with tissue coming through. In my professional opinion, William is in imminent danger of infection due to the inadequate treatment of the wound by D.C. Village staff.

29. Another example of the inadequate care being given is Moses D., who has had to have portions of both of his legs amputated. On October 17, 1994, Moses underwent below-the-knee amputation due to gangrene of the right foot. His record indicates that on December 15, 1994, the attending physician notes that "the ulcers of the L [left] leg not healing well." On December 28th, thirteen days later, a progress note documents

that Moses still suffered from multiple leg ulcers and necrotic tissue. The note identifies a moderate amount of drainage and indicates that the ulcer is "foul smelling." A consult to the surgical clinic was forwarded. On January 3, 1995, the same physician who examined Moses on December 15th, notes the decubitus ulcers on his left leg and states that the patient has a surgery clinic appointment. On January 15, 1995, a month after the physician's note of improper healing, the monthly nursing note states "Leg ulcers doesn't look good. Consult for the surgical unit was sent." It is not until January 24th that the record indicates that Moses was seen in the surgical clinic and not until February 7, 1995, almost two months after the severity of the problem was initially noted, that surgical treatment at the clinic was obtained. A week later, on February 13, 1995, Moses was admitted to the hospital with gangrene and ulcers of the left foot and leg. The following day, February 14, 1995, Moses' remaining left leg was amputated above-the-knee.

30. On May 30, 1995 I entered Moses' room to find him lying in his own urine and feces. Moses was lying inappropriately on an inverted egg crate donut which not only failed to provide any pressure relief but, in fact, may serve to increases pressure in other decubiti prone areas. Moses currently suffers from two decubitus ulcers. The wound by the base of his spine had an opening that was approximately 4 x 5 centimeters. I asked the nurse to probe the wound with an applicator tip so that I could gauge the size of the underlying wound. It was evident that the

wound was quite deep as the nurse was able to place the probe three inches into the wound. The ulcerated area was dusky and dry due to the inappropriate dry dressing ordered by the physician. Such wounds need to be kept hydrated to increase circulation. In my opinion, Moses is at imminent risk of infection due to his inadequate treatment.

31. My review of Moses D.'s record also reveals that he has a recently documented (May 22nd) penile ulceration due to the improper use of a condom catheter by the nursing staff.

32. Marco W. is another resident at D.C. Village who recently lost a limb after a long history of deteriorating decubitus ulcers that became infected and gangrene. While in Marco's case the deterioration was exacerbated by poor circulation due to peripheral vascular disease, the inadequate care and neglect by D.C. Village was a significant contributing factor.

33. A review of the medical record of George A. who was hospitalized the day before our tour, May 23, 1995, is further reflective of the inadequate care at D.C. Village. George A. was rehospitalized (he had been hospitalized several times during the past year for infected multiple decubiti) with a fever and with a listed diagnosis of multiple stage III and IV decubiti that were septic and gangrene (dead tissue due to lack of blood supply). My review of George's medical record reveals that on May 13, 1995, the nursing progress note stated "AM reported to supervisor -- decubitus stage IV has no written orders for specific

treatment." It was not until May 17, 1995, four days later, that the record reflects that George was examined by a physician and specific treatment ordered. His decubitus ulcer was classified by the D.C. Village physician as "deep to the muscle and bone." The physician referred George to the surgical clinic for debridement (removal of dead skin) and reevaluation. George was then not seen by the surgical clinic physician until May 23, 1995, another six days later. He was immediately hospitalized with a diagnosis that the hip area had become septic and gangrene. He remained hospitalized during the time of my tour.

34. My review of hospitalizations since January 1, 1995 reveal numerous residents being hospitalized due to infected decubiti. Examples include the hospitalizations of Willie V. (January 2, 1995 - flap closure), Claude B. (January 9, 1995 - flap closure), George A. (February 16, 1995 - infected decubitis), Houston J. (February 17, 1995 - surgical flap, left hip), William S. (March 19, 1995 - cellulitis, right knee), Marie D. (March 24, 1995 - amputation, left leg), Milton B. (March 30, 1995 - cellulitis, right leg), William S. (April 13, 1995 - septic right knee, subsequent amputation), James T. (April 21, 1995 - cellulitis), and George A. (May 23, 1995 - multiple decubitus ulcers, septic and gangrene).

35. My review of death records highlights the tragic consequences of the inadequate care being rendered at D.C. Village. For example, during the past nine months, D.C. Village lists "multiple decubitus ulcers" as a cause of death for Willie

B. (died on August 20, 1994), Savina C. (died on September 16, 1994), John B. (died on March 5, 1995) and Marie D. (died on May 5, 1995).

36. Medical and nursing staff throughout the facility report shortages of essential medical supplies normally used to treat decubitus ulcers. In particular, shortages of duoderm tape and 4x4 pads were continually reported. I personally observed a medical doctor forced to do a debridement of dead skin tissue using improper equipment (a suture removal kit) because of lack of adequate supplies. In addition, this same doctor used an improper ointment because he thought the facility still had a shortage of the appropriate Silvadine ointment. In sum, the care and treatment of decubitus pressure ulcers at D.C. Village is inadequate and jeopardizes the health and well-being of residents.

Inappropriate Feeding and Medical Care of D.C. Village Residents Poses Life-Threatening Risks

37. Many D.C. Village residents have eating disorders. Further, many of these residents have difficulty breathing and swallowing. Improper feeding techniques and inappropriate positioning of the residents during feeding can cause acute and chronic aspiration problems in persons with these disorders. Aspiration of large amounts of food or liquid may result in asphyxiation; aspiration of smaller amounts will compromise breathing and lung functioning and chronically damage lung tissue through repeated or chronic infection. Medically fragile

individuals with weak respiratory systems, compressed chest cavities from scoliosis or poor positioning, and decreased muscle tone and lung capacity have greater difficulty coughing and clearing their lungs, conditions which contribute to both choking and gagging. Repeated aspirations damage the lungs and can lead to a spectrum of chronic respiratory problems, including asthma, aspiration pneumonia, chronic lung disease and even sepsis, all of which can be fatal.

38. During my most recent investigation, I learned that D.C. Village residents continue to suffer from aspiration and that several more aspiration-related deaths (e.g., Jessie H., Elsie E., John B., Agnes S., John S., and Charles H.) had occurred since my last tour in June 1994.

39. These deaths are described in D.C. Village records as either directly related to aspiration or as a contributing cause of death. It is my opinion that at least some of these deaths may have been prevented if appropriate practices had been followed by trained staff.

40. Despite the fact that last year I had indicated a need to properly and adequately assess individuals at risk for swallowing problems, I saw little evidence that any such evaluations had been conducted at D.C. Village. Upon our arrival this year, the facility was initiating its "Dysphagia Clinic" to assess residents with swallowing disorders including feeding/aspiration issues. However, it is important to note that this clinic had not been commenced until May 25, 1995, the first

day of the Department of Justice's investigative tour and almost one year after we had toured in 1994. During my investigation, I observed a general failure to adequately monitor residents during meal times to identify those with swallowing problems.

Medical Diagnosis and the Management and Treatment of Residents with Aspiration and Related Medical Problems are Inadequate

41. It is also my opinion that the medical diagnosis, management and treatment of aspiration and related medical problems are inadequate and place the health of residents at D.C. Village at risk.

42. The lack of appropriate identification of residents at risk of aspiration and insufficient care thereafter is documented in individual charts. Medical reviews are not conducted until the individual circumstances of residents become extreme.

43. Relevant information regarding the identification, care and treatment of residents' feeding problems and related disorders is not sufficiently communicated between the direct care staff, therapists, nurses and doctors. To the extent that symptoms are observed at the direct care staff level, this information often does not appear to be communicated adequately to medical personnel or, if so, is often not translated by the physicians into appropriate directions for assessment or treatment. In my review of residents' charts, I identified instances where nursing and/or direct care progress notes report symptoms of aspiration that are not discussed in physician notes and are not followed up with appropriate evaluation. Similarly,

when appropriate occupational therapy or dietary consults are obtained, there is often little indication of implementation of recommended interventions or follow-up by nursing or direct care staff.

44. D.C. Village's physicians also do not routinely provide standard medical assessment and treatment for residents at risk for chronic aspiration. D.C. Village's medical and nursing staff are not identifying and acting upon the clinical symptoms of chronic aspiration and related illnesses. Because staff are not carrying out this critical function, illness, aspiration and injury are occurring which otherwise could be prevented through early detection and intervention.

Delayed Medical Response

45. A review of death records revealed several cases of respiratory distress in which nursing staff documented but failed to notify the physician, or where the physician failed to promptly respond until the resident was in extreme respiratory failure or dead.

46. An example is the death record of Jessie H., who died on April 27, 1995. The record reflects failed/delayed notification and appears to have been altered so as to indicate a quicker notification and response time. An initial note that day states that Jessie "doesn't look good." The note looks like it was initially written at 7:30 a.m. but was rewritten to indicate 8:30. A second note at 8:45 reports that Jessie was congested full of mucus. A third note, also appearing altered, states

"looks not to [sic] good." The note continues to state "Reported ... (HN) that pt. congested & needed to be suction." A 10:00 a.m. note indicates that Jessie was in distress and taken to his room. CPR was commenced at 10:05. Jessie was pronounced dead at 10:20 that morning. The failed and delayed notification in this instance is a significant departure from professional standards. If Jessie had been assessed promptly and adequately and then given proper treatment, he may have survived.

47. Another example is Agnes S. who died on February 20, 1995. On February 11, 1995, Agnes was hospitalized with an unexplained hand fracture and placed in a cast. The next day, February 12, 1995, the record reflects that the "resident very congested and wheezing both lung sound congested (sic)." On February 15th there is documentation of thick yellow mucus. Later that day, Agnes began to run a fever. The next day, February 16, 1995, the nurse's note indicates that Agnes continued to run a fever (101.4) and states that Agnes "is observed to be coughing, having labored breathing, wheezing most times during the night." Later that day, the physician was finally notified and an x-ray taken. At 12:45 p.m., Agnes was finally examined by a physician and hospitalized with possible pneumonia and sepsis. Agnes died four days later on February 20, 1995. The delayed notification is a significant departure from professional standards. With earlier notification and proper intervention by the physician, this death could have been prevented.

48. In conclusion, an overriding concern which encompasses the finding of inadequate medical care and treatment systemwide, is the inadequate assessments, evaluations and diagnoses I found to exist at D.C. Village. The result is that medical interventions and treatment are often inadequate and improper.

I declare under penalty of perjury that the foregoing is true and correct. Signed this 12 day of June, 1995.

Rebecca D. Elon, M.D., M.P.H.

CURRICULUM VITAE

REBECCA DAVIS ELON, M.D., M.P.H.

CURRENT APPOINTMENTS:

University:	Associate Professor of Medicine Division of Geriatric Medicine and Gerontology Johns Hopkins University School of Medicine
Hospital:	Staff Physician Johns Hopkins Bayview Medical Center

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DATE OF BIRTH: July 6, 1954

PLACE OF BIRTH: Milwaukee, Wisconsin

SOCIAL SECURITY NUMBER: 389-60-6154

EDUCATION AND TRAINING:

High School	Brown Deer High School Milwaukee, Wisconsin	1968 - 1972
College	Rice University Houston, Texas (B.A., *cum laude*, 1976)	1972 - 1975
	Barnard College Columbia University New York City	1975 - 1976
Research Assistant	Cornell Medical School New York Hospital New York City	1976 - 1977

Medical School	Baylor College of Medicine Houston, Texas (M.D., 1981)	1977 - 1981
Residency	Internal Medicine Baylor Affiliated Hospitals Houston, Texas	1981 - 1984
Fellowship	Geriatrics Baylor College of Medicine Houston, Texas	1984 - 1985
Public Health	University of Texas School of Public Health Houston, Texas (M.P.H., 1991)	1988 - 1991

PROFESSIONAL EXPERIENCE:

Hospice Physician	Texas Medical Center Hospice	1984 - 1986
Instructor	Department of Internal Medicine Baylor College of Medicine	1985 - 1986
Assistant Professor	Department of Internal Medicine Baylor College of Medicine	1986 - 1989
Adjunct Asst. Professor	Department of Internal Medicine Baylor College of Medicine	1989 -
Assistant Professor	Division of Geriatric Medicine Department of Health Care Sciences George Washington University Medical Center Washington, DC	1989 - 1991
Assistant Professor	Division of Geriatric Medicine and Gerontology Johns Hopkins University School of Medicine	1991 - 1994
Associate Professor	Division of Geriatric Medicine and Gerontology Johns Hopkins University School of Medicine	1994 -

CERTIFICATION AND LICENSURE

Board Certified	Internal Medicine	September, 1985
Specialty Certification Geriatrics		April, 1988
Medical Director Certification		September, 1991
Maryland Licensure		July, 1991
District of Columbia Licensure		September, 1989 - September, 1991
Texas Licensure		December, 1980 -May, 1994
Federal Licensing Exam		June, 1980

AWARDS AND HONORS

1975	Brown College Service Award, Rice University
1980	First place award, Texas Medical Association, Student Writing Competition on Aging
1987	Awarded stipend to participate in the Summer Institute for Research on Aging sponsored by the National Institute on Aging and the American Geriatrics Society, Baltimore, Maryland
1987	Selected as one of four physicians to represent The Methodist Hospital, Houston, at an awards ceremony in Guatemala City, Guatemala, during which a surgeon from Houston received Guatemala's highest civilian honor
1988	Award stipend to spend four weeks in West Germany on a Group Study Exchange sponsored by the Rotary International Foundation
1990	First place award, American Medical Directors' Association, Medical Care Evaluation Study Competition
1989 - 1992	Kellogg National Fellowship Program Award

PROFESSIONAL ACTIVITIES:

American Medical Directors Association

1989-1991	Chair, Public Policy Committee
1991 -	Representative to Senate Aging Committee Symposium
1992 - present	Co-Chair, Education Committee
1992 - present	Member, Certification Council
1993, 1994	Member, Annual Meeting Program Committee
1993 - present	Member, House of Delegates

Maryland Medical Directors Association

1992 - present	Founding Board Member

Health Care Financing Administration

1990 -	Expert Advisory Panel, Case-Mix Demonstration Project
1991 -	Expert Advisory Panel, Quality Indications in Long-Term Care Project

United States Justice Department

1990 - present	Consultant regarding quality of geriatrics services for chronically institutionalized elderly living in state institutions

Institute of Medicine

1993 - 1994	Member, Committee to Evaluate Ombudsman Program of the Older Americans Act
1994	Chair, Symposium on Ombudsman Program

University of Minnesota School of Medicine

1990 - present	Instructor for Medical Director Training Course, Office of Continuing Education, (Program has been presented in Minnesota, New York City, Cleveland, Baltimore, Houston, San Francisco)

University of Cincinnati School of Medicine

1993	Consultant to Dr. Robert Luke, Chairman, Department of Internal Medicine, regarding an academic affiliation agreement with a long-term care institution, Drake Center

Expert Advisory Panels

1991 - present	University of Maryland, Robert Wood Johnson Foundation Project: "Developing Clinical Practice Guidelines for Long-Term Care"

1990 - 1993	George Washington University, National Institute on Aging Project, "National Evaluation of Alzheimer's Special Care Units"

Institutional Administrative Appointments

July 1994	Medical Director, Johns Hopkins Geriatrics Center
1993 - 1994	Associate Medical Director, Johns Hopkins Geriatrics Center
1991 - 1993	Associate Medical Director, Lorien Frankford Nursing and Rehabilitation Center
1993 - present	Co-director, Annual Geriatrics CME Review Course
1993 - present	Member, Johns Hopkins Health System, Geriatrics Networking Steering Committee
1993 - present	Member, Francis Scott Key Medical Center TQM Committee on Cost Effective Care
1993 - present	Member, Subacute Care Oversight Committee
1993 - present	Member, PACE demonstration Feasibility Study working group

Editorial Activities:

1994 - present	Co-editor, *Geriatrics Review Syllabus; A Core Curriculum*, The American Geriatrics Society, Third Edition. (David Ruben and Tom Yoshikawa, editors)
1994 - present	Co-editor, *Nursing Home Assessment* (John Beck & Dan Osterweil, editors)
1990 - 1993	Member, Editorial Advisory Board, The Journal of Medical Directors
Ad hoc reviewer:	Manuscript Reviewer Annals of Internal Medicine Journal of the American Geriatrics Society Johns Hopkins University Press Public Health Reports, United States Public Health Service Health Professionals Press Association for Gerontology in Higher Education Oxford University Press The Gerontologist

Expert Witness, long-term care related litigation, experience in cases for both defendants and plaintiffs

TEACHING RESPONSIBILITIES

1. Course Director, Growth Development and Aging, Year II medical student curriculum (worked with the Curriculum Committee and representatives from pharmacology, pathology, pediatrics, geriatrics to develop and implement a new 21-hour course), 1993.

2. Small Group Facilitator, Physician and Society Course (2 hours per week for 26-week curriculum developed for Year II medical students), 1993-1994.
3. General Medicine/Geriatrics Hospital Ward attending (1 or 2 months per year, supervising team of resident-interns-students) with didactic teaching rounds 5 days per week.

4. Preceptor for Year III and Year IV medical students and physician assistant students during my weekly geriatrics outpatient clinic.

5. Supervise geriatric assessment clinic with fellows, residents and students one month a year.

6. Teach introduction to geriatric medicine to core medical students one month each year.

7. Developed medical director curriculum (in conjunction with Susan J. Denman, M.D.) for geriatrics fellows.

8. Participate in fellows' journal club schedule.

9. Give one lecture per month in A-4-West geriatrics lecture series.

10. Weekly teaching rounds with multidisciplinary team on 54-bed chronic hospital unit.

11. Participate in divisional weekly conference schedule.

12. Teach seminar in Introduction to Gerontology Course for students at the School of Public Health.

13. Teach management module in Faculty Development Course

14. Teach physical diagnosis to year II students

PROFESSIONAL MEMBERSHIPS

American College of Physicians	Member 1981 - present Fellow, 1994
American Geriatrics Society	Member 1981 - present
American Medical Directors' Association	Member 1989 - present
Gerontological Society of America	Member 1981 - present

PUBLICATIONS

Journal Articles

1. Elon R. Urinary Tract Infections Asymptomatic Bacteriuria: Treatment of the Positive Urine Culture. A Medical Care Evaluation Study. Journal of the American Medical Directors Association 1:32-39, 1990.

2. Winters WL, McIntosh HD, Cheitlin MD, Elon R, et al. The Relationship of Cardiovascular Specialists to Patients, other Physicians and Physician Owned Organizations: Report of Task Force #2. Ethics in Cardiovascular Medicine. Position Paper of the American College of Cardiology. JACC 16(1):11-15, 1990.

3. Elon R, Pawlson LG. The Impact of OBRA 87 on Medical Practice within Nursing Facilities. J Am Geriatr Soc 40: 958-963, 1992.

4. Elon R. Abuse and Neglect of Elderly Persons Living in Nursing Homes: Prevention and Intervention. Journal of the American Medical Directors Association, 2: 76-80, 1992.

5. Elon R. The Nursing Home Medical Director Role in Transition. J Am Geriatr Soc 41:131-135, 1993.

6. Elon R. The Current and Future Role of the Medical Director. Nursing Home Medicine. (In press)

Other Publications

1. Elon R. "Urinary Incontinence in the Elderly." Audio-Digest for Family Practice 38(10), March 5, 1990.

2. Elon R. Reducing Chemical Restraints: Learning by Example. In: Proceedings of a Symposium of the Senate Special Committee on Aging. Government Printing Office, 1991.

3. Elon R. Commentary on Federal Nursing Home Regulations. In: Long-Term Care Administration Manual: Standards and Guidelines for Long-Term Care Facilities. National Health Publishing, Baltimore, Maryland, 1990, 1991.

4. Elon R. Letter to the editor regarding "Geriatric Fellowship Training: A revisionist Proposal," by William Hazzard. J Am Geriatr Soc 41:578, 1993.

5. Elon R. Letter to the Editor regarding American Geriatrics Society Medical Student Initiative. J Am Geriatr Soc 42:355, 1994.

Book Chapters

1. Elon R. Approaches to Assessment: Outpatient Evaluation for Nursing Home Admission. In: Yoshikawa T, Cobbs E, Brummel-Smith K, eds. IN *Ambulatory Geriatric Care*, St. Louis: Mosby Year Book, Chapter 16, pp. 142-145, 1992.

2. Elon R. Final Placements: Home or Nursing Home? In: Kane RA and Caplan AL, eds. IN *Managing Compassion: Toward an Ethic for Case Management Care of the Elderly*, New York: Springer Publishing Co., pp. 137-142, 1993.

3. Elon R and Lucco AJ. Long-term Care Financing and Systems. In: Leverson S., ed. Medical Direction in Long-term Care, IN *LTC: A Guidebook for the Future*. 2nd edition. Durham NC: Carolina Academic Press, pp 78-98, 1993.

4. Elon R. Medical Practice in Nursing Facilities: Assessing the Impact of OBRA. IN Advances in Long-term Care. P.R. Katz, R.L. Kane, & M.D. Mezey (eds). Springer Publishing, New York (in press).

5. Elon R. OBRA 87 and Its Implications for the Medical Director. In Clinics in Geriatric Medicine. J.G. Ouslander and E. Tangalos (eds). (in press)

6. Finucane TE, Elon R, Keeman JM. The Medical Director in Non-Institutional Long-Term Care Programs. In Clinics in Geriatric Medicine. JG Ouslander and E Tangalos (eds). (in press)

Book Reviews

1. Elon R. Book Review on *Adding Life to Years: Organized Geriatrics Services in Great Britain and Implications for the United States* by William Halsey Baker. Gerontologist 28 (3): 426. 1988.

2. Elon R. Book Review on *The Geriatrics Review Syllabus*. J Am Geriatr Soc 40: 1191-1192, 1992.

3. Elon R. The Scholarship of Geriatrics: Priorities Reconsidered. J Am Geriatr Soc 42: , 1994.

Abstracts

1. Taffet G, Elon R, Teasdale T, Mallette L, Luchi R. Elevated parathyroid hormone in elderly males. J Am Geriatr Soc 34:906A, 1986.

2. Elon R, Mallette L, Luchi R, Pirozzolo F, Levy J, Taffet G. Hyperparathyroidism and cognitive function in the elderly. The Gerontologist 29:187A, 1986.

3. Elon R, Kolpakchi A. The interface of psychiatry and medicine in the care of geriatric patients: psychiatric problems seen in a geriatric medicine clinic. The Gerontologist 27:272A, 1987.

4. Teasdale TA, Wilson NL, Elon R, Luchi RJ: Low cost information management in a day center. The Gerontologist 28:167A, 1988.

5. Wilson NL, Teasdale TA, Elon R, Flaugher J. The Gerontologist. Development and use of an information system for a dementia day center. The Gerontologist 28:221A, 1988.

6. Melvin T, Elon R. House calls in geriatric medicine. The Gerontologist 28:6A, 1988.

7. Kolpakchi A, Elon R, Teasdale T, Wilson N. Evaluation of dementia in elderly outpatients in a community hospital general medicine clinic. J Am Geriatr Soc 36:670A, 1988.

8. Auerbach H, Elon R, Finucane T. Developing public policy: a scholarly activity. The Johns Hopkins University School of Medicine Department of Medicine Research Retreat. 9A, 1993.

9. Auerbach H, Elon R, Finucane T. Fellowship training in public policy. Submitted, American Geriatrics Society, 1994.

GRANTS:

1989 - 1992	Authored Kellogg Fellowship Grant Proposal.
June, 1987 - June, 1989	Co-author, Program Evaluation of an Alzheimer's Day Center, funded by the Hogg Foundation.
July, 1975 -	Co-author, Fellowship in Geriatric Medicine training grant, July, 1988 funded by the Veterans' Administration.

SELECTED PRESENTATIONS

1. The Geriatric Continuum of Family Medicine. A Texas Consortium of Geriatric Education Centers symposium for Family Medicine Faculty from teaching hospitals from a five state region, Waco, Texas, January 1987 and 1988.

2. Human Rights Considerations in the Care of the Demented Elderly. Amnesty International Regional Conference, Houston, Texas, March, 1987.

3. The Physician's Role in Long-Term Care. Symposium on long-term care with Dr. T. Franklin Williams, visiting professor, Houston, Texas, March, 1987.

4. The Differential Diagnosis of the Dementias. Invited presentation to the First National Congress of Geriatric Medicine in Guatemala City, October, 1987.

5. The Interface of Psychiatry and Medicine in the Care of Geriatric Patients. Gerontological Society of America annual meeting, Washington DC, November, 1987.

6. The Texas Medical Center: An Historical Overview. Presented in German to the Frankfort, Homberg, Giessen, and Korbach, West Germany Rotary Clubs, May, 1988.

7. Long-Term Care in West Germany: Report from the Rotary Group Study Exchange. Houston, Texas, September, 1988.

8. Demography, Health Care, and Economics. Symposium on Ethical Issues in Geriatric Health Care Delivery with Drs. Christine Cassel and Robert Binstock, Houston, Texas, October, 1988.

9. Should Active Euthanasia be Legalized? A debate with Don Murphy, M.D., George Washington University, September, 1989.

10. Ethical and Social Implications of Chronic Illness. Invited presentation for the National Health Policy Forum workshop on Chronic Illness and Long-Term Care. Washington, DC, October, 1989.

11. The Role of the Nursing Home Medical Director: Three Perspectives. Poster session at the Gerontological Society of America annual meeting, Minneapolis, MN, November, 1989.

12. Residents' Rights and Safety: Finding the Balance: Symposium on Quality Assurance and Residents' Rights in Long-Term Care. Houston, Texas, March, 1990.

13. Urinary Tract Infections/Asymptomatic Bacteriuria: Treatment of the Positive Urine Culture. A Medical Care Evaluation Study. American Medical Directors' Association and American College of Health Care Administrators annual meeting joint symposium, Toronto, Canada. May, 1990.

14. Legal and Ethical Issues in Nutritional Support. Maryland Society of Enteral and Parenteral Nutrition. Bethesda, Maryland. March, 1991.

15. Death at the Ethical Edge. Plenary Session. National Council on the Aging. Miami, Florida, May, 1991.

16. Nursing Home Medical Directors and the OBRA Regulations. American Geriatrics Society. May, 1991.

17. Reducing the Use of Chemical Restraints in Nursing Homes. Learning by Example: Good Practice in Nursing Homes. Invited presentation, Forum of the U.S. Senate Special Committee on Aging. Washington, D.C., July, 1991

18. Career Options in Long-term Care for Geriatrics Fellows. American Geriatrics Society. Washington DC, November, 1992.

19. Disincentives for Physician Practice in Long-term Care. American Geriatrics Society. Washington, DC. November, 1992.

20. Nutrition as a Quality Indicator in Nursing Homes. Annual Symposium of the Johns Hopkins University Division of Geriatric Medicine and Gerontology, Baltimore, February, 1993.

21. Nursing Home Medical Directors as Expert Witnesses: Defining the Standard of Care. Annual Meeting of the American Medical Director's Association, Phoenix, March, 1993.

22. Education in the Nursing Home. Annual Meeting of the American Medical Directors' Association. Phoenix, March, 1993.

23. Linking Acute and Chronic Care: Deconstructing the Dichotomy. Annual Symposium on Medical Care in the Nursing Home, sponsored by the Western New York Geriatric Education Center and Monroe Community Hospital, September, 1993.

24. Invited presentation to the 200th Anniversary Celebration of the University Hospital Civil de Guadalajara. Guadalajara, Mexico, May, 1994.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF CURMET FORTE

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Curmet Forte, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") since 1986. I presently live on Unit 3A. I am also the President of the DCV Residents' Association. In this job, I regularly talk to the other residents about things that are currently affecting them at the facility. I then talk to the DCV administrators, including the facility director, Ms. Brasfield, about the residents' concerns. I try to get a solution for whatever problem may come up.

2. I appreciate the job Ms. Brasfield is trying to do here at DCV. She is responsive to my concerns and the concerns of the residents' association. Nonetheless, resident care and services have suffered in recent months due to the District's budget crisis. Ms. Brasfield has told me that some DCV vendors haven't been paid. This has created shortages of food, medical supplies and other things residents need. Even though the city's budget problems are not her fault, and even though she has done the best

she can, the financial crisis has caused real problems for residents at the facility.

3. In the past few months, there have been food shortages at all meals. Once the outsiders arrived last week, conditions improved and we had everything we needed. We were fed chicken and pork chops and other good foods. Before they arrived, the meals were bad. We were often served peanut butter sandwiches as a meal. The cooked food was usually not served to us hot. There were no lids to keep individual hot items warm. Until the outside surveyors arrived, we had not received juice at lunch or dinner for a long time. Now that the outsiders are gone, conditions are worsening again.

4. We typically have to eat our meals with plastic utensils. On most occasions, we are not provided with plastic knives. Needless to say, this makes eating difficult.

5. There have also been shortages of needed supplies and medicine at DCV. I've noticed that staff have run short of medical supplies needed to treat residents on a daily basis such as gauze, four by fours, and duoderm tape. There has also been a shortage of cups here.

6. There have been recent hot water problems as well. It's my understanding that the vendor who had been under contract to repair the plumbing had not been paid. As a result, he stopped coming out to service the plumbing to ensure that we all had adequate hot water. Many units were without hot water for a week. The residents could not bathe or take showers.

7. There are other sanitation problems here including roaches and mice. I've often heard mice running above me in the ceiling while I'm trying to go to sleep. I've also heard them running down the heating pipe. Roaches are often seen in residents' rooms if there's food around.

8. Some contract nurses have been a problem at DCV. They pass medications with their hands dirty and they have committed a lot of medication errors. On many occasions, I've been handed the wrong medication by a contract nurse, forcing me to correct her mistake. They simply don't know the residents very well.

9. I've often noticed nurses writing in the record that they perform certain duties and yet I know they don't. A lot of residents have gotten what I call a "pencil bath" where the nurses write in the record that they bathed the person, but in fact, they had not. Many residents don't get turned in their beds as they should. I've also seen residents left wet for prolonged periods of time. You can smell the urine. I noticed this just a few days ago.

10. The staff also sometimes become impatient with the residents and holler at us. This may result from the shortage of staff I always notice on the units. We're usually short-staffed all the time. Some staff are forced to work two shifts in a row. This makes them irritable. These shortages continue today.

11. I've noticed that residents' clothes are often stolen when they are sent out to the laundry. I don't even send my clothes to the laundry any more.

12. I've recently noticed a problem with our personal needs funds. We are entitled to certain personal monies from Medicaid. These funds are to be deposited directly into our own accounts. However, it seems that because of the budget crisis, the District is putting all our money into an account in the District's Department of the Treasury. They are supposed to give us the money we are entitled to from Medicaid directly, not keep it for themselves until we ask. I've been able to get my money, but that's because I can speak up for myself. Other residents have recently come to me upset because they were told that their money was tied up. I approached Mr. Brown here at DCV and he agreed to pay the residents who requested funds. I still worry about those other residents who cannot speak about their concerns or come to me and ask for help.

13. I think the best way to resolve the problems here at DCV would be to place the operation of the facility under federal control or under the control of a receiver.

I certify under penalty of perjury that the foregoing is true and correct. Executed this ___ day of June, 1995.

Curmet Forte

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	
	)	
	)	

DECLARATION OF BLAINE S. GREENWALD, M.D.

I, Blaine S. Greenwald, M.D., the United States' psychiatric consultant in this case, pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), do hereby declare:

1. I am both a practicing and academic physician specializing in geriatric psychiatry. I have focused primarily on treating elderly patients, including in long-term care settings, as well as teaching, writing, and studying about the provision of appropriate psychiatric care for the geriatric population.

2. To acquaint the Court with my specific qualifications, I provide a summary of my background below. My curriculum vitae, which is attached to my Declaration, provides further details about my experiences and qualifications.

BACKGROUND, EXPERIENCE AND EDUCATION

3. Educational background: I received my medical degree from New York Medical College in 1981. I completed a medical

internship at Metropolitan Hospital Center in New York City. My residency was in psychiatry and I served a fellowship specializing in geriatric psychiatry both at Mount Sinai School of Medicine in New York.

4. Academic experience: I am the Associate Chairman of Department of Psychiatry at the Long Island Jewish Medical Center, and an Associate Professor, Department of Psychiatry at the Albert Einstein College of Medicine in New York. I am also the Program Director for one of the largest accredited fellowship training programs in geriatric psychiatry in the country.

5. Administrative and clinical experience: Currently, I hold the positions of Director, Geriatric Psychiatry Division, and Attending Psychiatrist for the Hillside Hospital-Long Island Jewish Medical Center; Gero-Psychiatric Consultant for the Hebrew Home of the Aged (a 700-bed nursing home); and Project Director for an affiliation between Long Island Jewish Medical Center and the Central Islip Psychiatric Center, a chronic state hospital for geriatric patients. In these capacities, I am involved in overseeing the psychiatric care and treatment for more than a thousand individuals, including a significant proportion who reside in a variety of long-term care facilities.

6. Professional Activities: I am board certified in psychiatry by the American Board of Psychiatry and Neurology. I have been granted the status of "Diplomate" by the National Board of Medical Examiners and the American College of Physicians. The American Board of Psychiatry and Neurology has

also granted me the status of "Added Qualification in Geriatric Psychiatry." I have also received awards for excellence in psychiatry, research in psychiatry and by the Northwest Bronx council on Aging, the Outstanding Gerontologist Award. In addition, I recently received a clinical mental health academic award in geriatric psychiatry from the National Institute of Mental Health ("NIMH").

I am an active member of the American Psychiatric Association ("APA") and serve on the APA's Council on Aging's Committee on Access Effectiveness of Psychiatric Services for the Elderly. I am also a member of the American Association for Geriatric Psychiatry and the Gerontological Society of America, and have made numerous presentations before these groups on issues related to geriatric psychiatry.

7. Publications: I have published extensively on a variety of topics in the field of geriatric psychiatry, including articles, book chapters, monographs, and abstracts in respected professional journals. Recent publications and presentations include: Geriatric Depression With and Without Reversible Cognitive Impairment: Clinical Comparison; Psychotropics and Hispanic Nursing Home Residents; Impact Of A Nursing Home Geriatric Psychopharmacology Education Program On Prescribing Practices; and Tailoring Adult Psychiatric Practices To The Field Of Geriatrics. In addition, I have been an invited speaker at numerous symposiums, grand rounds and annual meetings of medical

associations. Many of my publications and presentations have focused on long term care and treatment.

8. Expert Witness activities and experience in long term care related litigation: I have served as an expert consultant in cases involving professional standards for geriatric psychiatry. I have worked with the United States Department of Justice since 1993 in the Department's investigation and enforcement activities under the Civil Rights of Institutionalized Persons Act ("CRIPA"). In this capacity, I have been involved with CRIPA investigations in Virginia and the instant action here in the District of Columbia.

INVOLVEMENT WITH THIS CASE AND FAMILIARITY WITH D.C. VILLAGE NURSING HOME

9. In April 1994, I was asked by the Department of Justice to serve as an expert consultant to assess the psychiatric care and treatment of residents at the D.C. Village Nursing Home in Washington, D.C. I first toured D.C. Village on June 6-7, 1994. Prior to the tour, I reviewed numerous documents provided by D.C. Village, including policies and procedures of the facility, internal reports and summaries, consultations and treatment protocols. During the investigative tour, I observed, among other things, routine medical and psychiatric care and treatment of residents within their living units. In addition, resident charts were reviewed and multiple staff members interviewed.

10. I toured D.C. Village again on Tuesday, May 30, 1995. Again, I observed the routine medical and psychiatric care and

treatment of residents and spoke with multiple staff members. During the tour, I reviewed more documents, including additional individual resident medical records.

11. During the more recent investigative tour last week, I saw that the deficiencies I had identified last year had not been corrected by the District, and that D.C. Village residents remain at serious risk of harm. In my opinion, D.C. Village is failing to provide residents with adequate and appropriate psychiatric care and mental health services in accordance with accepted professional standards to residents who need such services.

Shortages at D.C. Village Have Led to Inadequate Basis Care

12. Before I address psychiatry issues, there are several areas of more general but immediate concern that I noted during the recent investigative tour. Multiple staff I talked with reported that there were staff shortages, particularly among nurses and nurse's aides and that there were supply shortages. Some staff commented that the consequences of these shortages included: "not enough nurse's aides to feed people;" "not enough nurse's aides to bathe people;" that the requirements of tube feedings, nebulizer treatments, and medication administration overwhelmed the nursing manpower and "there's gotta be mistakes;" "inadequate food on trays;" and "medication shortages." In addition, several physicians told me in confidence that because of medication and staff shortages, they believed nursing staff would either mark in the record that the drug had been given, even if it had not been given, or indicate that the resident

refused the medication. The physicians further indicated their belief that low drug blood levels are a consequence of medications not being given because of either medication shortages or lack of nursing manpower.

Inadequate Psychiatric Assessment of D.C. Village Residents

13. The principles underlying modern psychiatric care are symptom-based diagnosis and diagnosis-based treatment. These basic premises are undermined regularly at D.C. Village. In both discussions with staff and review of medical records, I found little documentary evidence that residents are adequately diagnosed via the traditional organized process of (a) collecting historical information, (b) interviewing the resident and significant others, (c) conducting a comprehensive mental status examination, including a cognitive examination (especially in the elderly or in those individuals with underlying brain disease), (d) collecting additional necessary corollary information, (e.g., neurological examination, blood tests, neuroimaging scans, neuropsychological testing), and (e) integrating these data into a diagnostic formulation and/or differential diagnosis that conforms with the generally accepted standard diagnostic nomenclature of American psychiatry as articulated in the Diagnostic and Statistical Manual ("DSM-IV") published by the American Psychiatric Association.

14. D.C. Village is not providing its residents with a comprehensive psychiatric assessment including adequate behavioral data and analysis where appropriate. The notion that

a potentially reversible medical or neurological problem might be expressed as a behavioral disturbance seems alien.

15. D.C. Village also appears to conduct no cognitive examinations or dementia work-ups of its residents. I found little evidence that mentally ill residents are provided with an integrated differential diagnosis and treatment plan signed by the psychiatrist.

16. It is generally accepted in the field that a proper DSM-IV diagnosis be formulated and recorded as part of the process of institutionalized residents receiving psychotropic medication. However, the D.C. Village medical staff is not familiar with and does not appropriately employ the DSM-IV criteria or terminology in formulating psychiatric diagnoses. Furthermore, reevaluation and revision of psychiatric diagnoses do not appear to occur in any regular or organized manner.

Psychiatric Treatment at D.C. Village is Inadequate

17. It is generally accepted that psychiatric treatment should be an amalgam of psychosocial, psychopharmacological, and psychiatric rehabilitative efforts that are organized into a coherent, multidisciplinary "treatment plan" that is regularly revisited to determine whether such treatment has been effective in ameliorating the psychiatric symptomology and disorders.

18. I found little evidence that such a process occurs at D.C. Village. There is no effort made to integrate psychiatric care for the residents in a multidisciplinary fashion. Furthermore, psychiatric notes are not integrated into the

individual's overall medical plan of care or with behavioral treatment programs. I could not find a single integrated medical/psychiatric/psychosocial plan in any D.C. Village resident's chart that I reviewed.

19. In addition, I found no organized use of psychotropic medication in a carefully considered plan of care. For example, for residents on antipsychotic medications, forms seem to have supplanted the traditional psychiatric note that incorporates the various aspects of symptoms, treatment, side effects, and other information (e.g., nursing notes/input), and ends with a conclusion/impressions and a carefully considered plan.

20. I found no consistent correlation between medication order changes and progress note documentation of such changes. In fact, there is no rationale provided when medication dosages are changed. Furthermore, examples of inaccuracies are apparent in psychiatric notes: e.g., a resident is titrated down and off of a particular neuroleptic and the psychiatric note indicates that neuroleptics have been discontinued and are not indicated, while in fact, the resident actually continues to receive another neuroleptic medication.

21. Psychotropic medications are often used incorrectly at D.C. Village. For example, I found medication dosing does not always conform to geropsychiatric standards, and the dosing of antidepressants to be inadequate and/or not properly titrated.

22. There are also many individuals with the medication side effect of tardive dyskinesia ("TD") living at D.C. Village.

TD is an untoward, usually irreversible effect, appearing after long term use of antipsychotic drugs, involving involuntary muscle involvement, spasms, and speech disturbances. Yet, I found evidence that anticholinergic/dopaminergic medications (medications given to control/influence nervous system activity) being improperly prescribed for TD, even though these agents will, in fact, worsen TD. The D.C. Village physicians are confusing TD and extrapyramidal symptoms. This indicates a lack of basic neuro-chemical/neuro-pharmacological understanding among medical providers at D.C. Village and highlights the need for inservice training in psychopharmacology and geriatric psychopharmacology.

23. Psychopharmacological treatment does not appear to be clearly tied to target symptoms, i.e., if the target symptoms are not improved, the treatment should then be modified (dosage increased, decreased, or drug changed). Side effect monitoring is erratic and potentially dangerous (e.g., not monitoring postural blood pressure in elderly residents on psychotropic drugs that can provoke postural hypotension and consequent falls). In addition, there currently is no regular review of prescribed psychotropic medications to integrate side effects with symptoms. The side effects testing that I observed in the records appeared to be perfunctory and did not in several cases correlate with my personal observations of residents.

24. Psychosocial and psychiatric rehabilitative treatments do not exist for the majority of the patients and are not part of

an integrated treatment plan that has defined goals and objectives.

25. In sum, in my opinion, D.C. Village is failing to provide residents with adequate and appropriate psychiatric care and mental health services in accordance with accepted professional standards to residents who are in need of such services.

Inappropriate Placement of D.C. Village Residents With Mental Illness

26. It is my opinion that many of the residents at D.C. Village with a psychiatric diagnosis are inappropriately placed and need not be in a nursing home setting.

27. Several staff commented to me that D.C. Village has been a "dumping ground" for Saint Elizabeth's overflow of schizophrenic patients. I was informed by a D.C. Village physician that "plenty of people are here who should not be here."

28. It is generally accepted that individuals with a primary psychiatric diagnosis should not be placed in a nursing home setting. One physician reported to me that the prior D.C. Village Medical Director explicitly instructed staff to "not list psychiatric illness as the primary diagnosis." If true, this is a dramatic departure from generally accepted professional standards.

29. My own review of medical charts suggests that the medical needs of many of the D.C. Village residents

classified with a secondary diagnosis of mental illness do not, in fact, necessitate placement in a nursing home.

30. At a minimum, everyone with a psychiatric diagnosis at D.C. Village should be re-evaluated, and for those who are determined to have a primary psychiatric diagnosis, they should be outplaced to a more appropriate setting. I found the process of complying with federal statutory nursing home regulations at D.C. Village to be undermined in terms of both improper admissions and a lack of review/outplacement of inappropriate residents. These regulations are part of the Nursing Home Reform Law ("OBRA legislation") and include a Pre-Admission Screening and Annual Resident Review ("PASARR") for mental illness.

31. In addition, even if residents with primary psychiatric diagnoses are considered to have secondary psychiatric diagnoses with medical or dementia qualifiers for nursing home placement, D.C. Village is still obligated, pursuant to federal nursing home law and generally accepted professional standards, to provide adequate psychiatric services. I find that D.C. Village fails to provide such services. For example, when I queried the D.C. Village psychiatrist about a work-up to rule out whether a resident with dementia may have a reversible component to their cognitive decline, he replied, "We don't do a dementia work-up."

I declare under penalty of perjury that the foregoing is true and accurate. Signed this 15th day of June, 1995.

Blaine S. Greenwald, M.D.

BLAINE S. GREENWALD, M.D.

Date of Birth:	12/5/52
Place of Birth:	New York City
Address:	(W) Hillside Hospital - Long Island Jewish Medical Center. PO Box 38. Glen Oaks, New York 11004 (H) 2 Lafayette Road Larchmont, New York 10538
Phone #:	(718) 470-8159 (W) / (914) 833-0521 (H)
Marital Status:	Married to Jayne Doreen Weiner - 4/8/79
Children:	Rebecca Kate Greenwald - born 10/18/81 Dorothy Hana Greenwald - born 4/8/8 Charles Evan Greenwald - born 3/2/91

Professional Experience:

Director, Geriatric Psychiatry Division, Hillside Hospital-Long Island Jewish Medical Center. Glen Oaks, NY. January 1989 -

Associate Chairman, Department of Psychiatry, Long Island Jewish Medical Center, Glen Oaks, NY. February 1994 -

Attending Psychiatrist, Long Island Jewish - Hillside Medical Center, Glen Oaks, NY. January 1989 -

Associate Professor, Department of Psychiatry, Albert Einstein College of Medicine, Bronx, New York. July 1989 -

Consultant Geriatric Psychiatrist, Hebrew Home for the Aged, Riverdale, New York, 198[illegible] -

Director, Division of Geriatric Psychiatry, Department of Psychiatry, Mount Sinai School of Medicine. New York, NY. December 1984 - December 1988.

Director, Clinical/Recruitment Core, Alzheimer's Disease Center, Mount Sinai School of Medicine, New York, NY. July 1987 - December 1988.

Assistant Professor, Department of Psychiatry, Mount Sinai School of Medicine, New York, NY. July 1985 - December 1988.

Assistant Attending Physician, Mount Sinai Hospital, New York, NY. January 1985 - December 1988.

Medical Director, Day Hospital Program, Bronx VA Medical Center, Bronx, New York. July 1983 - June 1985.

Instructor, Department of Psychiatry, Mount Sinai School of Medicine, New York, NY. July 1982 - June 1985.

Fellow in Geriatric Psychiatry (Division of Extended Care - VA Central Office), Bronx VA Medical Center / Mount Sinai School of Medicine, New York, NY. July 1982 - June 1983.

Chief Resident in Psychiatry, Special Treatment Unit, Bronx VA Medical Center Psychiatry Service, Mount Sinai School of Medicine, New York, NY. July 1981 - June 1982.

Resident in Psychiatry, Mount Sinai Medical Center, New York, NY. July 1979 - June 1981.

Intern in Internal Medicine, Metropolitan Hospital Center, New York, NY. July 1978 - June 1979.

Education:

M.D., 1978, New York Medical College, Valhalla, New York.

B.S., 1974, summa cum laude, State University of New York, College at New Paltz.

Awards:

M. Ralph Kaufman Award for Excellence in Psychiatry, Mount Sinai Medical Center, 1982

Marcel Heiman Memorial Award for Research in Psychiatry, Mount Sinai Medical Center, 1982

Northwest Bronx Council on Aging Outstanding Gerontologist Award, 1990.

Licensure:

New York State Diplomate, National Board of Medical Examiners

Diplomate, American Board of Psychiatry and Neurology, 1983

Diplomate, American Board of Psychiatry and Neurology Added Qualification in Geriatric Psychiatry, 1991

Membership:

American Psychiatric Association
American Association for Geriatric Psychiatry
Gerontological Society of America

Other:

Consultant - American Psychiatric Association (APA) Work Group: Practice Guidelines for the Treatment of Major Depression, 1991-1992

Past Member: American Association for Geriatric Psychiatry (AAGP), Committee on Fellowship and Residency Training

Member: American Psychiatric Association (APA) Council on Aging's Committee on Access and Effectiveness of Psychiatric Services for the Elderly, 9/93-

Grants:

NYS OMH, Central Islip Psychiatric Center-Long Island Jewish Medical Center Affiliation Contract 4/91-6/91, $8,000.00 (B. Greenwald, Project Director)
Renewal 7/91 - 6/92, $32,000
Renewal 7/92 - 6/93, $32,000
Renewal 7/93 - 6/94, $33,000

Bristol-Myers Squibb Pharmaceutical Research Institute, "A Multicenter Placebo Controlled Comparison of Nefazodone and Fluoxetine in the Treatment of Elderly Patients with Major Depressive Illness" 3/92 -9/93, $142,000 (B. Greenwald, site P.I.)

National Institute of Mental Health (NIMH), Clinical Mental Health Academic Award (CMHAA) in Geriatric Psychiatry: "Brain Morphometry in Geriatric Depression" 4/94-3/99, $721,478.00 (BS Greenwald, PI)

Publications:

1. Nurnberg, H.G., Greenwald, B.: Stuttering: an unusual side effect of phenothiazines. American Journal of Psychiatry 138: 386-387, 1981.

2. Rosenberg, G.S., Greenwald, B., Davis, K.L.: Pharmacological treatment of Alzheimer's disease. In: Alzheimer's Disease. The Standard Reference, Editor, B. Reisberg, The Free Press, MacMillan Publishing Co., 1983.

3. Greenwald, B.S. and Davis, K.L.: Experimental Pharmacology of Alzheimer's Disease. In: The Dementias: (Advances in Neurology, Vol. 38). Edited by R. Mayeux and W.G. Rosen. Raven Press, New York, 1983.

4. Greenwald, B.S., Mohs, R.C. and Davis, K.L.: Neurotransmitter deficits in Alzheimer's disease: Criteria for significance. Journal of the American Geriatrics Society 31: 310-316, 1983.

5. Davis, K.L., Mohs, R.C., Rosen, W.G., Greenwald, B.S., Levy, M.L., Horvath, T.B.: Letter: Memory enhancement in Alzheimer's disease with oral physostigmine. New England Journal of Medicine 308: 721, 1983.

6. Johns, C.A., Levy, M.I., Greenwald, B.S., Rosen, W.G., Horvath, T.B., Davis, B.M., Mohs, R.C., Davis, K.L.: Studies of cholinergic mechanisms in Alzheimer's disease. In: Biological Aspects of Alzheimer's Disease (Banbury Report 15); Cold Spring Harbor Laboratory Press, 1983, pp. 435-449.

7. Johns, C.A., Greenwald, B.S., Mohs, R.C., Davis, K.L.: The cholinergic treatment strategy in aging and senile dementia. Psychopharm. Bulletin 19:2, 185-197, 1983.

8. Davis, K.L., Mohs, R.C., Davis, B.M., Horvath, T.B., Greenwald, B.S., Rosen, W.G., Levy, M.I., Johns, C.A.: Oral Physostigmine in Alzheimer's disease. Psychopharm. Bulletin 19: 451-453, 1983.

9. Davis, K.L., Johns, C.A., Mohs, R.C., and Greenwald, B.S. Reply to letter, Re: Cholinesterase inhibitors and opiate antagonists in patients with Alzheimer's disease. New England Journal of Medicine, 309: 555-556, 1983.

10. Mohs, R.C., Rosen, W.G., Greenwald, B.S., Davis, K.L.: Neuropathologically validated scales for Alzheimer's disease. In: Assessment in Geriatric Psychopharmacology. Edited by T. Crook, S. Ferris, R. Bartus, Mark Powley Assoc., New Canaan, Connecticut, 1983.

11. Greenwald, B.S., Denicoff, K., Meyerson, A.T. Treatment Planning: Chronic patient has numerous changes in drugs, therapists; Makes only limited gains. Hospital and Community Psychiatry 36: 233-235, 1985.

12. Mohs, R.C., Davis, B.M., Johns, C.A., Mathe, A.A., Greenwald, B.S., Horvath, T.B., Davis, K.L. Oral physostigmine treatment of patients with Alzheimer's disease. American Journal of Psychiatry, 142: 28-33, 1985.

13. Greenwald, B.S., Edasery, J., Mohs, R.C., Shah, N., Trigos, G.G., Davis, K.L. RBC and plasma choline in Alzheimer's disease. Biological Psychiatry, 20: 367-374, 1985.

14. Kanof, P.D., Greenwald, B.S., Mohs, R.C., Davis, K.L. Red blood cell choline uptake kinetics in Alzheimer's disease. Biological Psychiatry 20: 375-383, 1985.

15. Johns, C.A., Haroutunian, B., Greenwald, B.S., Mohs, R.C., Davis, B.M., Kanof, P., Horvath, T.B., Davis, K.L. Development of cholinergic drugs for the treatment of Alzheimer's disease. Drug Development Research, 5:1, 77-96, 1985.

16. Davis, B.M., Mohs, R.C., Greenwald, B.S., Johns, C.A., Horvath, T.B., Davis, K.L. Clinical studies of the cholinergic deficit in Alzheimer's disease: I. Neurochemical and Neuroendocrine Studies. J. American Geriatrics Society, 33:741-748, 1985.

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DECLARATION OF M. ANNE HART

1. My name is Meredith Anne Hart. I am the individual designated under the federal Older Americans Act Amendments of 1992, 42 U.S.C. § 3058g, Pub. L. No. 102-375, 712, 106 Stat. 1277 (September 30, 1992), and the D.C. Long Term Care Ombudsman Program Act of 1988, D.C. Code 6-3512, to perform the mandated functions of the Long Term Care Ombudsman Program. I have been employed as the D.C. Long Term Care Ombudsman for the last ten years.

2. I received a Bachelor of Arts in English Literature from the University of Michigan in 1977 and a Masters in Gerontology and a Masters in Public Administration from the Andrus Gerontology Center at the University of Southern California in 1980.

3. The mandated duties of the Office of the Long Term Care Ombudsman include 1) to advocate for the rights of nursing facility residents; 2) to investigate and resolve complaints made by or on behalf of nursing facility residents; 3) to monitor the quality of care, services provided and quality of life experienced by nursing facility residents to ensure that the care and services are in accordance with applicable District and federal laws; 4) to analyze, comment on and monitor the development and implementation of federal, State, and local laws, regulations and governmental policy and actions that pertain to the health, safety, welfare and rights of nursing facility residents; and 5) to represent the interests of residents before

governmental agencies and seek administrative, legal and other remedies to protect their health, safety, welfare and rights. The Long Term Care Ombudsman has the statutory duty to assert the rights of nursing facility residents under the District of Columbia Nursing Home and Community Residence Facility Residents Protections Act, D.C. Code § 32-1401 et. seq. and the Older Americans Act.

4. I have personal knowledge of D.C. Village Nursing Home ("D.C. Village") through the performance of my statutory responsibilities. The statements contained in this declaration are based upon that knowledge. Based on my personal knowledge and observations as the District of Columbia Long Term Care Ombudsman, I have concluded that the level of care is so inadequate at D.C. Village that health, safety and welfare of its residents is in ongoing danger.

5. I have verified from medical records that the care being provided to residents at D.C. Village is inadequate and jeapordizes their health, safety and welfare. I have also verified that the care provided at D.C. Village is dangerously poor based on complaints and my investigation of those complaints.

6. For example, one D.C. Village resident was hospitalized on February 11, 1995 with a broken arm after she was found with a swollen arm, her bedside curtain full of stool, and blood on the floor. This was not the first such incident, incident reports show that she suffered contusions and

lacerations of the scalp on three separate occasions in the summer and winter of 1993. On February 11, as a result of her new injuries, the resident was put in a wheelchair to be taken to the hospital and then left outside to wait for the ambulance without even a blanket to cover her. Five days later, the resident was hospitalized again with pneumonia, e. coli urosepsis, and dehydration. The resident died on February 22, 1995.

7. A resident of D.C. Village was hospitalized on December 31, 1994 with pneumonia, stage III decubitus ulcers which were infected with staph and strep, septicemia and anemia. The same resident was previously hospitalized only in September for urinary tract infection, dehydration and decubitus ulcers. The resident was again hospitalized on May 19 of this year with a urinary tract infection and stage IV decubitus ulcers. The ulcers are now so severe that the bone is visible.

8. A resident of D.C. Village was sent to the hospital on March 10, 1995 with dehydration and decubitus ulcers. On April 11, 1995, the resident was again sent to the hospital with a septic decubitus ulcer which was infected with gangrene. He was also noted to be malnourished and dehydrated. By the time of the second hospitalization, the ulcer went to the joint of the knee. The resident's lower leg below the knee was thereafter amputated.

9. Another resident was sent to the hospital on December 27, 1994 with severe dehydration, multiple decubitus

ulcers, anemia, emaciation and a stage IV decubitus ulcer. The resident died on January 6, 1995. The resident had previously suffered repeated hospitalizations due to the poor care he received.

11. Another resident found on January 4, 1995 slumped over her food during a meal. She was taken to a hospital and found to have urosepsis and stage II decubitus ulcers. The resident died on January 14, 1995.

11. There is an extremely high and recurring incidence of residents falling at D.C. Village. A review of incident reports reveals that the same residents fall over and over again, often receiving serious injury and hospitalization, yet they continue to fall after they return to D.C. Village. For example, a resident fell six times in four months, sustaining lacerations. Another resident fell five times in three months. Another resident fell four times in two months, twice going to the hospital and once falling twice on the same day. This indicates a shortage of staff to supervise residents and the lack of planning to address the prevention of falls. Medical records and incident reports also show a pattern of unexplained injuries that demonstrate a lack of proper care and monitoring of vulnerable residents.

12. A resident was hospitalized on April 12, 1995 with a fractured bone from a fall. She was diagnosed upon hospitalization with sepsis from a urinary tract infection, and Stage III decubitus ulcers. The resident died on April 23, 1995.

13. On May 12, 1992, a resident was hospitalized with dilantin toxicity, dehydration, and an unexplained head trauma. The resident had a history of falling frequently, and in each case she would be found on the floor. The resident suffered from tardive dyskenisia as a direct result of years of taking neuroleptics which were prescribed because of chronic mental illness. Although the resident was at high risk, she did not receive the staff monitoring or intervention necessary to prevent her from sustaining so many multiple injuries.

14. A resident of D.C. Village had his physician request glasses for him on February 16, 1995. By May 11, 1995, the resident has still not been fitted for glasses and a second referral was made by his physician. To date, the resident has no glasses.

15. I receive many complaints about the shortage of supplies at D.C. Village. I have verified through direct investigation and personal observation that various units at D.C. Village have been without diapers, bibs, clean sheets, ducderm tape for changing dressings for decubitus ulcers, drinking cups, juice, milk, Procardia, Xantax, A & D Ointment, and all manner of vitamins that are prescribed to assist in the healing of decubitus ulcers.

16. The quantity and quality of food provided residents at D.C. Village is insufficient. Residents frequently tell me and my observations have confirmed that they are hungry, the portions of food are too small, substitutions and snacks are

not available, and they are simply not getting enough to eat. One resident, for example, was forced to discontinue medication for hypoglycemia because he was not getting enough food, food necessary for him to take his medication.

17. For example, D.C. Village rarely, if ever, serves fresh vegetables. I have spoken to a dietician at D.C. Village about the issue this year and she responded that fresh vegetables are only served "when available." I have never seen fresh vegetables served to residents.

18. Some residents are also not receiving enough quantities of food because of the use of "sporks" at D.C. Village. A spork is a plastic utensil that is a combined spoon and fork. Some residents cannot eat with a spork and, as a result, do not eat sufficient food. In response to my complaints about this issue this year, D.C. Village staff told me that the silverware were locked up.

19. On May 10, 1995, residents on unit 3B were eating with their fingers because there were no eating utensils available. The dietician told me that the silverware was locked up. Also on that date, there were no cups available for residents to use for drinking liquids and there were no bibs so that after eating their food with their fingers, residents' clothes were covered with residual food. Residents in the day room were crying and very distressed that they had no utensils with which to eat.

21. On April 27, 1995, residents were served a plate of liver for lunch, but were given no knife to cut it. The previous day's dinner was a burned hot dog. Staff on both days stated that no substitutions were available.

22. Instead of serving food to residents, D.C. Village increasingly depends on liquid nutritional supplements as their entire source of food because there is a shortage of food and a shortage of staff to feed the residents. There is an inordinate use of these supplements when adequate nutrition should be provided.

23. I have also learned that there are many residents suffering from dental problems that are not being treated. As a result, residents are not able to eat solid food and liquid food is prescribed for them. These residents would be able to eat solid food if they received some attention to their dental care needs.

23. As a result of these problems, many residents are suffering dramatic weight loss. One resident on unit 3B went from 190 pounds in August 1994 to 140 pounds in December, 1994.

24. Based on my review of medical records, I have also found that a very high percentage of residents at D.C. Village are dehydrated. Residents are often dehydrated because they are not being given sufficient quantities of water each day. The consequences of dehydration, particularly in the vulnerable population at D.C. Village, can be severe. If residents do not drink liquids they are prone to urinary tract infections and

dehydration. The incident of dehydration and urinary tract infections is very high as a result of these shortages.

25. For example, one resident has a physician's order on his chart for juice, but juice is not available. This resident is vulnerable to chronic renal failure if he does not receive sufficient liquids.

26. During my visits to D.C. Village, I always see roaches. They are commonly present in the dining areas for example.

27. The day room on unit 3B consistently has an overpowering smell of urine which has totally saturated the rug. The smell is intense and residents on that unit complain that they can't breathe and ask for fresh air.

28. Many residents are inappropriately dressed. They are wearing clothes that do not belong to them. Their clothes are routinely covered with crusted and dried food from their last meal. Their clothes are missing buttons and have holes and tears in them. Their shoes are often too small and hanging off their feet or too large, making them shuffle and fall when they try to walk.

29. I have been onsite at D.C. Village as recently as last week and have reviewed case histories and records of residents during this week. The statements made in this affidavit are thus true as of the date of this affidavit. Based on my experience at D.C. Village, absent court action, I also

anticipate that these problems and ongoing threats to the safety and health of D.C. Village residents will continue.

I swear under penalty of perjury that the foregoing is true and correct.

Meredith Anne Hart

Dated: [illegible] 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	DECLARATION OF CHARLEASE HATCHETT
	)	

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Charlease Hatchett, do hereby declare:

1. I am the great-granddaughter of Mazie Edwards, who was a resident at D.C. Village ("DCV") for about two years before her death on December 10, 1993. A few months before she died, my grandfather asked me to look after my great-grandmother if I could.

2. When I visited my great-grandmother at DCV in August 1993, I was shocked at the conditions there. The rooms smelled like urine. There were no staff around as far as I could see. Every resident on the unit was herded in front of the TV with no staff present. There were no scheduled activities. She was dressed in a hospital gown, not real clothes. In fact, there were no clothes in her closet or in her furniture. All of her clothes were missing.

3. I am a certified therapeutic recreation specialist, so I'm familiar with elderly patients' therapy needs. When I looked through my great-grandmother's record, I was surprised to

discover that she had been given no therapy whatsoever at DCV. There was no current therapy plan of care in her chart with goals and objectives, and there was no indication in the chart I reviewed that therapy or stimulation had been provided to her at all. She was just left in bed all day. In fact, when I visited DCV, no one came in to provide any form of service for or therapy to her.

4. When I called up the relevant professional at DCV to ask why such needed services were not being furnished, I was given a harsh, abrupt and arrogant response. It was completely unprofessional. He made it seem as if I was at fault somehow for merely inquiring about my relative's health and welfare. I also spoke with my great-grandmother's physician at DCV, and he blamed conditions on the budget and the agency nurses -- anyone else but him.

5. My great-grandmother died of a fractured skull. At the hospital, the doctors believed that she must have been dropped to have sustained this type of injury. They didn't see how an elderly person with severe contractures in her upper and lower limbs could have sustained such a traumatic fracture.

6. Even though this was a serious injury and eventually led to her death, DCV had failed to fill out an incident report on the matter within 24 hours. Only when I brought this to their attention did they take steps to have the matter investigated. Even then, no one could really pinpoint exactly what happened to

her. None of the staff seemed to have any hard information about why she sustained the fracture.

I certify under penalty of perjury that the foregoing is true and correct. Executed this ____ day of June, 1995.

Charlease Hatchett

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF ANDREW HAWKINS

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Andrew Hawkins, do hereby declare:

1. I am the brother of Charles Hawkins, who was a resident at D.C. Village ("DCV") for about two years before his death on January 3, 1995.

2. A few years ago, at age 59, my brother suffered brain damage that caused him to require specialized attention and care. My brother had lived with me and my wife for a few years, but he needed more services than we were able to provide for him. We decided to place him at DCV. I visited him as often as I could. Sometimes I would see him twice a week; other times I would see him three or four times a month.

3. Every time I visited my brother at DCV, I became upset over the deplorable conditions. The longer I stayed, the more it got to me. I found myself needing to leave earlier than I had planned, because if I didn't, I would have confronted people and gotten myself in trouble. Yet, I found that talking to staff was

always a useless exercise. I couldn't trust anyone there. They all banded together to tell me half-truths.

4. I'm overcome with guilt sometimes because I left my brother there and he ended up dying. It's been very difficult for me to live with. I wish the place could be shut down so that no one else will have to suffer like my brother did. I'm afraid alot of other people will die needlessly. It's a national disgrace.

5. While he was alive, the DCV staff did not take care of my brother adequately; they didn't provide for his basic care needs. It was a crime the way they treated him. They just ignored him. They would leave him and the other residents in front of the TV unattended. The staff were very unprofessional; in fact, they were a disgrace to their profession. Whenever I visited him, I found him needing a shave and needing to be cleaned up. I couldn't even find staff to help me take care of him when I visited. I would have to find my own razor and shave him myself. I would also do my best to clean him up myself. I never saw staff around to help. I think this was outrageous neglect.

6. I was always surprised to find that my brother had been left poorly dressed in clothes that were three sizes too large for him. None of the clothes he wore were ever his. They weren't really clothes, they were more like rags. That never made sense to me because I made sure that my brother had enough to wear when I first left him at DCV. In fact, he had quite an

extensive wardrobe. But it seems that whenever my brother's clothes were sent to the laundry, certain items would become lost forever. I could never find any clothes in his closet or in his drawers. As a result, he was always dressed like a ragamuffin. It was just criminal.

7. I think my brother's death was suspicious and mysterious. He died after having choked on a very large piece of meat. He had never had any eating problems or choking episodes in the past. I think the meat may have been forced down his throat, but I can't prove it. In telling me about his death, the hospital doctors looked at themselves as if something was grossly wrong. When I talked to staff at DCV about the circumstances surrounding his death, they all looked scared to death. No one would talk to me about it.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 4Th day of June, 1995.

Andrew L. Hawkins

Andrew Hawkins

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	Civ. A. No. 95-943 TFH DECLARATION OF JOSEPH HAYNES

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Joseph Haynes, do hereby declare:

1. I currently work for the Hill-Rom Company, Inc. as a credit manager. Hill-Rom provides hospital beds and therapy beds to nursing homes, hospitals and others nationwide. Some of our beds are used for the prevention and treatment of decubitis ulcers or pressure sores.

2. For at least the past seven years or so, Hill-Rom has provided rental therapy beds to D.C. Village ("DCV"). Our arrangement with DCV is for rental of the beds on a day to day basis.

3. We are currently owed $16,667.50 in past due amounts from the District of Columbia for the rental therapy beds used at DCV. We received our last payment from the District in late March 1995 in the amount of $3,925.00. This was only a partial payment and did not meet all past due amounts owed us at that time. Traditionally, the District has been slow in paying our

invoices. However, the current delay is much longer than the normal delay.

4. At the present time, we have removed all of our rental therapy beds from DCV.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 15th day of June, 1995.

Joseph Haynes

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 95-948 TFH
	)	
THE DISTRICT OF COLUMBIA, et al.,	)	
	)	
Defendants.	)	DECLARATION OF MARIA LAURENCE
	)	

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Maria Laurence, do hereby declare:

1. I am the Supervisor of Volunteer Advocacy Services at the District of Columbia Arc, Inc. ("DC Arc"). As part of our many duties and responsibilities, DC Arc serves as the court-appointed Monitor for the class of approximately 830 individuals with developmental disabilities known as the Pratt class, who have been out-placed into the community from Forest Haven, a District-run institution that was forced to close under court order in 1991. We routinely visit the class members at their residences and day programs to ensure that they are provided with adequate habilitation, care and other support services to meet their needs pursuant to a series of consent decree provisions that govern their outplacement.

2. Upon the closure of Forest Haven, 23 individuals with mental retardation were placed at D.C. Village ("DCV"). At the time, DC Arc voiced opposition to these placements because we considered DCV to be an inappropriate institutional setting that

was overly restrictive and that would fail to meet the needs of the class members. In fact, the class members have not fared well at DCV. Of the 23 class members who were initially placed there in 1990-91, 10 have since died. Many class members' health deteriorated rapidly and they died shortly after placement at DCV. For example, Renee W., Anna May H., and Linda T. all died within two months of placement at DCV; Russell S. died within five months of placement; Willie R. died within nine months of placement; Donna C. died within thirteen months of placement; and Maxwell E. died fourteen months after placement at DCV. Other class members, Joseph M., Deborah K. and Earl V., also have died while under the care of DCV.

3. In order to monitor conditions and services provided to the remaining class members at DCV, I have visited the facility on many different occasions over the years. In 1995, I have visited DCV about once or twice a month.

4. I have noticed that in response to cited problems and pressure from DC Arc and other outside groups, DCV has put a lot of new processes in place. However, during my visits, I have not found that these new processes resulted in significant improvements for the residents. The facility director, Ms. Brasfield, and the District administrators seem to have good intentions, but their initiatives, like total quality management and peer review, seem to have had little real impact on resident care and services. For example, in several recent conversations with DCV staff, in meetings and on the residential units, the

staff have indicated that certain activities related to the care of the class members and of the other residents do not occur in the manner they are supposed to because of a lack of necessary equipment, staffing or training.

5. Generally, my observations at DCV have led me to conclude that there are not an adequate number of staff to meet the needs of the class members and of the other residents, especially individuals with mental retardation. The staff often do not interact appropriately with the residents. For example, in April of this year, I stood in a dayroom on Unit 5A for about thirty minutes. Nine residents were present, but no staff were in the room. After a few minutes, two staff then entered the room and began talking to and tending to the needs of some of the people. On several occasions, I have observed the staff sitting in the dayroom at a table talking to one another with class members and other persons sitting idle while the TV is on in the background. I have never seen a supervisor tell the staff that this type of behavior is unacceptable. As a result, there is a total lack of habilitation provided to the class members and residents who need it. At times, when I have identified myself as being from the Monitoring program, staff have increased their interaction with the class members and the other residents. The residents are usually all lined up in their wheelchairs in the dayroom or they are in bed and receive minimal interaction from the DCV staff.

6. It appears that the food served to the people living at DCV is a concern. While I observed a meal a few weeks ago, I heard one staff member comment on the poor quality of the food, saying to the individual she was feeding, "I'm surprised you can eat it, it's so hard."

7. While reviewing resident charts a few months ago, I noticed that DCV did not have a sufficient supply of Jevity, a liquid nutrient used for tube feedings, for one of the class members, Franklin M. In the chart, the nutritionist wrote that the food could not be given "because of unavailability." Jevity had been carefully selected by a DCV physician as the food that best met Franklin's individual nutritional needs. In fact, the doctor wrote a prescription for the Jevity. Because the Jevity was not available, the facility was forced to substitute it with Complent, a liquid food with a different nutritional value.

8. When I observe meals, I usually notice that the DCV staff do not follow the written feeding protocols specifically tailored for the residents. As a result, the staff often feed the residents incorrectly. This is dangerous because many of these individuals have swallowing problems or other medical concerns requiring careful feeding.

9. At a recent meal, I found that a shortage of staff led to long delays in feeding certain residents. While the individuals who live at DCV waited, the staff left the trays of food uncovered so that the food became cold by the time it was fed to the residents. As a result, the residents became clearly

uncomfortable. The individuals with mental retardation resorted to crying and whining to get the attention of the staff.

10. Certain individuals with mental retardation require close supervision. However, whenever I visit DCV, I invariably notice staff not doing anything to intervene when a person with mental retardation begins to engage in inappropriate behaviors. Just last month, I noticed that Arnethia R., a resident with mental retardation, had become agitated. DCV has provided her with virtually no meaningful activity in which to be involved. Typically, she ends up playing with tin cans by herself. In addition, the poor staff ratio usually leaves her confined to the dayroom where the few staff on duty can keep an eye on her. Arnethia seems to enjoy being active. On this particular day, she was walking out into the hallway trying to leave the dayroom. Initially, in response to her agitation, staff yelled at her but did not move away from their table to intervene. Eventually, they moved to physically stop her. In response, Arnethia resorted to sitting on the floor, rocking back and forth, flapping her hands and banging her hands on the floor. Eventually, she even approached me and tried to get me to escort her off the unit. It was clear the DCV staff did not know what to do. They definitely did not refer to Arnethia's behavior program to determine what they should do. Fortunately, a Georgetown University staff person who is contracted to provide clinical services to persons with mental retardation, came by and intervened by implementing her behavior management program. The

residents with mental retardation are fortunate that the independent contractors from Georgetown are there to intervene appropriately whenever they can. When intervention is left to the DCV staff alone, the residents have suffered.

11. Generally, program plans are not implemented by DCV staff. For example, instead of following the behavior plan for Cynthia W., a resident with mental retardation who excessively rubs her ear until it becomes raw, staff will apply restraint mitts instead. According to her Individual Habilitation Plan ("IHP"), Carla L., a resident with mental retardation, is to receive training to use a soft glove to wash herself. However, the Georgetown staff have told me that this has never happened. Generally, DCV staff have not demonstrated knowledge of the residents' IHP's to properly implement them. In fact, it is never clear to me that the residents' IHP's are even kept on the given living units. This makes implementing the written plans very difficult.

12. In response to repeated concerns expressed by DC Arc, the Long Term Care Ombudsman, and the U.S. Department of Justice, the District has recently begun taking steps to place in the community all remaining class members and any other individuals with mental retardation who currently reside at DCV. We applaud this decision because DCV is and will remain an inappropriate institutional setting for individuals with mental retardation. We have been working closely with facility administrators and the designated community vendors to ensure that the placements are

appropriate and will meet the specialized needs of these individuals with developmental disabilities. Outplacement efforts should continue and new admissions to DCV of people with mental retardation should be prohibited.

I certify under penalty of perjury that the foregoing is true and correct. Executed this ___ day of June, 1995.

Maria Laurence

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	Civ. No. 95-948 TFH SUPPLEMENTAL DECLARATION OF MARIA LAURENCE

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Maria Laurence, do hereby declare:

1. Since signing my previous declaration, I visited D.C. Village ("DCV") on two separate occasions, Monday, June 12, 1995 and Friday, June 16, 1995. This supplemental declaration details observations I made on these two visits.

2. On each day, there was no adaptive equipment available at mealtimes for the use of residents who need it. No staff seemed to know where it was. The unit staff called the kitchen to look for it, but they could not find it either. For some individuals with severe disabilities, adaptive equipment is critical to allow them to feed themselves, or to be fed safely and effectively. When it is not available, these individuals struggle and often are unable to take in sufficient amounts of food to meet their nutritional needs.

3. Because of the lack of the adaptive scoop plate she needs, I noticed that Shirley A. was unable to feed herself properly. As a result, food was flying off the plate onto her

bench. I noticed her eating the fallen food off the bench. No staff intervened to help her.

4. I observed Patricia A. eat only about one tenth of her meal on Monday because the adaptive cup and other adaptive equipment she needs was not available. I asked the Georgetown contract staff about her. I learned that Patricia has lost ten pounds, which places her below her ideal body weight. I understand that her dramatic weight loss is attributable directly to the lack of proper feeding equipment at DCV.

5. As a result, tracking Patricia's weight is exceedingly important to her health and well-being. However, in an interdisciplinary team meeting for Patricia on June 16, 1998, a DCV nurse indicated that Patricia could not be weighed properly at DCV because the unit scale was broken. The nurse admitted that the vendor who normally comes out to repair the scale would not come out to DCV because he had not been paid past due amounts for services he had rendered.

6. On Monday, while observing activity in the dayroom on unit 5A, I observed a large puddle of liquid on the floor by DCV resident Franklin M. It turned out to be a puddle of Jevity, the liquid nutrient provided to Franklin through a feeding tube. The Jevity was spilling on the floor because Franklin's tube had become dislodged. I immediately notified staff who then reconnected the tube without sterilizing it. Throughout my 45 minute stay in the dayroom, no staff had interacted with or checked on Franklin. Had I not been present, noticed the puddle,

and alerted the staff, Franklin may have continued to sit with his feeding tube disconnected and leaking for a much longer time. I learned later that Franklin has suffered with many different infections at his tube site. My understanding is that this could be due to the fact that his tube repeatedly becomes dislodged, and yet the staff reconnects it without sterilizing it first.

7. On Friday, I observed Pierce L., a DCV resident, sweating, with cold, clammy skin and audible labored breathing. He started coughing and spitting up mucus. I immediately alerted the staff in the dayroom who alerted the registered nurse. She intervened by stopping the flow into Pierce's feeding tube. Pierce's condition seemed to improve, however, it was clear that the nursing staff had not been monitoring his condition closely enough to prevent him from suffering such discomfort.

8. I have recently learned that for a variety of reasons, the District will not meet its stated goal of outplacing into the community all DCV residents with mental retardation by June 30, 1995. I have also learned that Georgetown University, the contractor who currently provides the DCV residents with mental retardation with needed clinical services, habilitation, and other services, will not provide such services at DCV without a formal contract with the District. District officials have indicated to DC Arc that they intend to extend the contract, but given that the contract has not yet been drafted or signed, there remains a real danger that needed services may not be available for the DCV residents with mental retardation as of July 1, 1995.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 17th day of June, 1995.

Maria Laurence

Maria Laurence

District of Columbia
900 Varnum Street, N.E. Washington, DC 20017
(202) 636-2950 • FAX (202) 636-2996

Arc

formerly the D.C. Association for Retarded Citizens, Inc. • State Member of The Arc
A United Way Member Agency • Non-profit tax exempt organization • Equal Opportunity Employer

June 19, 1995

Frances Bowie
Acting Administrator
Mental Retardation & Developmental
Disabilities Administration
429 O Street, N.W.
Washington, DC 20001

Dear Ms. Bowie:

I am writing to you to confirm our telephone conversation on Friday, June 16, 1995 regarding the need to extend the Georgetown University contract for services provided to Pratt class members and other persons with mental retardation at DC Village. As we discussed, it has become apparent over the past several weeks that all 22 individuals with mental retardation who were scheduled to be outplaced to ICFs/MR by June 30th, will not be moved to the community by this deadline. My conversations with Georgetown administrators indicate that they will not continue to provide services at DC Village past June 30th, the date on which their contract expires, unless they receive written confirmation of the District's intent to extend their contract for a given period of time.

After speaking with you on Friday, it is my understanding that MRDDA is in agreement that the Georgetown contract needs to be extended in order to ensure that the class members and other persons with mental retardation at DC Village receive the clinical, habilitation and other services which they require and to ensure that the transition process for these individuals occurs in a safe and effective manner. You indicated that you are in the process of working out the details of a letter which would extend the Georgetown contract.

As we discussed, the DC Arc Pratt Monitoring Program strongly recommends that whatever action necessary be taken to ensure that the Georgetown clinicians and other staff remain in place at DC Village until all class members and other persons with mental retardation are transitioned safely to community placements. Thank you in advance for your

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF RONALD L. MESSENHEIMER

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Ronald L. Messenheimer, do hereby declare:

1. I am the President of National Nurses Service ("National"), a division of ATLIS Health Services, Inc. National provides nurses on a part-time contractual basis for hospitals, nursing homes, and private individuals.

2. For about the last four or five years, National has furnished the D.C. Village Nursing Home ("DCV") with agency nurses pursuant to a contractual arrangement with the District of Columbia.

3. Until recently, our arrangement with the District had been a positive one. Although payments were often delayed, the District eventually paid us for the services we had rendered at DCV. However, last Fall, we stopped receiving payment altogether for our contract nursing services. As a result, we were forced to call repeatedly various District officials in an attempt to obtain the funds we were due. Many times, our phonecalls were not returned. Whenever we were finally successful in talking to

someone, we were often asked to re-fax the invoices we had already submitted causing further delay. In response to our pleas, the District made numerous promises and assurances to us that we would be paid in a week or ten days, yet we never received payment.

4. In March or April 1995, we finally received partial payment for the months of October, November and December 1994. As is obvious, this payment was long overdue. We are still owed money for services we've rendered at DCV for the months of January through May 1995.

5. On May 23, 1995, I sent the attached letter to Vernon Hawkins, the Interim Director of the District's Department of Human Services ("DHS"), expressing my extreme concern about the overdue amounts owed us totalling $184,964.56. As I indicated in the letter, some of the invoices dated back seven months. I alerted Mr. Hawkins that we would be forced to discontinue service to DCV if we were not paid.

6. On June 6, 1995, I sent another letter to Mr. Hawkins advising him that we still had not received payment for services rendered at DCV. I told him that we would be unable to continue service at DCV after the evening of June 9, 1995 unless we received payment for the past due amounts. I have also attached a partial list of overdue amounts stemming from work performed at DCV primarily in March, April and May 1995. Some of the overdue amounts involve invoices submitted as far back as October 1994.

7. Since February of this year, we have been providing services to DCV in good faith based upon the professional and official representations of Mr. Hawkins, who expressly told my organization and other DCV providers that our contracts were being verbally extended by the District. He asked us to work with the District during its fiscal crisis. We agreed to do so, but we have reached the point now where we cannot continue to provide service on the representations of the District alone, which in the past have proven empty.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 9th day of June, 1995.

Ronald L. Messenheimer

NATIONAL NURSES SERVICE

A Division of ATLIS Health Services, Inc.

June 6, 1995

Vernon E. Hawkins
Interim Director
Department of Human Services
Building 801 East, Second Floor
2700 Martin L. King Avenue, S.E.
Washington, D.C. 20032

Re: JA/90701 - D.C. Village
JA/93941 - D.C. Village
Quantum Merit - D.C. Village

Dear Mr. Hawkins:

Since our May 23, 1995 letter to you (copy attached) we have had many discussions with various representatives of the D.C. Government and received payments under Contract JA/90746, however we have received no payments for services at D.C. Village.

We regret to advise you that we will be unable to continue service at D.C. Village after the evening shift on Friday, June 9, 1995 unless we receive payment for these seriously past due invoices.

Thank you for your assistance in this matter.

Sincerely,

Ronald L. Messenheimer
President

RLM:ejf
Enclosure

cc: Alberta Brasfield
Gladys Fountain
Annie Wilson

NATIONAL NURSES SERVICE

A Division of ATLIS Health Services, Inc.

May 23, 1995

Vernon E. Hawkins
Interim Director
Department of Human Services
Building 801 East, Second Floor
2700 Martin L. King Avenue, S.E.
Washington, D.C. 20032

Re: JA/90701 - D.C. Village
JA/93941 - D.C. Village
Quantum Merit - D.C. Village
JA/90746 - Forest Haven

Dear Mr. Hawkins:

We are extremely concerned about overdue invoices which total $184,964.56. These invoices date back seven months (see attachments). Despite repeated assurances, we are simply not being paid. It is vital that we obtain payment immediately or we will be forced to discontinue service.

Please advise us by Thursday, May 25, 1995, with respect to when we will receive payment. Your personal assistance in this urgent matter is greatly appreciated.

Sincerely,

Ronald L. Messenheimer
President

RLM:ejf
cc: Peggy Butler
Gladys Fountain
Annie Wilson

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al. Defendants.	Civ. A. No. 95-0948 TFH DECLARATION OF JOHN MOGENSON

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 205(c), I, John Mogenson, do hereby declare:

1. I work as a credit analyst for the Sandoz Nutrition Corporation.

2. Sandoz supplies tube feeding products and other dietary and medical-related products to nursing homes, hospitals and private individuals.

3. Pursuant to an arrangement with the District of Columbia, Sandoz has supplied the D.C. Village Nursing Home ("DCV") with such products for the past few years.

4. The District currently owes Sandoz past due amounts totaling about $9,000. Specifically, we are owed $1,120.00 for a November 8, 1994 invoice; $5,670.00 for an April 18, 1995 invoice; and $1,800.00 for a May 19, 1995 invoice. The last payment we received from the District was on May 24, 1995 for an invoice we had submitted on February 12, 1995, three months earlier. The District has regularly withheld payments long past the due date. Certain invoices seem to be tied up in the system.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 12th day of June, 1995.

John Mogenson

John Mogenson

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF MARIA MORTON

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Maria Morton, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") for the past four years. I am 41 years old and presently live on Unit 2A in a room with two other women.

2. The food served to us in the last few months has been horrible. It is not adequate and often inedible. It is served to us all dried up and bland. Potatoes are overcooked and hard. The meals are not hot. We haven't been served salad for months. Last week, I was happy because I knew the food would improve while the outside surveyors were here. In fact, the food did improve while they were here. Upon their arrival, we were provided with better meals, and with salt, pepper, sugar and juice at lunch and dinner for the first time in months. We used to get juice all the time last year.

3. I can't eat certain foods like seafood. However, they still keep sending me fish to eat. Even after I remind staff that I cannot eat fish, they still get it wrong. For example,

when I've mentioned that I can't eat the salmon served me, they will replace it with tunafish. It's still fish so I'm left unable to eat it. This type of service continues today. As recently as a week ago, they served me fish inappropriately and I was left with nothing to eat. The dietician knows about all this, but the problem still keeps recurring.

4. I have difficulty hearing, yet DCV doesn't provide me with hearing or speech therapy. I'm not given any formal sign language instruction. Without such training, I'm not able to move out of DCV and into a more appropriate community setting. I'm only 44 years old, and yet without proper training, I'm stuck at DCV. DCV doesn't even provide me with a proper battery for my hearing aid. I need to use my own money to buy the batteries.

5. On my unit, we were entirely without hot water for a day about a month ago. They put up signs telling us that hot water was not available to us. This made bathing difficult.

6. The staff and nurses often don't groom the residents properly. I've seen residents in need of such services left with their hair not combed and nappy all day long. Sometimes staff do not bathe residents for months. The nurses typically don't respond when you press the service button near your bed.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 3 day of June, 1995.

Maria Morton

Maria Morton

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al. Defendants.	)	Civ. A. No. 95-0948 TFH DECLARATION OF JACK H. ROBINSON

Pursuant to the provisions of 28 U.S.C. § 1746 and L.D.C. R. 105(h), I, Jack H. Robinson, do hereby declare:

1. I am the President and CEO of Nutech Laundry and Textiles, Inc.

2. Nutech provides commercial laundry services for such items as sheets, pillow cases, towels and other personal items.

3. Nutech has provided service to the D.C. Village Nursing Home ("DCV") since December 1992. We have always provided service through a purchase order arrangement with the District of Columbia. In the beginning, we were used sporadically, however, from October 1993 through February 1995, we laundered DCV items on a somewhat regular basis. The last service we provided DCV was in late February 1995.

4. The individuals at DCV have always been pleased with our work. Mike Pantazis of DCV wrote us a few months ago indicating that we provided a "quality linen service ... [t]he work was always very well done and always returned in a timely fashion ... you always responded to energencies in accordance to

our needs and for this we are truly grateful. You have an operation that you should be proud of." See attached letter.

5. As the attached letter indicates, even though they were very pleased with our work, DCV officials "terminated" their use of Nutech because "budgetary restraints have forced us to take this action." Mr. Pantazis indicated that he would be concentrating his efforts on paying us the outstanding invoices we were due.

6. Currently, the District owes Nutech $80,827.96 for services rendered at DCV. As the attached invoice analysis report reveals, we are still owed monies for services we provided at DCV as far back as May 1994.

7. In trying to obtain the monies Nutech is due, we have been forced to speak with many different District officials. Working with the D.C. Government has been an administrative nightmare.

8. It seems that DCV has called upon my business only when they are facing an emergency need for service. They wait until their machines, or the machines at St. Elizabeth's hospital, break down before contacting us. Naturally, the cost for emergency work is higher than it would be if we had a relationship established where there was some semblance of continuity in service. We have tried repeatedly to tell District officials that they are wasting their resources by procuring laundry services in this manner. However, we have been unable to succeed in creating a more orderly and reliable working

relationship with the District. Without better planning and foresight, the District will continue to obtain emergency services way over market prices whether from Nutech or from some other vendor. Nutech remains willing to quote lower prices for services in return for a more orderly and reliable working relationship with the District.

9. The District recently put out an invitation for bids for laundry services at DCV, yet our company declined to bid on the work. Even though we are actively seeking additional contracts, we declined to bid on the job because of the past amounts we are due from the District and because there is no one in the District Government who we can deal with on a regular basis who we can count on. As we recently indicated in the attached letter to the District's Department of Human Services, "[w]hen open and accurate communication can be instituted, Nutech will be ready to respond."

I certify under penalty of perjury that the foregoing is true and correct. Executed this 12TH day of June, 1995.

Jack H. Robinson

-TESTIMONIAL-

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON, D.C. 20002

Received 2/24/95

IN REPLY REFER TO

Mr. Jim Quayle
Nutech Laundry and Textiles
5214 Monroe Avenue
Hyattsville, Maryland 20781

Dear Mr. Quayle:

Please be advised that effective Friday, February 24, 1995, we will be terminating our use of Nutech Laundry and Textiles to process the D.C. Village laundry. We have now reached the point where budgetary restraints have forced us to take this action.

Our efforts now will be concentrated on trying to get those outstanding Nutech invoices paid and satisfied.

I can make no guarantees but I will do all that I can to effectuate payment. I would suggest that you submit all outstanding invoices as soon as possible.

Please allow me to personally thank you firstly for providing a quality linen service. The work was always very well done and always returned in a timely fashion. Secondly, you always responded to emergencies in accordance to our needs and for this we are truly grateful. You have an operation that you should be proud of. Again, thank you.

If you have any questions or comments concerning this matter, please feel free to contact me on (202) 645-4466.

Sincerely,

Mike Pantazis, Chief
Facility Support Services
Division, D.C. Village

LAUNDRY AND TEXTILES, INC.

17 April 1995

Claudia Booker
Contracting Officer
Department Of Human Services
801 East Building/St. Elizabeth Campus
2700 Martin Luther King Jr. Ave. S.E.
Washington, D.C. 20032-4047

Re: Invitation For Bid: JA/95928

Ms. Booker:

I regret to inform you that Nutech Laundry and Textiles declines from entering a bid relating to D.C. Village. Currently, D.C. Village has an unpaid debt to Nutech Laundry in the amount of $80,926.96. This outstanding obligation dates back to May, 1994.

Even though Nutech is actively seeking additional contracts, without having some formal agreement as to when payment would be received on previous or future contracts, we at Nutech feel that it is prudent not to submit a bid at this time.

As stated above, Nutech is actively looking for new business. Nutech has on numerous occasions proven its abilities by providing the peace of mind associated only with a quality linen service. Nutech has never failed to be there in time of need for D.C. Village or St. Elizabeth.

When open and accurate communication can be instituted, Nutech will be ready to respond.

Sincerely,

Timothy Sutphin
Vice President

cc. Jack Robinson, President and CEO

NUTECH LAUNDRY & TEXTILES

08, 1995 17:20:37 INVOICE ANALYSIS REPORT PAGE: 2

SHORT NAME	INV #	INV DATE	LAUNDRY AMOUNT	SALES TAX AMOUNT	INVOICE AMOUNT	PYT//DSC DATE	PAYMENT AMOUNT	DSC AMOUNT	DUE AMOUNT
DC VILLAGE	8011	08/06/94	4723.68	.00	4723.68	10/05/94	4723.68	.00	.00
	8042	08/13/94	4849.65	.00	4849.65	10/06/94	4849.65	.00	.00
	8072	08/20/94	2029.17	.00	2029.17	10/06/94	2029.17	.00	.00
	8103	08/27/94	7211.49	.00	7211.49	TOTAL >	2992.95	.00	4218.54
						PAYMENT : 12/28/94	837.81		
						PAYMENT : 11/18/94	2155.14		
	8132	09/03/94	4593.03	.00	4593.03	12/19/94	4593.03	.00	.00
	8162	09/10/94	6130.41	.00	6130.41	12/28/94	4558.51	.00	1571.90
	8194	09/17/94	6532.89	.00	6532.89	12/28/94	4857.79	.00	1675.10
	8223	09/24/94	6792.63	.00	6792.63	12/19/94	1939.08	.00	4853.55
	8314	10/15/94	6583.20	.00	6583.20	01/13/95	6583.20	.00	.00
	8343	10/22/94	4635.93	.00	4635.93	01/24/95	4635.93	.00	.00
	8401	11/05/94	4489.68	.00	4489.68	01/24/95	4489.68	.00	.00
	8469	11/19/94	2309.97	.00	2309.97	03/23/95	2309.97	.00	.00
	8504	11/26/94	1923.48	.00	1923.48		.00	.00	1923.48
	8716	01/07/95	2625.25	.00	2625.25		.00	.00	2625.25
	8752	01/14/95	11350.55	.00	11350.55	06/05/95	99.00	.00	11251.55
	8787	01/21/95	9418.11	.00	9418.11		.00	.00	9418.11
	8823	01/28/95	6674.46	.00	6674.46		.00	.00	6674.46
	8859	02/04/95	6680.31	.00	6680.31		.00	.00	6680.31
	8895	02/11/95	8885.76	.00	8885.76		.00	.00	8885.76
	8932	02/18/95	9335.04	.00	9335.04		.00	.00	9335.04
	8968	02/25/95	6041.10	.00	6041.10		.00	.00	6041.10
	ACCOUNT TOTAL		222030.12	.00	222030.12		141202.16	.00	80827.96

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al. Defendants.	Civ. A. No. 95-0948 TFH DECLARATION OF ALAN I. ROOMBERG

Pursuant to the provisions of 28 U.S.C. § 1746 and L.D.C. R. 205(c), I, Alan I. Roomberg, do hereby declare:

1. I am the Chief Financial Officer of National Patient Care Systems, Inc. ("NPCS"). NPCS supplies hospitals, nursing homes and private individuals with health care support systems and products that aid in the prevention and treatment of bed sores. Bed sores are a terrible problem for people who are immobile. If these individuals are not cared for and treated properly, they will likely develop skin breakdown and infections.

2. Specifically, we provide mattress overlay systems which mitigate the formation of bed sores and aid in their healing. This is accomplished by a series of bubble tubes in which air is pumped through the mattress overlay. NPCS provides not only the mattress overlays but also the support staff to service the equipment and to inservice the consumers and their care givers on how to use the product most effectively.

3. Since the Spring of 1994, NPCS has had a formal arrangement with the District of Columbia to provide the services described above at the D.C. Village Nursing Home ("DCV"). We have provided mattress overlay systems and support to DCV for a number of residents on an as-needed basis. We charge the District twenty-five dollars per day per unit for our systems and service.

4. As of May 31, 1995, the District owes NPCS $66,535.00 in past due amounts for goods and services supplied to DCV. We have not received any payment at all for services rendered since October 1994. The last check we received from the District arrived to us in December 1994 for services rendered at DCV in September 1994.

5. We have made repeated telephone calls to Ms. Alberta Brasfield, the DCV facility director, and to Mr. Silas Butler, also of DCV, in an attempt to obtain payment. We are always promised payment, but it never arrives.

6. Despite the non-payment, NPCS has continued to honor its agreement with the District because we believe it is against public policy to stop service to the medically fragile DCV residents who are using our products. We fully understand that in many cases, their lives may be at stake. This attitude has forced us to incur the many additional expenses associated with non-payment. While we are not yet at the point of being forced to terminate services at DCV completely, I can envision a day when that would be the case.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 7th day of June, 1995.

Alan I. Roomberg

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF LAMONT ROYSTER

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Lamont Royster, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") for the past six years. I presently live on Unit 3A in a small room with three other men. I'm 33 years old, but I need nursing care because I'm paralyzed from the neck down.

2. Recently, the facility has been running out of needed supplies. A couple of weeks ago, the staff didn't have gauze to treat my sores. This shortage lasted for a few days. A week ago, they ran out of stretch/cling wrap for my foot. The facility has also run out of catheters for me. In fact, I've had to pay for a catheter myself. They have also run out of duoderm tape.

3. Overall, there is a shortage of basic care supplies such as toothbrushes, toothpaste, combs, brushes, soap, lotion, paper towels and cups. I've noticed these items in short supply and I've had this confirmed by unit nurses. As a result, I've had to buy some supplies, like toothpaste, on my own.

4. Not too long ago, my unit was without hot water for a week to a week and a half. With no hot water, I was not provided with my normal tub baths during that time; I only had my face washed for the entire period.

5. We have had to use plastic utensils instead of silverware alot recently. I would estimate that this year we have used the plastic about half of the time. It's my understanding that the silverware cannot be washed properly so we have to use the plastic. The plastic utensils are a combination of a spoon and a fork, called a "spork." It is difficult for me to eat with the plastic "sporks" they give to us. I've noticed other residents having difficulty eating with the "sporks" as well.

6. The food served to us here is terrible and inadequate. It has gotten worse in recent months because there have been food shortages. I understand that there is no money to buy enough food for us. The portions we've been served recently have been smaller than in the past. I haven't been served a salad in very long time. We haven't been served juice for lunch or dinner in about three months. In addition, the food we get is often overcooked and mushy with no taste. I can't eat it. Just about every day I leave most of the food I've been served without eating it. As a result, I'm left hungry, so I order food from outside vendors like the local Chinese restaurant. I do this three or four times a week. Sometimes, my brother will bring me food. This is how I get by.

7. While the outside surveyors were here last week, we were provided with juice at all meals for the first time in months. The meals improved during that time as well. However, I fully expect the quality of the meals to go down again once they're gone. This is always the pattern.

8. Some of the staff are disrespectful of our condition. Nurses and staff have directed hurtful comments to me such as "at least I'm walking and you're not!" They have told me to "shut up." Some have treated me like a child; when I objected, I was told, "At least my children can do for themselves." They often use profanity.

9. Last year, my wheelchair was in need of repair. Instead of furnishing me with a replacement wheelchair, I was left in bed for four to five months.

10. There are not enough activities to keep me occupied during the day. I wish I could socialize with others to keep my mind active. However, DCV provides me with little such stimulation.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 4th day of June, 1995.

Lamont Royster

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. *THE DISTRICT OF COLUMBIA, et al.* Defendants.	Civ. A. No. 95-0948 TFH DECLARATION OF TED SCHIMPFF

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Ted Schimpff, do hereby declare:

1. I am the President of National Creative Growth Industries, Inc. We do business under the trade name Health Care Laundry Services ("HLS").

2. HLS provides personal and institutional laundering services. We primarily launder sheets, pillow cases, towels, adult diapers, bed pads and patient gowns.

3. We have been providing such laundry services for the D.C. Village Nursing Home ("DCV") twice a day, every day for the past eight months.

4. As of June 9, 1995, the District owes HLS $103,255.50 for services rendered at DCV. A few days ago, we had been owed substantially more than that, but on June 5, 1995, we were paid $50,600.00 for ten or twelve past due DCV invoices. Many of the payments we receive now are only partial payments. We still are

owed monies from invoices submitted to the District in February 1995.

5. Despite the financial hardship delayed payments cause us, HLS will do its best not to discontinue services to DCV. We do not want to leave the residents in the lurch.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 14th day of June, 1995.

Ted Schimpff

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al. Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF LAURA SCOTT

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Laura Scott, do hereby declare:

1. I am 72 years old. I am a resident of the D.C. Village Nursing Home ("DCV"). I presently live on Unit 3A in a small room with two other women.

2. While I've lived at DCV, items of my clothing have been lost or taken from my room. I've lost forever many such personal items. I have to keep clothing on the bed and not in the closet. My name is now on all my clothing.

3. I don't like the food I'm served here at DCV. The food is nasty. Because it is not adequate, I can't eat many of the meals served to me. As a result, I'm repeatedly forced to make my way down to the kitchen to see if they'll prepare something else for me. In addition, my niece has to bring in fruit for me to eat. DCV doesn't provide fresh fruit for me.

4. Last week, when the outside surveyors were here, the food was positively beautiful. This always happens when outsiders are visiting. However, the food is not to my liking once they go.

5. A few weeks ago, we had no hot water on my unit. Because the water was too cold, I was not able to be bathed as I normally am. I had to be washed up at the sink in cold, cold water.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 3rd day of June, 1995.

Laura Scott

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff,	)	
v.	)	Civ. No. 95-948 TFH
THE DISTRICT OF COLUMBIA, et al., Defendants.	)	DECLARATION OF WILLIE VEASEY

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Willie Veasey, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") for about the past fifteen years. I presently live on Unit 5A in a room with one other man. I need nursing care because I'm dependent on staff for bathing, dressing, and toileting.

2. Recently, there have been shortages of needed medical supplies at DCV. For example, I need to use a urine bag every day. In the past, after the bag had become soiled, I had been able to replace it every day. In recent months however, there aren't enough bags available at DCV. I've had to re-use the same dirty bag two to three days in a row. This creates a sanitation and health problem. I recently suffered from a urinary tract infection which I believe was caused by my having to re-use the urine bag. I had to go to the hospital to get treatment for the infection and I had to take antibiotics. As far as I can

remember, I had never had a urinary tract infection when I was able to change my bag everyday.

3. I've had two different pressure sores on my buttocks and feet. When staff come in to dress my sore, I've noticed recently that they often lack tape, gauze and bandages.

4. About three or four months ago, the meals served to us started getting bad. The food they serve us now is terrible. The meals have been unappetizing, they're not nutritious, and they're usually not hot. In addition, the meal portions have been greatly reduced. My three meals together now equal one regular meal. The kitchen workers have told me that they haven't had anything to serve us. The meals used to be much better last year. At that time, we were served vegetables, meat and pasta.

5. We haven't been served fresh vegetables in about three months. We are also served very little meat. I'm given peanut butter sandwiches alot. We are routinely not given anything to drink for lunch and dinner except water. We are also not provided with little things like sugar, salt or pepper.

6. Many times, I don't eat the meal served and I'm left hungry. Since December 1994, I've lost about fourteen pounds. This is certainly not due to any positive intervention from my dietician; as far as I can tell, I'm still on a "regular" diet. My weight loss has resulted simply because I end up not eating the bad food they serve me.

7. The facility always improves conditions and services when outsiders tour DCV. Other than when the outside surveyors were here last week, we had not had juice for months. In fact, last week when the surveyors were here, food quality improved greatly. I ate virtually all food served to me for the first time in a long time. However, once the surveyors leave, things always revert back to the way they had been. I expect this to happen again now.

8. There are staff problems at DCV that are affecting resident care right now. Recently, there have been alot of forced retirements and lay-offs, resulting in not enough staff to meet our needs.

9. There is also a problem with contract nurses. They don't want to pay attention to us. They don't know who we are. As a result, they have made quite a few mistakes in dispensing medications to me. I know what I'm supposed to be taking, and when I tell the nurses that they've made a mistake, they don't like it.

10. I would have complained about conditions to someone, but I've realized over the years that complaining doesn't do any good.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 4th day of June, 1995.

Willie Veasey

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al., Defendants.	)	Civ. No. 95-948 TFH DECLARATION OF MARCO WATERS

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Marco Waters, do hereby declare:

1. I have been a resident of the D.C. Village Nursing Home ("DCV") for the past five years. I presently live on Unit 2A in a small room with three other men. I don't like living at DCV, but I have nowhere else to go. I have no choice but to stay.

2. I had my lower leg amputated in December 1994 after my foot had become infected from a sore that had developed here at DCV. At first, the sore was limited to the top of my foot. In the course of the next few months, the sore became infected and spread to the rest of my foot and to my lower leg. My doctor at DCV told me it would heal, but it never did. It kept getting worse. Throughout the worsening of the infection, my doctor came to see me personally only a very few times. Instead of visually inspecting me and my foot, he would rely on the written reports of the nurses. This is true even though his office was right around the corner from me. I'm bitter about the lack of medical

attention he gave me during this period. This doctor still works at DCV.

3. When the infection became more pronounced and my foot turned completely black, I was eventually sent to Hadley Hospital. The doctors and nurses there were shocked at the condition of my foot and leg. They said that my condition should have been caught long ago. I was told that my leg would need to be cut off so that the infection wouldn't spread to the rest of my body and kill me. The lower part of my right leg and foot were amputated.

4. After I was returned to DCV, at times, the nurses, especially the contract nurses, wouldn't give me medicine to alleviate the pain even though the pain was excruciating. The contract nurses come in and out; we don't know them and they don't know us. In fact, the nurses got mad at me for asking for the medication I was entitled to. Ms. Brasfield never came to see me after I returned.

5. I used to be able to walk with a walker. Now, I can't walk at all. I'm trying to learn how to walk with crutches. I spend most of my day in a wheelchair.

6. A few weeks ago, my unit was without hot water for a full day.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 9 day of June, 1995.

Marco Waters

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff, v. THE DISTRICT OF COLUMBIA, et al. Defendants.	)	Civ. A. No. 95-0943 TFH DECLARATION OF PERNELL J. WILLIAMS

Pursuant to the provisions of 28 U.S.C. § 1746 and D.D.C. R. 106(h), I, Pernell J. Williams, do hereby declare:

1. I am the President of District Healthcare and Janitorial Supply, Inc. ("DHJS")

2. DHJS distributes medical products and supplies such as duoderm tape, four-by-four's, ointment, gauze, catheters, tongue depressors, needles, syringes, bedpans and specimen cups. We also provide textiles, linens and janitorial supplies such as toilet paper, trash bags, cleanser and laundry bags.

3. DHJS has been providing such goods to the D.C. Village Nursing Home ("DCV"), pursuant to an agreement with the District of Columbia, since February 1993. Since that time, DCV has placed an order with us about once or twice a week every week for medical or cleaning supplies.

4. Currently, the District owes DHJS $59,152.17 in past due amounts related to DCV. There are about twenty-five invoices outstanding for goods we have already provided to DCV. The last payment we received arrived in February 1995, and yet it was only

for a total of $257.20. Nonetheless, DCV continues to order goods from us. We most recently supplied them with products in early May 1995. However, without payment of the past due amounts, we won't be able to supply them with goods in the future simply because we can't afford to do business indefinitely without getting paid. We hope to be able to resume a good business relationship with the District where they will pay us in a timely fashion for the goods they order for use at DCV.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 15TH day of June, 1995.

Pernell J. Williams

LONG TERM CARE/D. C. VILLAGE

VENDOR'S NAME	AMT OWED THRU 6-30-94	AMT OWED 10-1-5 1	TOTAL OWED	DESCRIPTION	METH OF SEL	PO/CONT NUMBER	VEND HAS PREV CONTR	IF YES CONTR EXP DATE	# OF OPTIONS REMAING	PDT OR WHICH PYMT IS OWED	DATE OF NEW CONTR AWD	EST AMT OF NEW CONTR	ARE SVCS PROV PER DOUR OR DOS/SPEC DEC
NATIONAL NURSES	0.00	138,267.00	138,267.00	NURSING	MAC	90701	YES	1/30/95	1	10/1-1/30/95			OBRA
SRT	31,000.00	117,708.00	154,708.00	NURSING	MAC	93677	YES	8/30/94	3			$85,000	OBRA
NATIONAL NURSES	0.00	165,004.00	165,004.00	NURSING	MAC	93841	YES	8/30/94	3			$101,370	OBRA
CUP	0.00	165,004.00	165,004.00	NURSING	MAC	93678	YES	8/30/94	3	10/1-4/30/95		$83,000	OBRA
ALLIED HEALTH	0.00	12,853.00	12,853.00	NURSING	MAC	93944	YES	8/30/94	3	10/1-4/30/95		$86,000	OBRA
TRI-AX	0.00	14,171.00	14,171.00	SOCIAL WORKER	MAC	95698	YES	3/14/95	0	10/1-3/14/95	5/1/95	$16,000	OBRA
IFD HOUSEKEEPING	0.00	0	0	HOUSEKEEPING	IFD	95700	STAFF				6/1/95	$400,000	OBRA
LAUNDRY	0.00	0	0	LAUNDRY	P.O.	110000		3/12-5/12/95			5/13/95	$200,000	OBRA
IRIS HUGHES	0.00	2,087.00	2,087.00	NURSE	MAC	90707	YES	2/10/95		10/1-1/30/95			OBRA
				NURSE	MAC	95699						$47,000	OBRA
OT	0.00	0	0	OT	MAC	95704						$35,000	8/1-9/30/95
LEA HARRISION	12,501.00	0	12,501.00	COUNSELING/DOV	MAC	494953	YES	8/30/94				0	
VNA	32,296.00	0	32,296.00	NURSING HOME THERAPY	EMER	94099	YES	8/30/94	0	1/1-8/30/95	4/28/95	$80,000	
WMC	8,708.00		8,708.00	PERSONAL CARE	MAC								
EASTMAN KODAK	10,876.88		10,876.88	LEASE									
DEER PARK	85.90		85.90	DRINKING WATER									
HEALTH CARE LAUNDRY		30,896.00	30,896.00	LAUNDRY SVS	MAC								
NUTECH LAUNDRY SVS	8,300.00	19,405.00	27,705.00	LAUNDRY SVS	MAC								
G.L. CORNELL	43.52		43.52	SUPPLIES									
WERRES CORP	299.88		299.88	XRAY									
FLAG WORLD		652.00	652.00	DISPLAY									
CENTRAL ARMATURE		4,440.00	4,440.00	HEATING	EMER								
RYDER TRUCK RENTAL		1,970.68	1,970.68	RENTALS	MAC								
ROBERT SHAW		4,775.51	4,775.51	MAINTENANCE									
CLASSEN GOVT SVC		1,000.00	1,000.00	TRANSPORTATION									
HILL-ROM		1,550.00	1,550.00	THERAPY BEDS	MAC								
NATIONAL PT CARE		40,725.00	40,725.00	BED/MATTRESS SVC	MAC								
MG INDUSTRIES		1,368.92	1,368.92	OXYGEN	MAC								
HILL-ROM		18,200.00	18,200.00	NURSING	MAC							$9,800	
OCE'		488.00	488.00	MAINTENANCE									
ROCHE BIOMEDICAL	8,300.00		8,300.00	LABORATORY									
AMBIANC		4,773.50	4,773.50	MAINTENANCE									
BIO, INC		85.00	85.00	MAINTENANCE									
CITY SUPPLY	75.50	76.50	151.00	MAINTENANCE									
DAYCON	1,553.57		1,553.57	MAINTENANCE									
DEHORN CORP		17,505.00	17,505.00	MAINTENANCE									
DH CARE	8,460.15		8,460.15	MAINTENANCE									
DOOR AUTO INC.		644.00	644.00	MAINTENANCE									
FWORD	652.00		652.00	MAINTENANCE									
NUTRITECH LAUNDRY TEX		12,871.84	12,871.84	MAINTENANCE									
PCS	740.12		740.12	MAINTENANCE									
WERRES	299.88		299.88	MAINTENANCE									
DISTRICT WAREHOUSE	8,468.15		8,468.15	NURSING	MAC								
ELECTRONIC DATA SYS		1,560.00	1,560.00	NURSING	MAC								
SANDOZ NUTRITION	167.55	3,120.00	3,287.55	NURSING	MAC								
SUPPORT SYSTEMS		3,025.00	3,025.00	NURSING	MAC								
ELECTRONIC DATA SYS		30,756.31	30,756.31	LEASE	MAC								
OSI DATA SYS	581.00	3,662.21	4,243.21	SUPPLIES	MAC								
TRANSCONTINENTAL PHARMACEUTICAL		43,863.40	43,863.40	DRUGS									
WARNER LAMBERT		2,224.36	2,224.36	DRUGS									
WELLS FARGO		1,325.20	1,325.20	ALARM									
MG INDUSTRIES	574.12		574.12	OXYGEN									
GRAND TOTAL	138,767.52	813,400.43	1,822,178.06									1,242,370.00	

Ted Attorney CPH/Financial Officer