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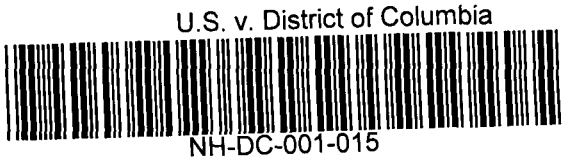

October 19, 1995

The Honorable Thomas F. Hogan
U. S. District Court for the District of Columbia
333 Constitution Avenue, NW, 4th Floor
Washington, DC 20001

Dear Judge Hogan:

Re: Civ. No. 95-948 TFH, D.C. Village Nursing Home

Enclosed is the first Status Report of the Court Monitor subsequent to the Preliminary Status Report submitted in September. On October 16, 1995, I submitted Section III. D. Services for Individuals with Mental Retardation.

I look forward to serving the Court and all concerned parties for the best interests of the long term care residents of the District of Columbia.

Sincerely,

Harriet A. Fields

Harriet A. Fields, Ed.D., R.N.
Court Monitor

encl.

cc. Mr. Richard Farano
Mr. David Deutsch
U.S. Department of Justice
Civil Rights Division
Washington, DC 20035

Mr. William Isaacson
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901 15 Street, NW, Suite 1100
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Assistant Corporation Counsel
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441 4th Street, NW, Suite 600
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STATUS REPORT

United States of America v. The District of Columbia, et al.

Civ. No. 95-948 TFH, Re: D.C. Village Nursing Home

Submitted by:

Court Monitor

Harriet A. Fields, Ed.D., R.N.

Date:
October 16, 1995

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STATUS REPORT

United States of America v. The District of Columbia, et al.

Civ. No. 95-948 TFH, Re: D.C. Village Nursing Home I.

Submitted by:

Harriet A. Fields, Ed.D., R.N.
Court Monitor

Date:
October 16, 1995

I. INTRODUCTION

Hundreds of hours of the Court Monitor and consultants time have been devoted to assessing D.C. Village (DCV) and developing and helping implement a tracking system so that compliance with the Court Order could be measured. The Court Monitor was appointed by the Court on August 1, 1995. The budget for monitoring activities was approved by the Court on September 6, 1995. The Court Monitor and the nursing home systems expert consultant first entered DCV on August 28, 1995. At that time it was apparent that there were no clear systems in place to determine compliance with the Court Order or other indicators of quality of care. Therefore, a systematic assessment was immediately implemented. This assessment consisted of meeting with all department heads and as many staff as possible and continuous touring of the units where DCV residents live. The Court Monitor met with all department heads as a group and then met with each department and staff separately. In order to report to the Court regularly and accurately on compliance with the Court Order, systems assessment of DCV is ongoing as well as touring the units on all three shifts, day, evening, and night.

The Court Monitor met with the following DCV departments: therapeutic activities,

nutrition/dietary, nursing, medicine, pharmacy, housekeeping, facility services, physical therapy, occupational therapy, speech therapy, social service, administration. The purpose of these meetings was to clarify the role of the court monitor, the content of the Court Order, the role of each individual department in complying with the Court Order, the integral relationship of the Court Order to the quality of care and the quality of life of the residents of DCV, identify and clarify the tracking system to be implemented in order to monitor facility compliance with the Court Order, and to assess the role and function of each department in resident care. Along with the Executive Director of DCV, the Court Monitor met with all nursing staff on all three shifts, day, evening, and night.

On numerous occasions at DCV, the Court Monitor has met with and toured the resident units with the Commissioner of Public Health for the District of Columbia, the Interim Administrator for Long Term Care for the District of Columbia as well as many other District of Columbia government officials. It is a tribute to the Court that the Monitor has been openly received and has been told by the District of Columbia officials as well as the Executive Director of DCV that the Court Monitor's presence has been a positive influence in helping to facilitate compliance with federal and District law and regulations and the Court Order. It is a privilege to serve the Court for the best interests of the residents of DCV.

This Status Report not only serves to inform the Court on a regular basis regarding compliance with the Court Order, but hopefully it will also serve as a guidepost for staff at DCV to facilitate improvement in care. No one area in the Court Order can be separated from the entire life of the institution and from how residents receive care, therefore, in order to give the Court a picture of the systems within DCV, and the relationship to the Court Order, a systems overview follows.

II. OVERVIEW OF SYSTEMS

A. Physical Restraints

Perhaps the most profound impact the presence of the Court has had at DCV to date is the reduction in the use of physical restraints. The use of physical restraints directly relates to the Court Order in the areas of pressure sores and incontinence by immobilizing residents and affording no opportunity for turning of position and toileting. The Nursing Home Reform Law of 1987 stipulated that nursing home residents have a right to be free from physical and chemical restraints. This has had a profound impact on long term care in this country, so much so that now the acute care settings are looking to nursing homes for guidance in "untying the elderly". When the Court Monitor and consultant first entered DCV at the end of August, there were 59 physical restraints in use at DCV, approximately 25 percent of the resident population, well above the national norm. At present, there are less than 10 physical restraints in use.

Hopefully the process implemented to reduce physical restraints will be utilized to improve other care areas, especially those identified in the Court Order. The process is the interdisciplinary care approach utilizing all systems or departments, for one goal of quality resident care. The newly hired physical therapists as well as the occupational therapists working with facility services, housekeeping, nursing, medicine, therapeutic activities along with the resident as a team achieved this result.

B. Dining

Another impact the presence of the Court has had at DCV is the engagement of the therapeutic activities department in the residents dining experience. Most of the resident dining areas on the units now have table clothes, flowers on the tables, and tables separated much as in a restaurant style. This can have the potential to add to residents improved nutrition by making dining more of a home event than an institutional routine.

C. Health Care Financing Administration (HCFA) Survey

As mentioned in my Preliminary Status Report to the Court, HCFA did return at the end of September to re-survey DCV. The surveyor's findings were that there were no level A deficiencies outstanding and, therefore, the intent to close and terminate federal funding were set aside. Two deficiencies were cited in care planning and pest control. At the exit conference, Dr. Harvey Sloane, Commissioner of Public Health for the District of Columbia acknowledged among others, the positive role of the Court Monitor and consultants in advising the facility on how to comply with federal regulations.

DCV must focus on an interdisciplinary systems approach to improve resident care as reflected in compliance with the Court Order. When the Court Monitor and nursing home systems expert consultant first entered DCV, the care plans and care planning process in place did not meet the minimum standards of care requirements reflected in the federal regulations. Part of the tracking system implemented to monitor compliance with the Court Order is a new care planning system which merely reflects the federal regulations.

Pest control continues to be a problem at DCV. According to outside, independent pest control experts who know DCV and the District of Columbia government, roaches, etc., can be eliminated or greatly reduced by utilizing a variety of products and proper application.

D. Physical Therapy, Occupational Therapy

A recent and very positive force at DCV is the new physical therapists and occupational therapists. They are contract staff but committed to DCV. The physical therapists are consummate professionals and can serve as a model to all other departments in their focus on interdisciplinary approaches to resident care.

The remaining overview reflects a systems breakdown at DCV and is directly related to the

ability of DCV to comply with the Court Order. It is my sincere hope that recommendations will be acted upon for the best interests of resident care.

E. Nursing

Intensive in-service sessions on the tracking systems for assessing compliance with the Court Order and care planning have been given to the licensed nursing staff by the Court Monitor's consultants. In addition, follow-up advice has been given on the units. These sessions merely reflect advice on how to comply with minimum standards of care as reflected in the federal regulations. I find an admirable and unanimous commitment to learning how to improve resident care. Nursing staff have come in on their days off and off shifts to attend. However, until two weeks ago with the hiring of a new Director of Nursing and an Associate Director of Nursing, there was no leadership from the nursing office.

I am very hopeful that this new administrative team will bring the direction that is needed. Both the new administrators are doctorally prepared. The Director of Nursing is a seasoned administrator from Howard University Hospital and the new Associate is a former Director of Nursing in a nursing home in the District and has a working knowledge of the minimum standards of care as reflected in the federal regulations. At the initiation of the new Director of Nursing (DoN), and commencing Thursday, October 12, 1995, weekly Thursday morning meetings will take place between the DoN and the Court Monitor for the shared purpose of improving resident care.

Policies and procedures must be updated, some are more than 20 years old. On-going and daily supervision from the nursing office of the unit clinical coordinators on all three shifts must commence immediately. The clinical coordinators on each of the eight care units are well intentioned, caring but floundering with no direction from nursing administration. Basic care practices are not part of daily and routine resident care which is a violation of

professional standards of practice. These absent routine care practices that directly relate to the Court Order are the following: daily range of motion; re-positioning at least every two hours; daily skin checks of the entire body to prevent the development, spread and worsening of decubitus ulcers; hydration; and restorative bowel and bladder programs for incontinent residents. The sections of this Status Report that address the appropriate sections of the Court Order will provide assessment data. I am hopeful that with the new nursing administration leadership, all future Status Reports to the Court will profile progress in these care areas.

F. Staff Development

Staff development at DCV is very weak. There is currently one staff development person at DCV. The section of this Status Report addressing nurse staffing will address recent new staff, one of whom has been assigned, as of the week of October 9, 1995, to the Staff Development department. This new contract staff apparently is knowledgeable of the minimum standards of care as reflected in the federal regulations. There has not been the on-going in-service and continuing education at the unit level that is necessary for the staff to become knowledgeable of and know how to maintain practice standards required for compliance with the Court Order. It is my hope that the new nursing administration will implement systems to immediately address this deficit.

G. Infection Control

Infection control is weak. There appears to be little to no follow-up when infections are discovered. Follow-up should consist of identification of a pattern if any, and appropriate and immediate in-service and training for staff involved. The Court Monitor consultants have shared with the staff a system that is clear and list the steps necessary to take for an accountable infection control program in a nursing facility. The HCFA surveyor team leader commended DCV for implementing this new infection control program. However, to date,

it is unclear which staff person, if any, at DCV is taking responsibility for appropriate follow through. This is very serious and directly relates to the Court Order in the areas of decubitus ulcers, incontinence, and nutrition of the residents. Frail nursing home residents are at great risk of infections and resultant hospitalizations as evidence in the '30 Day Compliance Report'.

H. Housekeeping

There are numerous housekeeping staff. I have found them to be open and courteous, yet not always present on the units. What is needed is for housekeeping to take ownership and pride in the operations of the units to which they are assigned. It has been suggested by surveyors and consultants to the Court Monitor that the housekeeping department make permanent assignments of staff to each of the units. Further, it has been advised that housekeeping staff assigned to the units work closely with the unit clinical coordinator regarding the maintenance of a clean and healthy living environment for the residents "home".

Housekeeping is an important and integral part of the interdisciplinary team. A sense of pride and ownership of the units and the hallways and public spaces at DCV would result in consistent proactive initiatives for the health and safety of all. This vital department directly relates to the Court Order and to infection control activities profiled above. Frail, compromised residents with open wounds, such as, decubitus ulcers, are prone to infections as listed in the '30 Day Compliance Report'. Hand-washing is essential for limiting the spread of infection from resident to resident and from staff to resident. Soap is the most important element in prevention of infections. And yet, on numerous occasions I have observed no soap in residents' rooms. This seems to be an especially chronic problem on Unit 5B. For the entire weekend of September 29, 1995, the majority of rooms on Unit 5B were without soap, yet the Facility Supplies Chief told me there were "152 cartons of soap" on hand. It is alarming to me that this situation existed, that staff did not report it, which

means proper Hand-washing technique was not being done, and that the situation was not rectified immediately.

I. Therapeutic Activities

There are eighteen therapeutic activities staff at DCV. For the first week of court monitoring activities, staff were nowhere present - absent from public rooms, the units, and resident rooms. After meeting with the therapeutic activities staff and advising them on how to comply with federal regulations, the dining areas on many of the units were transformed into the positive environments described in the Dining section above. The staff has been very open since this first meeting. In fact, the Director of the Therapeutic Activities Department told the Court Monitor that "at first we thought you were the enemy, now we know you are here to help us." Another staff member, who has taken great pride and effort in creating a home like environment in the dining area on his assigned Unit 4A, has specifically expressed openness to any suggestions for improving care.

The D.C. Village Residents Choir performed during Resident Rights Week on October 4, 1995. Residents who are normally not engaged in their environment, nor particularly present to time and place, sang solos. This event was organized by the therapeutic activities staff and the residents.

Therapeutic activity is crucial to the life of frail, institutionalized people. Activities department staff must continually be present in the life of all the residents of DCV, including working with nursing department staff and teaching nurse aides how to meaningfully engaged all the residents. The challenge is to provide purposeful activities to total care residents from shift to shift, instead of, for example, putting residents to bed directly after dinner, as I so often observe at DCV. Total care residents at DCV are a neglected group. This will be described more fully under the sections addressing the Court Order and

decubitus ulcer, incontinence, and nutrition care.

J. Medicine

The Medical Director is a positive presence at DCV and a role model of professional behavior. The Medical Director has been in the position for one year.

There are four full-time medical doctors, including the psychiatrist, and one part-time medical doctor on staff at DCV. In addition, a fee for service medical doctor has recently been brought in to provide medical coverage for the unit previously covered by Dr. Barnes, who died suddenly in September. DCV likely has more medical doctors on staff than most nursing home in this country.

I believe the medical doctors at DCV are committed and care. However, they are currently organized in such a way as to prevent them from functioning as team members within the Department of Medicine. The DCV medical staffs belong to the Doctors Council union.

On September 7, 1995, the Doctors Council staff representative met with Dr. Harvey Sloane, Commissioner of Public Health for the District of Columbia. Dr. Sloane asked the Court Monitor to attend. Also attending the meeting were Ms. Gladys Fountain, Interim Administrator for Long Term Care for the District of Columbia, the Executive Director of DCV, the medical doctors on staff at DCV, the Medical Director, and a labor representative from the Department of Human Services of the District of Columbia .

The Doctors Council staff representative described the medical staff as "labor" and the Medical Director as "management". Dr. Sloane, who is also a medical doctor, stated that in all his experience he has never known attending medical staff and psychiatrists to be unionized and defining themselves as "labor". Apparently, in the District of Columbia, only medical doctors who work in public facilities are unionized. Historically in other east coast

cities doctors unions were formed and needed for interns and residents to protect their working conditions while still formally learning within institutions, not for attending physicians and psychiatrists.

In the somewhat small meeting on September 7, the Doctors Council staff representative spoke for the DCV medical staff (all of whom were present) to the medical director and to the rest of the attendees. Not once did any of the medical staff address the Medical Director directly. There appeared to be near anger and hostility toward the Medical Director from the union representative, who expressed negative input she received from medical staff with no effort to validate the input.

The staff representative of the Doctors Union is not knowledgeable of the Nursing Home Reform Law and, thus, of its minimum standards of care for nursing facility residents identified in the federal regulations. The Doctors Union staff representative is not a health professional and, thus, does not have the professional focus on the resident centered care required in long term care. The focus seems to be on maintaining the artificial dichotomy between five medical doctors and one medical director and the administration.

A non-collegial and unprofessional relationship currently exists at DCV between the medical staff and the Medical Director. The medical staff alliance with the Doctors Council instead of the Medical Director creates an inherent tension within the medical department at DCV where there should be collaboration for the good of resident care. The current structure has fueled a malaise and a lack of motivation within the medical staff to continually upgrade their education, which is manifested in the low level of knowledge of the federal regulations that are the minimum standards of care for nursing facility residents. This directly relates to the Court Order in the areas of care of decubitus ulcers, nutrition, and medications which will be addressed in this Status Report under the appropriate sections of the Court Order.

The medical staff virtually ignore all recommendations by the Medical Director for attendance at continuing education programs (offered locally) that directly relate to resident care issues at DCV and care areas identified in the Court Order. For example, on October 11, 1995, a nationally recognized expert on pressure ulcers (a medical doctor) spoke locally on the latest treatment modalities for the care of decubitus ulcers. The medical staff, treatment nurses, and the Court Monitor were informed of the meeting and invited. The two day-treatment nurses and the Court Monitor attended, but no medical staff from DCV were present. At the September 7, meeting the psychiatrist commented that "if DCV is going to close why should we upgrade our continuing education".

A number of the medical staff are dedicated and concerned professionals, but their alliance with the Doctors Council creates the pervasive attitude of mistrust and defensiveness to constructive input and feedback from the Medical Director and is obstructing the ability of the medical department to participate fully as an interdisciplinary team in the care of residents at DCV. These attitudes and practices then permeate to the rest of the institution.

The Doctors Council staff representative is the only presence associated with DCV whose primary goal is not focused on improving resident care. This is a reflection on the nature of the position and not the person. Much of the Medical Director's time is spent responding to communications from the Doctors Council. The relationship is destructive to the process of improved resident care, and impedes the ability of DCV to comply with the Court Order.

Request to the Court

I, therefore, respectfully request that the Court advise the medical staff at DCV to suspend their relationship with the Doctors Council staff representative for as long as DCV remains open. And, further, to communicate and relate directly to the Medical Director in all areas related to resident care and to follow the Medical Director's direction, especially in her

recommendations for continuing education, which are always based on the best interests of the residents of DCV.

III. STATUS OF COMPLIANCE WITH COURT ORDER

Future monthly status reports will address each of the areas in the Court Order. In order to commence monitoring and responsibly assess data, the above systems assessment was required. Updates on systems functions will be given in future status reports when applicable to compliance with the specific areas of the Court Order.

A. Medical and Nursing Care

1. Care of Decubitus Ulcers

a. Defendants shall immediately cease the use of Elase and Intrasite gel inappropriately for treatment of decubitus ulcers.

b. Defendants shall immediately ensure that all DCV residents receive appropriate and adequate preventive medical and nursing care and timely treatment for decubitus ulcers and/or other skin breakdown sufficient to maintain their good health. To this end, Defendants shall assess all residents for risk of skin breakdown within two days from the date of entry of this Stipulated Order, and shall develop and implement within twenty days thereafter, for each resident identified as at risk, a treatment plan fully adequate to prevent skin breakdown and/or to treat existing skin breakdown.

Status Re: Court Order Partial Compliance

Elase is not being used for the treatment of decubitus ulcers. Intrasite gel is prescribed and is used. The treatment nurses have been interviewed and observed and they are appropriately applying intrasite gel. Further monitoring is required to determine the current level and source of knowledge of the medical staff prescribing intrasite gel.

There are four treatment nurses, two on the day shift and two on the evening. On each shift one nurse covers Units 5A, 5B, 4A, 4B, and the second treatment nurse covers Units 3A, 3B, 2A, 2B. The treatment nurses treat identified decubitus ulcers. One treatment nurse is a DCV employee and has known the residents for many years. The three other treatment nurses are contract nurses but are permanently assigned. The treatment nurses have been observed to use appropriate sterile technique. At present there is still lack of coverage for the care of decubitus ulcers on the weekends.

Concerns

I have a number of serious concerns regarding the care of residents with decubitus ulcers, which require further and on-going monitoring. I am hopeful the new leadership in nursing administration will tend to these concerns immediately. They are the following:

(1) There are no systematic and daily assessments to check for skin breakdown and to give early warning signs of the development of decubitus ulcers. On several occasions in the past month, decubiti were first observed at Level III. This means that the wound is deep and possibly draining. It is alarming that these wounds were not discovered earlier at Level II which means broken skin, at Level I superficial wound, or preventive measures implemented. It is not clear how decubiti are discovered and get on the treatment nurses list.

Daily nursing skin check rounds would discover possible pressure sores. It is hopeful that with the new nursing administration, unit coordinators will receive proper supervision, and in turn properly supervise the nurse aides on their units. On-going continuing education is needed for all staff.

(2) The treatment nurses know the residents decubitus ulcers but not the total care of the residents. This can lead to communications breakdown and delay in the timely sharing of information necessary for an up-to-date interdisciplinary care plan and continuity of care.

(3) When the treatment nurses are not present on the units, including weekends, decubiti care and skin care are not part of nursing practice. This violates general standards of nursing practice.

On Sunday evening, September 24, 1995, the Court Monitor was touring the units with a nursing home systems expert consultant. From the hallway on unit 3A came a distinct odor - the odor of decubiti and urine. Upon entering the resident room which was the source of the odor, Mr. J.B. was found lying on his Level IV stage decubitus ulcer and soaked with urine. The nurse on duty did not seem to notice. I have no doubt that the nurse on duty, who has been on the unit for years, has affection for Mr. J.B., who had also been on the unit for years. In 1990 he was walking, on September 24, he was totally contracted in his bed, so much so that decubiti were developing on his knuckles which were contracted up under his chin. Mr. J.B. was scheduled on Tuesday of that week to enter a hospital in the District for a surgical procedure for the decubiti on his hip. The Medical Director was notified on Monday, September 25, as well as the physical therapist who assessed Mr. B. and noted that there was no range of motion or rehabilitation plan of care in his chart. The Medical Director had Mr. B. transferred that morning to the subacute unit of the hospital to receive the care he was not receiving at DCV. On Monday afternoon, the HCFA surveyors arrived.

(4) Decubitus ulcer care and prevention especially for frail, institutionalized people require an interdisciplinary approach including all departments. Currently, this is lacking at DCV.

I believe, if medicine more fully participates in the interdisciplinary team and upgrades it continuing education; nursing administration provides leadership to nursing which will really provide direction for the entire facility; nutrition and dietary become proactive; housekeeping

keeps and maintains clean living spaces; pharmacy becomes proactive; while the physical therapy and occupational therapy departments are already fully participating as interdisciplinary team members, residents rights will be protected. However, it will take nothing less than the full commitment of all departments.

2. **Care of Incontinent Residents**

Defendants shall immediately ensure that all incontinent DCV residents receive appropriate, adequate and timely nursing care in accordance with generally accepted nursing standards. For residents who have been identified as subject to becoming incontinent, nursing staff shall make rounds to check on their individual condition at least once every two hours. Nursing staff shall take all appropriate steps to care for and clean those residents who need nursing attention due to their incontinence. Nursing staff shall take special care to clean and treat ulcerated areas that may have become soiled due to incontinence.

Status Re: Court Order Partial Compliance

The best way to assess compliance in this area is to periodically assess the residents. At times residents are clean and dry and, therefore, there is partial compliance. However, on other occasions, I have found residents to be sitting in urine for quite some time, that is, time enough for an odor to develop.

On-going continuing education is necessary for all staff including certified nurse aides and the treatment nurses.

In all due respect, the position charts which are placed at the end of resident beds and which make the '30 Day Compliance Report' so voluminous, are meaningless. On numerous occasions I have observed residents in urine for several hours on a shift and yet the position chart has been neatly checked and initialed. On the evening of October 4, 1995, I observed a resident, Ms. M.H. at 7pm, 8pm, and at 9:30pm-at that time with the evening nurse

supervisors. At all those times, Ms. B. was in the same position and she and her bed clothing were wet. At 7pm, the position chart intended to document turning every two hours had not been completed since 3pm. At 8pm the chart had been filled in, and at 9:30pm Ms. B's bed clothing was soiled with feces. Check-off charts often lead to slovenly practices and not necessarily with deliberate intent.

Immediate Remedies Needed

(1) Leadership from the nursing office by developing and providing a role description for unit coordinators outlining basic care practices, supervisory requirements and techniques for nursing assistants, and daily reporting procedures to nursing administration. In this way, the unit coordinators take ownership and responsibility for the care status of the residents on their units, and nursing administration becomes accountable for the care being given on the units. Nursing administration must be a constant presence on the units.

(2) Interdisciplinary team approach to resident care as described above in the decubitus ulcers section under Concerns (4). Housekeeping and the ever presence of soap to prevent spreading infections from one incontinent resident to another are especially vital.

(3) There are procedures for a restorative bowel and bladder training program now on each unit. With the assistance of nursing administration and staff development, this should be systematically implemented.

I have come to realize a pattern at DCV which saddens me. Residents who cannot advocate for themselves are victims of passive neglect. These are residents who for the most part cannot communicate; have restricted mobility; need nearly total care; have decubitus ulcers; are incontinent; have severe contracture; and are dehydrated. Many of these conditions are often preventable, or are susceptible to improvement. A definition of passive neglect is the

"deprivation of goods or services which are necessary to maintain physical or mental health, without a conscious attempt to inflict physical or emotional distress (for example, abandonment or denial of services because of inadequate knowledge.)" Persistent neglectful practices result in abuse.

I stand by my statement at the end of the Preliminary Status Report, submitted in September. That is, I find the staff at DCV to be caring and motivated, but there is an immediate need for on-going continuing education. Neglect and abuse occur when staff are poorly trained and poorly supervised. Frail, institutionalized residents present care challenges which require sensitivity and daily support to the staff to prevent neglect and abuse of the residents.

Recommendations in this Report do not cost money, they do cost in a priceless commodity - time, commitment, and caring.

3. Adequate and Appropriate Nursing Staff

a. Defendants shall ensure that continuity of nursing staff is maintained to the maximum extent feasible during all shifts, seven days a week, on all DCV living units.

b. By no later than January 1, 1996, Defendants shall ensure that there is a sufficient permanent nursing staff at DCV to ensure that DCV does not routinely rely on contract nurses. Nothing herein prevents the use of contract nurses in emergency situations or to ensure that adequate nursing staff is available to care for DCV residents.

Status Re: Court Order Partial Compliance

With the announced closure of DCV in August 1995, this section will probably never achieve full compliance. Many staff are resigning or opting for early retirement offers, and it is difficult to attract new staff. However, there are efforts to stabilize the staffing.

In the first week in October, seven contract nurses were hired under a special arrangement with one of the vendors, National Nurses, Inc. These contract nurses will be permanently assigned to DCV, forty hours per week and apparently have many years experience in long term care. Three will be placed as unit coordinators on three of the units. Two are planned to be placed in the Staff Development Department. One will be placed in quality assurance,

In terms of numbers of licensed nursing staff and certified nurse aides (CNAs), DCV is not understaffed. In fact, it likely has one of the lowest staff to resident ratios in the country. The problem is the utilization of staff and continuity of care with the use of contract nurses. For example, on the night shift of October 5, 1995, at 12:30AM, I observed the licensed Nurse on duty (a contract nurse) and four nurses aides sitting in the day room with the television on. One nurse aide was with a resident who has a nurse aide solely assigned to him. One nurse aide did not have her uniform on, I asked the CNA where it was and she pointed to a chair with her bags in it.

The new Director of Nursing (DoN) in the first of weekly meetings with the Court Monitor on October 12, indicated that one of her priorities is to "get a handle on contract nurses," which, I must admit, is difficult to do. I asked a nursing administrator - who does the nurse staffing and the response was "anyone who can get their hands on the book". At any one time I have observed three to four nurses in the nursing office who claimed to be doing staffing for the day. These particular nurses are former DCV nursing administrators who took early retirement and are now employees of the contract nurse staffing vendors which supply the contract nurses to DCV. There are approximately six vendors. In addition, there is also a DCV non nurse employee who solely does staffing.

A daily staffing form has been implemented to track nurse staffing for court monitoring. This form includes daily data for each unit listing the census, numbers of licensed staff,

numbers of contract agency nurse staff, and numbers of CNAs. Future status reports will provide an analysis of this data.

4. **Medication Errors**

a. Defendants shall ensure, within fifteen days from the date of entry of this Stipulated Order, that all nursing staff on duty are trained in proper medication administration practices, and are adequately in serviced on and/or are sufficiently aware of the individual needs of the residents to whom they are administering medications.

b. Defendants shall ensure, within fifteen days from the date of entry of this Stipulated Order, that all medication errors are recorded, that adequate procedures are established to track all medication errors, that any causes for medication errors are identified and remedied, and that any other needed corrective action is taken in a timely manner to minimize medication error risk to the DCV residents.

Status Re: Court Order Further monitoring required

The next Status Report to the Court will provide in-depth data in this area. Random medication pass reviews conducted on September 27, 1995, identified two medication errors by a contract nurse - eye drops prescribed for the left eye and administered in the right eye. Random medication pass review conducted on October 10, 1995, found six medication pass errors.

A profile of the Pharmacy Department and the medications prescribed for DCV residents will be given in an upcoming status report. There are five pharmacists on staff at DCV. The national norm for the number of prescribed medications a nursing home resident takes is five to six. The average number of prescribed medications DCV residents are taking is eight to thirteen.

In a meeting with the Department of Medicine on September 12, 1995, the psychiatrist indicated a lack of clarity regarding the appropriate use of prescribed psychotropic

medications as indicated in the federal regulations.

Assessing medication errors cannot be separated from a medication review to identify possible unnecessary drug use.

B. Measures Needed to Remedy Shortages

1. Food and Drink

Defendants shall immediately ensure that sufficient supplies of nutritious and appropriate food and drink are consistently maintained at DCV and that each resident daily receives adequate, well-balanced, nutritious and appropriate food and drink according to their individual nutritional needs.

Status Re: Court Order Further monitoring required

The next Status Report to the Court will provide a profile of the Nutrition/Dietary Department. The Court Monitor has met with the Chair and a faculty member of the Department of Nutritional Services at Howard University. This meeting took place at DCV. I expect to have by the next report, and analysis of residents nutritional needs and a daily nutritional intake profile.

Monthly weight logs have been instituted on each unit. This should be a clear tool for quality assurance activities and monitoring nutritional status. The Dietary Department must assume a critical role in taking responsibility for calculating monthly weight loss or gain and initiating proper assessment and care planning if indicated. The interdisciplinary team plays a vital role in appropriate nutrition. Meal observation is also important in ensuring daily nutrition.

Dehydration is a reason given for several hospital admissions. When asked her opinion about dehydration as a reason for hospital admission a nursing administrator said, "it is embarrassing." Proper hydration for nursing home residents, including those with gastric

tubes, requires vigilance and routine offering of liquids and flushing of gastric tubes with water.

2. **Medications, Medical Supplies and Equipment**

a. Defendants shall ensure that adequate and appropriate supplies of necessary medications, that meet the individual needs of the DCV residents, are consistently maintained at DCV no later than two days from the date of entry of this Stipulated Order.

Further monitoring required See A. 4. above

b. Defendants shall ensure that an adequate and appropriate quantity of medical supplies and equipment, that meet the individual needs of the DCV residents, are available for use, as needed, no later than five days from the date of entry of this Stipulated Order.

Data will be presented in next Status Report.

c. Defendants shall maintain the plumbing and heating system at DCV to ensure that adequate amounts of hot water, at safe temperatures, are available for use by residents within two days from the date of entry of this Stipulated Order. Defendants shall also ensure that there is sufficient hot water to properly sanitize and clean eating utensils, plates and meal-related items.

Status Re: Court Order Compliance

The Facility Services Department conducts regular random checks and charts findings. On two occasions temperatures in resident bathrooms and common bath areas were validated by the Court Monitor and consultant to be within the mandated temperatures required in D.C. regulations (100 to 110 degrees f.) The actual readings observed were 104 degrees and 105 degrees.

3. **Personal Care Items**

Data will be presented in next Status Report

C. Payment of Vendors

Request to the Court

I respectfully request that the Court advise the Corporation Counsel on behalf of the District of Columbia to supply the Court Monitor with contact names and phone numbers for the vendors listed. I am unable to validate the data in the '30 Day Compliance Report' and to monitor compliance with this area of the Court Order without this information.

For weeks I have asked for this information from administration within DCV and from various District of Columbia government officials. I have witnessed bureaucratic groupthink - a pattern of thinking which stifles the potentially competent into inertia.

Data is presented for the following vendors whose names and numbers were supplied to me by the Department of Justice.

Status Re: Court Order As of October 3, 1995 Out of Compliance

NUTECH Laundry is owed $3535.90 from February 1995. NUTECH no longer has a contract with DCV.

Health Care Laundry Services is owed $24,962.93 for services from July 14-28, 1995. Health Care Laundry is not planning to suspend service.

Central Armature Works is paid in full.

Hill Rom supplier of specialty beds has referred back payment of approximately $20,000 to a collection agency, and with no response forwarded the case to an attorney.

As of October 12, 1995:

National Patient Care Systems supplier of specialty beds has $8110 outstanding from March 1995. Outstanding: for June - $9030; for July - $9300; for August 1995 - $9400. National Patient Care Systems does not intend to suspend services.

D. Services for Individuals with Mental Retardation

1. Defendants shall place all DCV residents with mental retardation in appropriate community-based residential and day programs which fully meet their individual needs as identified by appropriate interdisciplinary assessments, no later than October 31, 1995. Defendants shall ensure that the placements are adequate to meet each individual's needs.

Status Re: Court Order Non-Compliance

Assessment Data

Data have been obtained primarily from the Georgetown University Child Development Center staff at DCV and the Social Services staff person from DCV assigned to the majority of the residents with mental retardation (M.R.).

Since the filing of the Court Order on July 6, 1995, two residents have been transferred out of DCV, they are the two people listed in the '30 Day Compliance Report'. As far as can be determined, there has been no assessment of the adequacy of current care to meet their needs. Four residents were outplaced on June 30, 1995. One resident, Mr. D.H., deceased, July 13, 1995. Currently, there are 15 individuals identified with mental retardation at DCV.

According to the Social Service staff person at DCV, the interdisciplinary assessment team involved with planning the outplacements of the M.R. residents consist of the following:

DCV Social Service social worker; case manager from the Bureau of Case Management, Mental Retardation and Developmental Disability Administration (MRDDA), Commission on Social Services, Department of Human Services, District of Columbia; Georgetown University Child Development Center (GUCDC) staff consisting of psychologist, nutritionist, speech therapist, therapeutic activities; the clinical nurse coordinator for the DCV Unit; M.R. resident's attorney if any; and family member(s) if any.

The case manager from the District of Columbia identifies the placement sites usually after the interdisciplinary team meeting. The placement sites are all under the jurisdiction of MRDDA.

Of the 15 residents identified with mental retardation at DCV, four are identified to be outplaced to the Kennedy Institute. According to the Georgetown University Child Development Center (GUCDC) staff and the Social Service staff from DCV, no date has been given for outplacement because of "contract/budget considerations" a definition of which is not known by either source.

Five residents are scheduled to be outplaced to CARECO. This outplacement is of great concern to the DCV Social Services Department social worker handling the majority of the mental retardation resident outplacements. The four residents identified to be outplaced to CARECO are wheelchair bound. These residents would be placed on the second and third floors of the residence. The concern is fire safety hazards. Currently, CARECO is remodeling and no date is given for outplacement. Further monitoring is needed to determine what are the remodeling plans in relation to residents needs.

Four M.R. residents are scheduled to be outplaced to Wholistic Habilitative Services. Attorneys for two of the residents oppose this outplacement because they believe the medical

needs of these residents require nursing home care beyond the capabilities of the identified Intermediate Care Facility/Mental Retardation (ICF/MR).

Another resident is scheduled to be outplaced to METRO, Inc. Again this is being delayed because of the residents "medical needs".

One resident scheduled to be outplaced to D.C. Family Services is currently hospitalized.

The Hearing Commission for a Pratt decree M.R. resident is concerned that his physical health problems may worsen upon discharge from the DCV nursing home care setting, where under the guidance of GUCDC staff his health problems improved. The concern is that in outplacement into the lower level care setting, he may revert to the worse health problems with which he came to DCV.

The social worker at DCV is concerned about the ability of some of the identified placements to care for the physical needs of the residents, such as, the two residents with tracheotomies. In addition the majority of the M.R. residents have gastrostomy tubes for feeding. Some of the residents scheduled to be outplaced have compromising medical conditions which leave their transfer in question at present. There is concern that their medical conditions may be beyond the capabilities of the staff at the MRDDA identified sites.

Georgetown University Child Development Center staff provides training for the staff of the identified outplacement sites. This training takes place at DCV. The District of Columbia assesses the outplacement site physical plant. The social worker from DCV usually visits the identified outplacement site before the resident is discharged.

According to the DCV social worker, at this point in time, it is not known if there are community based day programs available and appropriate for the needs of the M.R.

residents. Further assessment and monitoring are needed to determine this.

Concerns

I have a number of concerns regarding the outplacement process for residents with mental retardation which require further monitoring, they are the following:

(a) Outplacement planning process and match of outplacement sites with individual needs Given the assessment data obtained above, I am very concerned about the decision making process and rationale for the identification and match of the outplacement sites with the individual needs of the M.R. residents. The Court Monitor will gather information from the Bureau of Case Management, MRDDA, DHS, District of Columbia.

(b) On-going supervision of placement site staff From my discussions with staff and observations of the M.R. residents at DCV, I am particularly concerned about the adequacy, on-going assessment and evaluation, and appropriate and effective supervision of the staff of the MRDDA identified outplacement facilities. The M.R. residents at DCV have complex physical, emotional, and behavioral needs. Staff training off site is one thing, but the implementation and 'how to' of the training in the actual care-giving setting is another. The current planning process for the outplacement of the M.R. residents identifies the case manager from the Bureau of Case Management, MRDDA to do this follow-up.

© On-going evaluation of outplacement site in meeting individual needs I am particularly concerned about the on-going assessments of the individual resident and the adequacy of the outplacement sites to continue to meet care needs. Seven of the residents with mental retardation at DCV do not come under the Pratt decree. The case manager from the Bureau of Case Management, MRDDA is identified as the monitor for this activity.

My concerns listed above are validated by the semi-annual report to the U.S. District Court for the District of Columbia, Evans v. Barry, et al., and the Pratt decrees. In the report submitted by the Court Monitor in this matter, the District of Columbia ARC, dated September 30, 1995, data is given on the limited capacity of the Bureau of Case Management, MRDDA to assess, evaluate, supervise, and monitor the adequacy of care for residents with mental retardation.

Further monitoring necessitates and will include contact with the outplacement vendors and MRDDA.

Concerns Re: Transfer, Outplacement, and Discharge of All DCV Residents

My concerns regarding the adequacy of outplacement of DCV M.R. residents also apply to the DCV resident population as a whole. The GUCDC staff have described the discharge planning process for the M.R. residents as "bumpy" without a "smooth flow of information among" all parties involved. In fact, GUCDC staff mentioned that there have been instances when they have gone to the unit and found that the M.R. resident has been discharged without their knowledge, yet the GUCDC are the primary caregivers for the residents with mental retardation. Some of my concerns are outlined in my September 21, 1995, letter to the Court. The patterns I have been able to assess to date regarding the outplacement process for residents with mental retardation as outlined above, can be generalized to the planning process for the remainder of the residents at DCV. Recent responses the Residents Council has received from the Mayor add to my concern that the discharge planning process is based on fiscal considerations and the meeting of arbitrary time deadlines not residents' health and welfare.

As Court Monitor, I am a bit surprised and disappointed in the response of the Office of Corporation Counsel on behalf of the District of Columbia to my September 21, letter to the

Court outlining some of my concerns with transfer and outplacement of residents. On numerous instances the Court Monitor has received feedback from the Executive Director of DCV, from department heads, from staff, from the interim administrator for Long Term Care in Department of Human Services of the District of Columbia, and from the Commissioner of Public Health for the District of Columbia that the presence of the Court Monitor at DCV has been a "positive" influence in advising DCV how to comply with minimum standards of care as outlined in the federal and district law and regulations and the Court Order. My concerns regarding the transfer and discharge of DCV residents are shared in the same spirit of constructive communication and advice for the best interests of the residents of DCV and the long term care residents of the District of Columbia.

In addition to my concerns relating to transfer trauma which is well documented in the literature, my continued concern regarding the transfer and discharge of the residents of DCV relates to the following data:

(1) Social services department staff at DCV has described the outplacement process as "chaotic". The social worker (s.w.) estimates that it will take "at least a year" to outplace all residents and that many residents no one may accept, especially the residents with mental illness. In addition, the s.w. mentioned that the transfer search will probably have to go beyond the 50 mile radius planned. An interesting point shared by the s.w. is that historically DCV has accepted hard to place residents, that is, "a dumping ground for residents no one else wanted." Therefore, closing of DCV may lead to increased homelessness of the helpless in the District of Columbia.

(2) Many nursing homes do not admit medicaid residents with the severe decubitus ulcers unfortunately many of the DCV residents still have.

(3) As gleaned from the `Outplacement Meetings for Residents with Mental Illness' to date there are not adequate numbers of appropriate placements for these residents. In the planning meetings, DCV position is to transfer these residents to a nursing home and then within a year or so, when and if adequate placements may develop, transfer them to the appropriate setting. This disruption in environment is detrimental to any older person, but especially to those with mental illness whose care needs for a sense of autonomy, security, and control of the environment are critical.

(4) In a meeting on Monday, September 18, 1995, at DCV with Dr. Harvey Sloane, Commissioner Public Health for the District of Columbia, Ms. Gladys Fountain, Interim Administrator for Long Term Care for the District of Columbia and other District of Columbia government officials, as well as DCV administration, Dr. Sloane suggested I visit a local hospital which is an identified outplacement site. Dr. Sloane suggested I visit this site to oversee the staff knowledge of and competence in the care of decubitus ulcers. Many of the decubitus ulcers at DCV either originate at this designated outplacement site or further develop and multiply there while DCV residents are admitted. In fact, one resident returned to DCV on Thursday, October 13, 1995, from this outplacement site with four new decubiti.

(5) The president of the Residents' Council at DCV, Mr. C.F., attended an interfaith ministers meeting last week in which the Mayor was also present. Mr. C.F. introduced himself and told the mayor of his concerns regarding closure of DCV, upon hearing this the Mayor told Mr. C.F. that he did not have time to speak with him and walked away. The mayor did meet with a few residents of DCV on October 11, 1995, at City Hall. The Mayor spent a few minutes with the residents and said that DCV costs "$30,000,000 a year to run" and it is closing.

There is enormous financial waste in the operation of DCV. In a future status report to the Court, I will present a profile of how DCV can be competently operated and at a savings of significant millions of dollars per year. This profile will reflect the input of health professionals in the District of Columbia who have a commitment to the District, a concern for the long term care residents of the District of Columbia, and expertise in long term care practice, education, research, and in the operations of cost effective and quality care giving facilities.

2. Defendants shall ensure uninterrupted clinical services, habilitation, and other services to all DCV residents with mental retardation. Such services shall remain in effect until all DCV residents with mental retardation are outplaced into appropriate community settings in accordance with the above provision.

Status Re: Court Order — Partial Compliance
Further monitoring required

Assessment Data

The Georgetown University Child Development Center staff provide habilitation services to the residents with mental retardation. GUCDC hours are primarily 9AM to 5PM, with some overlap into the evening hours, Monday through Friday. Currently the contract for the GUCDC is due to expire on December 31, 1995.

Further monitoring is required to more fully assess the staff on duty on the evening, night, and weekend shifts. Observations of M.R. residents and staff and interviews with DCV staff indicate that on hours, shifts, and days that GUCDC staff are not present on the unit, habilitation and clinical services are not performed. During the evening, night, and weekend shifts when contract nurses are on duty this is even more problematic because of the lack of knowledge of the residents, which leads to lack of continuity of care.

3. No individuals with mental retardation shall be admitted to DCV in the future except where this Court specifically approves the proposed admission.

Status Re: Court Order Full Compliance