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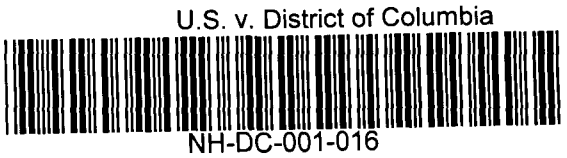

November 30, 1995

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

Re: Court Order The United States of America v. The District of Columbia, et al., Civ. No. 95-948, TFH, D.C. Village Nursing Home (DCV);
November 7, Order Modifying Stipulated Order of July 6, 1995

Dear Judge Hogan:

Enclosed is the Court Monitor's second Status Report to the Court. It follows the October Status Report, and submission of the Preliminary Status Report in September.

This is the first Status Report since the November 7 expansion of the monitor's duties to oversee the outplacement process. Since there was an acute and critical need to assess and advise the facility, the majority of the Court Monitor's time and the majority of this report is devoted to the discharge process.

It is a privilege to serve the Court and work with 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 J. Farano
✓ Mr. David Deutsch
Civil Rights Division
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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:

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

November 30, 1995

STATUS REPORT

United States of America v. The District of Columbia, et al.
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Submitted by:
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Court Monitor
Date:
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federal and District law and regulations, and the Court Orders, including Stipulated Order of July 6, 1995. The Court Order of July 6, pertains to the establishment and maintenance of residents rights and the status of compliance will be directly reflected in the quality of the outplacement plans and the transfer of residents. It will also be a measure of the humanity of the District of Columbia. The transfer of the residents literally can be a life or death determining factor for the residents of DCV. The outplacement of the residents, the planning surrounding it and the transfer of residents to new homes is the most important activity to take place now until closing.

Nothing less than a full commitment on the part of every single employee at DCV is vital to making the outplacement process a humane one for the residents. I am confident DCV can rise to the occasion.

This Status Report is divided into three main sections. The first addresses the outplacement process and the November 7, 1995 Order Modifying Stipulated Order of July 6, 1995. The second section gives an update of systems as a follow-up to the Overview of Systems in the October Status Report. The third section addresses the Stipulated Court Order of July 6, 1995.

I. NOVEMBER 7, 1995, ORDER MODIFYING STIPULATED ORDER OF JULY 6, 1995

B. The Monitor shall have authority to review and advise on Defendants' compliance with District and federal law.

C. Review compliance with provisions of discharge plan to ensure the safe and orderly removal of the residents and to protect their health, safety, welfare, and rights, including the residents' rights to an opportunity for participation in their discharge process.

This section of the first Status Report after the expansion of the Court Monitor's duties will address the November 7, 1995, Order Modifying Stipulated Order of July 6, 1995 in the following areas:

1. Assessment of the outplacement process to date, before and since the November 7 modification of duties;

2. Recommendations based on assessment data;

3. Action Steps put in place by DCV to address the concerns regarding the outplacement process;

4. A profile of one unit and a brief case study of one resident which can be generalized to all the residents at DCV, profiling life at DCV, how it impacts some residents now, and how with the implementation of the recommendations of a humane outplacement process, life could improve for the residents and also provide a discharge outplacement plan that would give direction to the receiving facilities at the residents new home;

5. Outplacement of residents with mental illness, assessment, and recommendations and action steps to be implemented by Dr. Mary Alice Crockett, the Medical Director, who is charged by Mr. Silas Butler to oversee the outplacement of the residents with mental illness. This section ends with a **Request to the Court**

The outplacement of the residents with mental retardation is addressed in this Report under the July 6, 1995 Stipulated Court Order Section D. Residents with Mental Retardation;

1. ASSESSMENT

The Court Monitor first began attending the weekly outplacement meetings on October 25, 1995. These meeting are chaired by Mr. Silas Butler, Deputy Administrator, DCV. In attendance are the social services department, usually the department head; the long term care ombuds person for the District of Columbia; Ms. Corrie Kemp, Chief, Central Referral Bureau for the District; and now the Court Monitor.

The following is assessment data the Court Monitor has gleaned from attendance at outplacement meetings, discussions with staff, conversations with all concerned parties to the Court Order, and most important from the residents on the units and at the bedside.

I want to assure the Court, that the assessment data listed has lead to the remedies recommended by the Court Monitor that follow, and which I am happy to report are in the process of being implemented. It is a tribute to the Executive Director of DCV, Ms. Alberta Brasfield, that she had the wisdom to appoint Mr. Silas Butler, Deputy Administrator to oversee the outplacement process for the residents. I find Mr. Butler to be a professional genuinely concerned about improving the life of the residents, proactive in improving the outplacement process, and completely open to and not defensive about recommendations and advice on how to comply with federal and district law and regulations and the Court Orders. Mr. Butler is rising to the occasion and has emerged as a constructive leader.

<u>Assessment Data</u>

Early on it became evident to the Court Monitor, despite the pronouncements and assurances from within DCV and District of Columbia government officials, that:

- there were no interdisciplinary care plans for the residents;

- DCV was relying on the receiving facilities to develop these plans, despite the fact it is the caregivers at DCV who know the residents, in some instances for decades;

- the pre-placement packages to be shared with potential outplacement sites developed by the social services department were sparse at best and did not present a clear picture of the individual, the resident;

- if this process was left to continue, the residents would be at a supreme disadvantage and likely to suffer transfer trauma and possible early death;

- the outplacement of residents was not cohesive and in fact was disorganized;

- the outplacement process was beyond the ability of one department (social services) to handle, that in fact all departments relevant to the life of the residents had to be involved in order to present a clear and relevant view of the resident to the outplacing facility;

- residents were not being systematically informed of their transfer and given choices;

- no resident was receiving any type of counseling whatsoever to decrease the anxiety and trauma associated with moving to a new home. The professional literature associates this lack of counseling with adverse consequences which in many instances leads to early and unnecessary death.

All of the above findings were in violation of residents rights, federal and District law and regulations, and the Court Order. Indeed several residents outplaced to date have suffered. One Ms. E.W. outplaced on October 9, died two and one half weeks later. At time of transfer Ms. E.W.'s health condition in no way indicated imminent death. One resident outplaced on October 17, Ms. M.T., stopped eating and was hospitalized, another resident outplaced October 20, Ms. D.L., stopped talking. A fourth resident, Ms. E.B., on the morning of outplacement, October 23, became so anxious that she began roaming the

halls and running into offices and rooms, seeking solace. Furthermore, she was unable to identify to which nursing home she was moving. Staff knowledge of transfer trauma phenomenon would have indicated a plan of action for Ms. E.B. which would have resulted in her not moving out that day, and not until her anxiety was diminished by therapeutic interventions such as counseling by a supportive staff. In addition, the Residents Council is actively campaigning through calling press conferences and letter writing to public officials to keep DCV open.

Two residents have been outplaced from the hospital where they were transferred. These residents were outplaced with no input from DCV describing their life and care needs gleaned from years of knowledge from living with these individuals at DCV. One resident with mental retardation, Mr. L.S., was outplaced from the hospital with both arms and legs restrained. Mr. L was never restrained at DCV. Clearly Mr. L.'s Individual Habilitation Plan was not communicated. Recommendations indicated by this event are listed in this Status Report under the July 6, 1995, Stipulated Court Order, Section D. Residents with Mental Retardation.

Since August 1995, 24 residents have been discharged. According to District of Columbia Law, the Long-Term Care Ombuds person is to receive written notice of intent to discharge. The Long-Term Care Ombuds person did not receive notice for 11 of the 24 residents discharged to date.

One proposed outplacement site, J.B. Johnson Nursing Home is in crisis as profiled in the media this week. There are dangerously low numbers of staff, food supplies, and lack of payments to employees and vendors. In fact some staff from DCV were detailed there this past week. The proposed outplacement of the five residents identified for acceptance

at this facility has been put on hold. Four D.C. long term care ombuds persons were scheduled to visit the facility as of today, November 30. The ombuds attends the weekly outplacement meetings and will commence devoting one day a week to follow up on outplacement sites as needed by the Court Monitor. In addition, the ombuds will be visiting residents who have already been outplaced and they will be providing data to the Court Monitor.

On November 29, the Court Monitor along with the ombuds person visited a proposed outplacement site, Hadley Hospital Skilled Unit, with 20 beds available for DCV residents.

At the monthly outplacement meeting held Monday, November 27, providers attending mentioned that nursing homes have not received payment for over 60 days approaching 90 days. In addition, the providers said that most facilities in Maryland with D.C. medicaid provider contracts are not accepting residents from the District of Columbia because of this lack of payment.

2. RECOMMENDATIONS

A) Expand Departments Involved in Outplacement The outplacement process team be expanded beyond the social services department to also include nursing, dietary, therapeutic recreation departments, and when appropriate physical therapy and occupational therapy.

B) Interdisciplinary Team Care Plans All residents must have an interdisciplinary team care plan which reflects a counseling program for minimizing

transfer trauma and which gives direction to the receiving home regarding the individual's unique care needs. This will help ensure that there will be continuity of care. Not only is this humane, but it is also in accordance with federal and District law and regulations. The format for these care plans are available on the units and in fact are in each resident's chart. Some have already been developed through the good work of some of the unit clinical nurse coordinators and the Associate Directors of Nursing (ADONs). Those already developed can serve as a model for other staff. The format is part of the tracking system the Court Monitor's nursing home systems expert consultant brought to the facility in order to assess compliance with the Court Order. If this interdisciplinary discharge care plan is carried out successfully, it can serve as a model for the long term care community of the District of Columbia.

C) Social Service and Nursing Departments Social services department must work closely with the nursing department and in all instances inform the two (ADONs) of all residents scheduled for discharge. In this way, priority can be given to the development of the above described interdisciplinary care plans.

D) 24 hour Availability of Staff to Counsel Residents At all times including day, evening, and night shifts, residents must have an opportunity to talk about their feelings regarding moving to a new home. To do this, all staff who come in contact with residents, including housekeeping, must first be sensitized to their concerns and feelings, so they can in turn help residents. This task is too much to ask of and beyond the capability of one department. However, the social services department should certainly continue to take the lead as the initial contact for the outplacement facilities, coordinating the sending of appropriate plans, arranging transportation so that the residents may visit proposed transfer homes, and assisting with counseling.

E) Therapeutic Music Soothing music at a low volume be piped into the public address system in order to effect a calming atmosphere conducive to healing from a major life stress - the loss of one's home. This has been requested by the Residents Council and also suggested by a nursing homes system expert consultant to the Court Monitor. Mr. Silas Butler, Deputy Administrator, DCV, has said he will follow through with this request. A good resource in choosing music which is therapeutic for this population of residents is Ms. Celeste Brooks, the music therapist from the department of therapeutic recreation.

3. ACTION STEPS

The following are action steps DCV has initiated and has indicated a commitment to continuing, I applaud these efforts. All these action steps will be closely monitored.

A) Model Plan to be Instituted on Each Unit for Counseling Residents to Minimize Transfer Trauma On November 13, 1995, Mr. Silas Butler and the Court Monitor met with the social services department. Mr. Butler requested that the social services department develop a model plan to be instituted on each unit for counseling residents to minimize transfer trauma. This plan is to be reviewed by Mr. Butler and the Court Monitor.

The rationale for this approach, according to Mr. Butler, is the following:

- direct care staff do not know how to deal with upset residents regarding transfer trauma;

- staff need to be sensitized to clues in changes in behaviors of residents which may indicate relocation stress and anxiety;

- research studies indicate that if signs and symptoms are identified early enough transfer trauma is minimized;

- everyone on the unit who comes in contact with resents should be part of the resident support system, especially the nurse aides, but also including housekeeping;

- a model will give unit supervisors a framework with which to operate;

- department heads will have a focus for expectations of performance to bring to their staff.

Mr. Butler indicated that this is a new mission for DCV and that closure presents an opportunity to improve the total system of care, which does not cost money, but does present a new way to add to the quality of life of the "people that we serve." The success of outplacement can only be measured in the way the residents are interacting in their new homes. Interdisciplinary care plans should reflect progress in this action step. The point should not be lost, that the bottom line for the receiving facilities is the reimbursable dollars they will receive for admitting the residents. Therefore, as Mr. Butler has said, "we must be advocates for the residents who cannot advocate for themselves."

In October the Court Monitor distributed to all department heads and administration current literature on transfer trauma which identifies model interdisciplinary care plans to minimize the stress of relocation and the trauma involved for the residents. These articles must be copied and be readily available to all staff directly involved in planning interdisciplinary discharge care.

On November 14, the Court Monitor met with Dr. Harvey Sloane, Commissioner of Public Health for the District of Columbia and Ms. Gladys Fountain, Interim Administrator for Long Term Care. I informed them of the following:

- there is a need for interdisciplinary team care plans reflective of the residents "highest practicable physical, mental, and psychosocial well being" including counseling regarding minimizing transfer trauma;

- the interdisciplinary care plan could be utilized as the discharge plan in compliance with federal and District law and regulations, and the Court Orders;

- the interdisciplinary team care plan could be used as a model discharge care plan for the long term care community of the District of Columbia;

- the discharge care plan could enhance the image of DCV employees in the community, which Dr. Sloane mentioned was low.

The Court Monitor assured Dr. Sloane that the interdisciplinary team care plans were not a new 'paperwork' requirement, but in fact exist on the units and are in the process of being implemented as described in recommendation "b." above.

B) Inform Clinical Nurse Unit Coordinators On November 21, the Executive Director, the Deputy Executive Director, and the Court Monitor met with the two ADONs), the unit clinical nurse coordinators, and the new nursing staff development and quality assurance nurses responsible for education at the unit level. The Executive Director stressed she expects the nursing department to rise to the occasion and assume the leadership role vital for the successful development and implementation of the interdisciplinary care plans. Mr. Butler stressed that these plans would be the "basis the receiving nursing homes will have in order to put in place supports that will ensure quality of care (and that) the residents deserve the best that we have to offer." The

meeting was turned over to the ADONs with the charge, "it is your plan not ours because you know the residents the best."

The success of the outplacement process and whether or not it can be called humane depends on the commitment of all departments but most especially the nursing department. It is this department that has the responsibility for the 24 hour care of the residents and has the responsibility by federal law and regulations to coordinate the interdisciplinary care plans. The following is pertinent for the nursing department, the social services department, as well as all the interdisciplinary departments: unproductive group process dynamics must be set aside for the one goal of a humane discharge planning process. Resident's life or death literally depends upon it.

Ms. Disu, the new Associate Director of Nursing shared her model care plan developed for Mr. J.B. who was profiled in the October Status Report. This is a fine example of what nursing care can be at DCV. Ms. Disu developed the care plan at the bedside involving Mr. J.B. as much as possible, helped implement restorative programs, such as range of motion, brought in nutrition consult, physical therapy and occupational therapy, discovered that Mr. J.B. had a urinary tract infection, and began discussing with Mr. J.B. his eventual transfer to another facility. All of this is reflected in the interdisciplinary care plan and is a fine example for all staff to utilize. I especially recommend that social service as well as the rest of the staff at DCV use this care plan as a model. Ms. Disu has initiated implementation of care plans that give direction on how to counsel residents and prepare them for their move

C) Meeting with Residents, Relatives, Conservators and Responsible Party

A 'Resident Outplacement Meeting with Residents, Relatives, Conservators and

Responsible Party' took place on Tuesday evening, November 21, 1995. In attendance were about fifteen residents and about fifteen family members. Presenting and discussing with the attendees were Ms. Gladys Fountain, Interim Administrator for Long Term Care, District of Columbia; Ms. Alberta Brasfield, Executive Director, DCV; Mr. Paul Offner, Commissioner Health Care Finance for the District of Columbia; Ms. Helen Green, Medicaid, Medicare, Income Maintenance for the District of Columbia; Ms. Anne Hart, District of Columbia, Long Term Care Ombudsman; Revered Wesley Toepper, Chaplain, DCV; the Vice President of Providence Hospital and proposed outplacement site; the Nursing Home Administrator for Hadley Hospital Skilled Unit, a proposed outplacement site; the Vice President of Managed Care Services, Global Health Management, purchaser of Carrol Manor Nursing Home, a proposed outplacement site. Also present was Mr. Silas Butler, Deputy Administrator, DCV.

These meetings are scheduled to take place again in December and in January. A poignant aspect of this meeting was the presentation by Rev. Toeffer on the grieving process the residents are experiencing (as well as the staff) in suffering a major life loss - the loss of one's home. Rev. Toeffer has been at DCV for thirty years, is a full-time Chaplain and a District of Columbia government employee.

D) Meet with All Department Heads to "lay groundwork to get everyone sensitive to issues of transfer trauma" (Mr. Butler) On Tuesday morning, November 28, Ms. Alberta Brasfield, Executive Director, and Mr. Silas Butler, Deputy Director, met with all department heads, the social service staff, and Rev. Toeffer. Rev. Toeffer repeated his presentation given Tuesday evening, November 21, to residents and families. Ms. Brasfield communicated her expectation for compassionate leadership behavior on the part of all. With Mr. Butler's leadership the outplacement process has a simple goal: at

every possible intervention opportunity and on a daily basis, all staff should be prepared to listen to the residents concerns regarding transfer, even for example, during bathing, dining, activities, physical therapy, occupational therapy, and "to be genuinely kind and concerned about each other, to take care of residents, and to take care of each other."

E) Formalize Above Action Steps and Goals At the weekly outplacement meeting on November 29, 1995, the model plan identified in "a)" above was reviewed. The two ADONs were asked to attend this meeting and will become part of the core weekly outplacement meeting team. Ms. Disu presented her model plans described above in Action Step "b)".

It was agreed that the formalized plan for implementing the goal of a humane discharge planning process will be the following: (Ms. Disu is writing the notes from this meeting which will be reviewed by Mr. Butler and formally instituted. The formalized plan will be presented in the next Status Report.)

1. Start at the unit level to sensitize staff. The ADONs will contact the unit clinical nurse coordinators to schedule meetings with Rev. Toeffer and the pastoral team. At all meetings the president of the Residents Council is to be invited and to be considered a vital part of this team;

2. Unit coordinators to collect data on resident concerns to give to the ADONs social services, Chaplain and pastoral care team, and the Residents Council;

3. Initiate counseling for residents including the Residents Council, social services, pastoral care team.

As of today, November 30, 1995, number one above has commenced. The formalized plan will be in full implementation by December 10. Any residents scheduled for discharge before that date will be immediately assessed and addressed.

4. PROFILE AND BRIEF CASE STUDY

Unit 5B is a particularly touching, sad, and poignant example of systems breakdown, complacency in viewing residents potential, and passive neglect described in the October Status Report. Guiding the clinical coordinator, licensed nursing staff, and the nurse aides will be a challenge for the newly assigned Associate Director of Nursing responsible for this unit, Ms. Batie Thomas, as well as the new quality assurance and staff development nurses responsible for educating nursing staff on this unit. However, care must improve for these residents in order for DCV to be in compliance with federal and District law and regulations and the Court order including humane outplacement discharge plans that reflect the residents full potential. According to the Nursing Home Reform Law, residents have a right to maintain and achieve the "highest practicable physical, mental, and psycho-social well-being." On Unit 5B, this is not the case.

Unit 5B is full of proud, elegant, old women, the majority of whom are for a good deal of the day and week flat on their back, neatly tucked in bed, and incontinent. For the most part these women are aware of their environment. On numerous occasions when visiting them and at various hours in the evening, they are as awake at 9pm as they are at 6:30pm. I ask them what they are thinking, and nearly all talk about their former lives, when they were active, productive, citizens engaged in life. I also ask all the residents: do you know DCV is closing, has anyone talked with you about it, do you know where you would like to go? The answers are almost always, no.

I generally find residents at DCV, especially the vulnerable ones who are frail, to be starved for human contact, affection, and touch. Mr. Donald Bertman, a volunteer ombudsman and pastoral aide who has been coming to DCV for over twenty-five years has said that to him, "the biggest problem is not turning people, that is what sticks in my mind." Without turning residents, decubitus ulcers develop, incontinence sets in, contractures develop, the body and spirit wither away. Mr. Bertman's statement is eloquent in its simplicity and from the Court Monitor's data gathering on the units and at the bedside, one in which I sadly agree.

I am sharing the following brief case study as a small example which can be generalized to all the residents at DCV. It demonstrates how as resident can be known as an individual and the potential for this knowledge to be reflected in an individualized, interdisciplinary care plan, improvement in care, attainment of the "highest practicable physical, mental, and emotional health," and an outplacement discharge plan that gives direction to the new providers of care in the receiving facilities.

There is a picture on the bedside next to one resident, Ms. M.L. The picture is of her on stage in the Moulin Rouge in Paris in 1917. Ms. M.L. is now totally contracted. How profoundly sad for a dancer in her youth to be at the end of her life unable to move her legs. Contractures occur when no range of motion exercises have been performed and once set in, they are irreversible. Contractures in a resident are a systems failure and most especially a nursing care failure. At the outplacement meeting for residents and their families held Tuesday evening, November 21, 1995, I met the guardian for Ms. M.L. She told me that Ms. L. Has a fine collection of old books, some dating back to the 1870's, and likes to be read to. I have never seen anyone reading to Ms. L. I doubt the staff knows this piece of data about this human being. I gleaned this information in one

minute of my conversation with the guardian. I am sharing this as an example of how really simple it is to get to know the resident, how information which is unique to the individual can be incorporated into an individualized interdisciplinary care plan and in turn is invaluable for a new facility to have and know about the human beings they will be receiving and providing a new home.

All data gathering, the resultant reflection and improvement in care, and the development of meaningful interdisciplinary care plans takes is the priceless commodity identified in the October Status Report to the Court - time, commitment, and caring.

Recommendations

(A) All staff get to know the residents in a way that something meaningful about them can be communicated in the interdisciplinary care plan and shared with the outplacement facility. This of course includes nursing staff, but it especially challenges the Therapeutic Recreation staff to become more meaningfully engaged in the lives of residents, especially those who do not appear to be meaningfully engaged in their environments, that is the frail, vulnerable bed bound residents. Depending on the needs of the residents, the core staff would be dietary, physical therapy, occupational therapy, therapeutic recreation, nursing.

(B) Actively engage the eighteen member therapeutic recreation staff to teach nurse aides at the bedside how to stimulate, engage, and provide activities that are unique to the individual, for example, reading to the resident as identified above, or listening to music.

© A rhetorical question, the answer to which I hope to see in action: What ever happened to the good old therapeutic backrub?

A nursing home systems expert pro bono consultant to the Court Monitor, toured Unit 5B with me. This consultant has been in hundreds of nursing homes throughout the country. Her assessment was profound and one which I hope will give motivation to immediately develop and implement the humane discharge planning process. That is, the "condition residents are discharged in is the way they will die." The consultant also assessed that the proud, old, elegant women on Unit 5B are "warehoused."

I am writing this, of course, to inform the Court, but also to hopefully give motivation to the staff to see the world of the resident with a larger vision. I do believe, if residents do not get the full potential of care they require and deserve while still remaining at DCV, then the outplacement process cannot possibly be humane, which will be a violation of federal and District law and regulations, and the Court Orders. I know the staff is capable of rising to the occasion, and focusing on the unanimous goal of, in the words of Mr. Silas Butler, the Deputy Administrator at DCV, "maintaining the level of care in outplacement by upgrading care here (at DCV) before the residents leave." To be sure, this is also a difficult time for the staff, who are faced with loss of their jobs and the necessity of finding new employment. However, as staff, the primary goal is the best interest of the residents.

I am using unit 5B as an example, there are similar care situations on all units. However, I want the Court to know that there are also fine examples of improvement in care which the Court Monitor has observed since first entering DCV on August 28, 1995. As Court Monitor, I must admit it is a bit frustrating, for I truly believe with the new leadership in

nursing, with the commitment to professional behavior on the Executive Director and the administration's part, and with the on-going monitoring of the Court, DCV Nursing Home could be turned around into a model facility within two years. However, now with the outplacement process taking place, it is my sincere hope that these leadership energies will be put into developing and implementing a model outplacement plan which will benefit the residents of DCV Nursing Home and also serve as a model to the long term care community of the District of Columbia.

5. OUTPLACEMENT OF RESIDENTS WITH MENTAL ILLNESS

This section addresses the special outplacement needs of residents with mental illness, including assessment and action steps to be implemented by Dr. Mary Alice Crockett, the Medical Director, who is charged by Mr. Silas Butler to oversee the outplacement of the residents with mental illness. The outplacement of the residents with mental retardation is addressed in this Report under the July 6, 1995 Stipulated Court Order Section D. Residents with Mental Retardation.

The assessment data for outplacement of residents with mental illness has been gathered from the following sources: the Court Monitor's attendance at the three outplacement meetings for residents with mental retardation; discussions with staff of the Commission of Mental Health and St. Elizabeth's Hospital; Ms. Corrie Kemp, Chief, Central Referral Bureau, District of Columbia; meeting with Dr. Sloane, Commissioner of Public Health, District of Columbia; meetings with social workers; staff on Unit b where many of the residents with mental illness live; conversations with the Bazelon Center for Mental Health Law; interviews with the members of the Dixon Committee and the Monitor for the Dixon committee; meeting with Dr. Donna Mauch, Special Master, Dixon

commission; review of the Dixon committee reports of the last several years; discussions with the D.C. Long Term Care Ombuds persons; discussions with mental health experts at the Mental Health Policy Resource Center; meetings with Dr. Mary Alice Crockett, Medical Director, DCV; discussions with Mr. Silas Butler, Deputy Administrator, DCV; observations of and interview with the residents.

Assessment Data

All the assessment data described above regarding the discharge outplacement process applies here to the outplacement planning process for residents with mental illness. However, there are critical and unique concerns which apply to this special population which primarily relate to the November 7, 1995, Order Modifying Stipulated Order of July 6, 1995 in the areas of monitoring:

"all residents are transferred to appropriate residences which meet their individual needs and

D. review whether all necessary services and support have been arranged and are ready to be provided at the new residence."

- there is a lack of consensus on the best assessments to use for residents with mental illness to determine the most appropriate outplacement;

- No one knows exactly how many residents there are at DCV with mental illness either as a primary diagnosis or as a secondary condition, some estimate there are 80 residents. However, as a result of the weekly outplacement meeting of Wednesday, November 29, the ADONs will gather data from the units on the number and names of residents identified by staff with behavioral symptoms;

- some residents with mental illness are inappropriately exempted from further psychiatric assessments as mandated by law (PASAR). The reasons given are medical conditions which do not qualify for exemption;

- there are not sufficient and appropriate residences, resources, services and supports in place for the outplacement of residents with mental illness;

- despite years of existence, the Dixon commission has been unable to develop appropriate community living situations;

- there are at least 100 residents of DCV who will be extremely difficult to place, many of whom have some form of behavioral symptoms.

- according to administration at DCV, DCV has funding through the end of 1996.

Action Steps

Immediate remedies are needed. The Court Monitor will closely oversee the following action steps to be implemented by Dr. Crockett or whomever Mr. Butler identifies.

(A) Focus Group A Focus group will be formed for the following purposes:

1. Validate assessments and appropriateness of recommendations for type of outplacement sites currently being conducted by a three person team from St. Elizabeth's and the Commission of Mental Health. The members of the focus group team will as much as possible be drawn from local experts within the Washington, DC area, including the National Institutes of Mental Health.

2. Identify potential appropriate outplacement sites.

(B) Consultant Team A consultant team will be identified to provide on-going specialty services to outplacement sites. It is generally agreed by most all those listed above from whom assessment data was gathered, that the only way nursing homes or other community based sites will accept residents exhibiting behavioral symptoms is to provide an on-going specialty consultant team. This team would be available to advise outplacement facility staff on the proper care, interventions, prevention strategies, environmental conditions suitable to the special needs of residents with mental illness or

exhibiting behavioral symptoms, and would be available on an emergency basis. The composition of this team should consist of a psychiatrist, psychologist, geriatric-psychiatric nurse, and when appropriate, a recreation specialist, and social worker. This would provide for the "necessary services and support" outlined in the November 7 Court Order.

© Home and Community Based Waiver Given the fact that the District of Columbia is the only jurisdiction in the country that does not have a home and community based waiver for care as an alternative to nursing homes and institutional care, and given the fact that DCV is funded until the end of 1996 (according to DCV administration), a home and community based waiver will be proposed. Dr. Donna Mauch, Special Master for the Dixon commission has agreed to assist the Court Monitor develop a proposal to be submitted in a future Status Report to the Court.

The need is immediate to find appropriate residences with appropriate support services and knowledgeable staff with access to a consultant team to care for this population of hard to place residents. In order for Dr. Mauch to be able to assist the Court Monitor, the Annual Costs Reports for DCV and the Budget for DCV is required to develop this proposal.

REQUEST TO THE COURT

Given the fact that the Court Monitor has still not received the list of vendor phone numbers requested in the October Status Report as a Request to the Court to advise the Corporation Counsel on behalf of the District of Columbia, and therefore, the Court Monitor is unable to fully monitor vendor payments, **I hereby respectfully request that the Court Order** the Corporation Counsel on behalf of the District of Columbia to

supply the Court Monitor immediately with the Annual Cost Reports and the Budget for D.C. Village Nursing Home.

II. UPDATE OF SYSTEMS

The October Status Report is recent and still current. Only those areas where there is a significant change in status will be profiled.

A. Medicine

On October 26, 1995, Dr. Harvey Sloane, Commissioner of Public Health for the District of Columbia conducted a meeting at DCV to discuss the Department of Medicine and the October 20 Status Hearing in the Court.

Present were Dr. Sloane, Mr. Garland Pinkston and Ms. Barbara Mann, Corporation Counsel for the District of Columbia; Mr. Louis Norman and Ms. Frankie Wheeler, Office of Personnel, District of Columbia; Ms. Lori Taylor-Hayes, labor attorney, District of Columbia; Ms. Gladys Fountain, Interim Administrator for Long Term Care, District of Columbia; Ms. Alberta Brasfield, Executive Director, DCV; Dr. Mary Alice Crockett, Medical Director, DCV; Drs. Phan, Nyguen, and Allin, medical staff, DCV; Mr. Curmet Forte, President, Residents' Council, DCV; Dr. Adrian Wilson (dentist), president of the Doctors Council, and the Court Monitor.

The purpose of the meeting was to discuss the medical staff functioning and "cooperating within the structure at DCV" as Mr. Pinkston stated in an attempt to set a constructive

tone for the meeting. However, after an hour and a half, it became clear to Dr. Sloane, that there was no willingness on the part of two of the medical staff and the Doctors Council President to follow the Request to the Court in the October Status Report and report directly to the Medical Director in all matters relating to resident care and to follow the Medical Director's suggestions for continuing education. Dr. Sloane ended the meeting indicating he would make his own decision on resolving the problem. As of the end of November, the psychiatrist and one medical staff have been detailed to other positions within the District of Columbia.

What saddened me most about this meeting was that the best interest of the residents was never the focus of the discussion from the Doctors Council, and that there was no indication of a willingness to entertain or heed the recommendations of the Court. The Doctors Council president exhibited an arcane view of health care delivery and certainly no knowledge of the minimum standards of care for nursing home residents.

Coincidentally, the most recent edition of Washington City Paper, November 24, 1995, has a front page cover story on the District of Columbia's public employee unions profiling the drain they are on the District. The first union profiled is the Doctors Council. The article describes the president of the Doctors Council as defending the indefensible.

A fee for service physician is covering the units previously covered by the departing medical staff. The Medical Director has supplied and made available necessary materials including the federal regulations for minimum standards of practice in nursing homes and current literature on treatment trends. Psychiatric services are to be arranged.

B. Nursing

Two Associate Directors of Nursing (ADONs) have been assigned with one ADON responsible for Units 2A, 2B, 3A, 3B and the other ADON responsible for the care on Units 4A, 4B, 5A, 5B. In addition a contract is in place with National Nurses to provide 16 FTE licensed staff to be permanently assigned to DCV. Three nurses are assigned as clinical coordinators on the units to replace nurses who have left DCV employ. Also now there are two supervisors during the evening and night shifts. This should help accelerate the needed supervision at the unit level. The two ADONS have offices on their units. From this contingent of permanent assignments from National Nurses, there are now in place two teams consisting of a staff development nurse and a quality assurance nurse with responsibility for training at the unit levels, one team for the Units 2 and 3 and the other team for the Units 4 and 5. I see much more training of staff. I also see leadership behaviors on the unit level.

C. Infection Control

Infection control is still very weak. The missing link is still no systematic and immediate follow-up when patterns emerge. I strongly recommend that one staff person be designated with responsibility for all aspects of infection control. Currently the staff person with jurisdiction for infection control does not have clear lines of authority for follow up inservice education. And, as quality assurance coordinator spends a good deal of her time compiling the '30 Day Compliance Report' as opposed to needed follow-up on the Units.

III. STIPULATED COURT ORDER, July 6, 1995

The October Status Report is recent and still current. Only those areas where there is a significant change in status will be elaborated on in this Status Report.

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

Treatment nurses now cover weekend day shifts. However, I still do not see routine skin care checks on the units by the staff. I know the ADONs are working to this goal, but it has not yet reached the bedside on a consistent level. Coordinated interdisciplinary care for prevention and treatment of decubitus ulcers has begun, it is still not routine. Dietary must become more involved in advocating for improvement in nutritional status of those residents with and prone to decubitus ulcers. In recent weeks, decubitus ulcers on Units 4 and 5 have decreased markedly. Patterns will be studied for Units 2 and 3.

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*

Restorative bowel and bladder programs have been instituted on each unit. Ms. Disu, ADON has been instrumental in establishing restorative programs. However, on numerous occasions I have seen toileting programs checked as having occurred every two hours when in fact residents have been up in wheelchairs all day.

I respectfully request that those compiling the '30 Day Compliance Report' cease including the position charts. They should be collected but kept with the unit coordinators. What would be a much more effective method of accountability is for the unit coordinators to document rounds they make to check for incontinence and positioning and to document interventions with staff when care is compromised with inaccurate charting. I still find numerous instances where residents are in the same position for hours, sometimes incontinent, most all contracted. In other facilities, staff who routinely indicate care given when it is not are terminated.

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

The rationale for staffing patterns seems to be a mystery. The numbers in the '30 Day Compliance Report' are meaningless unless the census for each unit is given. There should be an overall rationale for staffing patterns in the nursing office. Staffing appears to be done for the convenience of staff not resident care needs. A nursing home systems expert consultant to the Court Monitor will develop an analysis DCV staffing patterns for a future status report. To date, I have still not seen a shortage of actual staff, shortage in care given has been the problem. I do anticipate potential staffing shortages as the facility moves closer to closing.

There are six contract nurse staff vendors DCV relies on, all are owed vendor payments, with some threatening to terminate services by the end of the month.

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.

A nursing home systems expert consultant to the Court Monitor will gather data on a regular basis commencing Sunday, December 3.

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 — Dangerously close to Non-Compliance this week

On Monday, November 27, DCV had a one day supply of vegetables and bread. This is an intolerable scenario that should never have escalated to the final day of basic nutrient supplies for frail, fragile, medically compromised individuals, the residents of DCV.

The head of the dietary department appropriately requested purchase orders at the beginning of October. On Wednesday, November 22, the Court Monitor through an interview with the head of dietary was able, with difficulty, to get information from Ms. Costley that purchase orders were not received from the procurement office. And, that in fact if not received by the following Monday, dietary would be out of supplies of vegetables, bread, fish, and margarine.

It is amazing to me that the dietary department chief did not advocate for the residents and communicate her lack of receipt of the purchase orders in a timely manner to the executive director. It is also intolerable that the procurement office, Ms. Perkins, was not

forthcoming with the necessary purchase orders. To me this represents a callous disregard for the welfare of the residents of DCV. What is most stupefying of all, is that part of the evidence gathered through affidavits which lead to the legal action resulting in the Stipulated Court Order of July 6, 1995, is precisely the fact that basic nutrients were not available to residents.

The presence of the Court at DCV was able to prevent a repeat of the scenarios leading to the Court Order. Purchase orders were received and vendors contacted and supplies delivered. However, in order for the scenario described above not to repeat, that is, so that basic food and nutrients do not become dangerously close to depletion, the Chief of the Dietary department:

- will submit to the Executive Director with a copy for the Court Monitor biweekly listings of outstanding purchase orders, identifying items required and dates existing supplies will end;

- must exhibit leadership behavior by advocating for the needs of her department for the best interests of the residents. Passivity is not appropriate.

Coincidentally, on radio and television news, Monday evening and Tuesday morning, November 27 and 28, lack of food supplies such as vegetables at DCV was mentioned. Apparently, though, these broadcasts were an amazing coincidence. The Long Term Care Ombuds office has said that the source of this story was the president of the D.C. Health Care Association. That in a conversation with the television new reporter, he in general terms discussed the difficulty of vendor payments in the District and the impact on care giving, citing the affidavits referred to above.

Howard University, Department of Nutritional Sciences has committed to the Court Monitor to perform the necessary assessments of supplies and nutrients, and adequacy of nutrition.

The following information on the diets submitted in the '30 Day Compliance Report' was supplied to the Court Monitor by the nutritionist for the Georgetown University Child Development Center, Dr. Golda Downer.

- The therapeutic value of the calorie diets, such as, 1200, 1500, and 1800 calories are impossible to judge without portions, which are not listed.

- The diet listed as high fiber in fact supplies an average amount of fiber intake, not high.

- The low sodium diet is too high in cholesterol.

The dietician from the Health Care Financing Surveyors (HCF) team in the exit conference on September 30, 1995, stated that DCV has more specialized diets, seven, than most nursing homes in the country. The fact of the matter is that residents have access to the canteens and vending machines and are free to add to any restrictions imposed by specialized diets.

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.

A geriatric-pharmacologist expert consultant to the Court Monitor will supply data for this section.

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

3. Personal Care Items

Status Re: Court Order Partial Compliance

I want the Court and the District of Columbia to know that Georgetown University School of Nursing is committed to community service in the District and has chosen to assist the Court Monitor at DCV. This is a tribute to the leadership of the Dean of the School of Nursing at Georgetown, Dr. Elaine Larson. It is also a tribute to the faculty member who is the Court Monitor's nursing homes system expert consultant, Dr. Sharon Mailey, a geriatric nurse practitioner and a former director of nursing in two nursing homes in the South. It is also a wonderful tribute to volunteers from the School of Nursing who have devoted their free time on weekends, under Dr. Mailey's and the Court Monitor's supervision, to collect the data for this section.

On Saturday, November 18, data on personal care items were gathered on Units 5A, 5B, 4A, 4B, and 3A, from 137 residents rooms. A check off list was developed by Georgetown for the following items: toothbrush, toothpaste, comb/brush, soap, lotion, deodorant, wash basin, water pitcher, cup, cup with water, water accessible to resident, arm ban ID, denture cup, shaving equipment.

The majority of items were present. Lotion was not present in over half of the residents rooms, which relates to the rhetorical question in section I. of this report, where are the backrubs? There are two items that were not present which is an alarming finding and directly relates to this Court Order in the areas decubitus ulcers, incontinence, and nutrition. That is in nearly all the rooms there were no cups with water and water was not accessible to the resident, cups were not present in over half of the rooms.

Hospitalizations for dehydration, sepsis, pneumonia, and the development of infections are no accident given this data. This data also supports the identified weakness in Infection Control profiled above under the Systems update and described in the October Status Report, and gives direction for immediate staff development.

On this same day, a nurse/attorney pro bono consultant to the Court Monitor reviewed the chart of a resident who recently died and was listed in the '30 Day Compliance Report', Mr. M.D. The primary finding was that there was no record of intake and output, that is no record of hydration.

C. Payment of Vendors

I regret to inform the Court, that my request to the Court in the October Status Report has gone unheeded. It was my understanding that the Corporation Counsel had the power and authority of its office to counsel their clients to perform in the best interests of the residents. It is my hope that the Corporation Counsel assumes the power and authority of their office and wrestle the list of vendor phone numbers from which ever bureaucrat has it. Having these numbers directly relates to residents quality of life, for I am unable to determine how close services may be to termination for lack of payment.

An example is the dietary services described above in B.1. Food and Drink. Purchase orders are now in place for needed nutrients, but I was unable to monitor the logical next step, and that is to determine if vendors were in fact going to deliver the needed supplies for the residents health and safety.

The following is data I do have.

Status Re: Court Order As of November 30, 1995, Non-Compliance

Nurse Staffing Vendors

Premier Nurse Staffing, Inc., formerly SAT, owed over $55,000 over 45 days outstanding.
Will terminate services December 1, 1995.

CUP Health Care Services owed $106, 027. Will terminate services November 30.

National Nurses owed $79,193. Will terminate services December 1.

AMC owed $40,215.

Physical Therapist

Therapeutic Management Services (TMS) owed $25,380. The physical therapist came on duty on September 5, 1995. TMS contract expires December 29, 1995. Will terminate services December 11.

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

Since the submission of the October Status Report three residents with mental retardation have been discharged. Two residents Ms. P. A. and Ms. D.L were discharged to Wholistic Health Services. One resident, Mr. L.S. described in the Assessment Data of the outplacement process in section I. above was discharged from DCV to the Greater Southeast Hospital and then to Washington Nursing Facility, where he is waiting placement to D.C. Family Services. There are twelve residents with mental retardation currently at DCV.

CARECO an identified site for five residents is no longer a proposed outplacement site. Physical plant renovations required, such as, installing sprinkles were not acceptable option as well as the reimbursement rate proposed.

Symbral Foundation was identified as a possible replacement site and visited DCV. On November 8, the Court Monitor sat in on the meeting with the Symbral representatives and Mr. Richard Clevenger, program coordinator for GUCDC and Mr. Silas Butler. Mr. Clevenger reviewed the Individual Habilitation Plans and then Symbral toured Unit 5A, where the residents with mental retardation live. Symbral had no staff in their proposed facility. The Court Monitor asked how staff were acquired, and was told, through advertisement in the newspaper, local colleges and universities, and networking. As of November 27, Symbral Foundation is no longer a possible outplacement site. The District of Columbia ARC, the Court Monitor for the Pratt decree raised serious concerns

with Mr. Butler the Court Monitor and the Ombuds about Symbral's ability to be financially solvent and train and maintain staff to care for the residents.

Kennedy Institute a proposed outplacement site for four residents with mental retardation has gone on record protesting their rate assignment and the fact that they are owed $203,504 for Fiscal Years 1988-1993. Kennedy Institute has threatened to withdraw their proposal to provide services on December 8, 1995. The Court Monitor is scheduled to visit Kennedy Institute.

The remaining group homes, Metro, D.C. Family Services, and Wholistic are appealing their rate designation by the Commission on Health Care Finance.

Three residents originally designated for assignment to group homes, Ms. A.B., Ms. C.W., and Ms. C.L. are designated to be outplaced to nursing homes because of their serious medical problems and nursing care needs. Although no homes are identified.

As of this writing, November 30, no residents are scheduled to be outplaced and in fact if Kennedy does withdraw, there will be no identified outplacement sites for any of the remaining 12 residents. If Kennedy Institute does not withdraw its proposal to provide services, then there will be no identified outplacement sites for eight, including the three residents needing nursing home care.

My concerns regarding the outplacement of residents with mental retardation are the same concerns listed in the October Status Report. I see similar issues in the outplacement of residents with mental retardation as raised in the Outplacement of Residents with Mental Illness in section I. of this Report. I remain particularly concerned

about the on-going demonstration of competency of the caregivers in the receiving facilities and homes. This major concern is based on the following assessment data:

- According to the Court Monitor for the Pratt decree, the staff at Wholistic Health Services refused to come to DCV to be trained by Georgetown University Child Development Center.

- Three residents with mental retardation outplaced to D.C. Family Services on June 30, 1995, although before the filing of this Court Order on July 6, were observed outside during the day: one resident was in pajamas on and no shoes; one resident disheveled and dirty; and the third resident's diaper was changed in public. One resident, Mr. L.S. is scheduled to be outplaced to this facility.

- This same resident Mr. L.S. profiled earlier in this Report was transferred to the hospital and from there discharged to a nursing home in restraints. To me this is a systems failure, and that the appropriate people who know Mr. L.S. were not involved in informing caregivers of his needs.

- I was very concerned to learn that a potential group home did not have caregivers in place and in fact did not know who they would get, described above under Symbral. This speaks to the 1970's and early 1980's which led to the Nursing Home Reform Law and the minimum requirements for nurse aide training and on-going continuing education, as well as requirements for licensure and continuing education for administrators, and a stronger role for surveyors to help ensure quality.

- In a telephone conversation on November 17 with Dr. Richard Birkel, President of the Kennedy Institute, Dr. Birkel identified a need for a plan for continuity of care and oversight of caregivers. He sees this oversight in the DCV instance coming from the GUCDC as the primary caregivers to residents with mental retardation. Dr. Birkel believes that this will afford an opportunity to correct and shape staff behaviors in the receiving facilities. Dr. Birkel sees a need for oversight at least once a week for several

months and then gradually taper off. Dr. Birkel believes an outplacing facility cannot assume that residents will get care required unless these safeguards are in place. Dr. Birkel said he would feel better about receiving DCV residents if he knew he had access to on-going support for these residents care needs.

- Dr. Birkel and Ms. Darlene Nipper, Director, Division of Residential Services at the Kennedy Institute, feel that the remaining residents with mental retardation at DCV are among the most fragile-medically of residents in group homes in the District of Columbia. Ms. Nipper believes that if the above described consultation services are not available to group home providers, then the special care needs identified in the Individual Habilitation Plans will not be met.

- In an interview with Dr. Golda Downer, the nutritionist for the GUCDC, Dr. Downer corroborated the statements of the Kennedy Institute experts. Dr. Downer believes that none of the caregivers in the group homes have experience with residents with dysphagia, which all the residents with mental retardation at DCV have. Dysphagia is an inability to chew and swallow on one's own, and it is neurologically based. Dr. Downer believes caregivers need training in food preparation and feeding and positioning before during and after meals. These residents are at great risk of aspiration pneumonia and death with each meal feeding. On-going consultation and supervision is vital until competency is demonstrated.

- I have observed staff at DCV during evenings and weekends when GUCDC is not present , who are not properly positioning residents.

- I believe GUCDC needs to be more active in the discharge planning process for residents with mental retardation and more proactive in assuring their needs are met in the community.

- Mr. Silas Butler of DCV as well as Ms. Corrie Kemp, Chief , Central Referral Bureau for the District of Columbia believe that a guarantee of an on-going consultation

specialty team would make outplacement more appropriate to residents needs and providers concerns, and that even nursing homes unwilling to take the three residents identified above may be more assured and inclined to do so.

- Mr. Butler believes that a small core team of specialty consultants, consisting of nutritionist, psychologist, speech pathologist, and recreation specialist preferably from Georgetown, where there would be access to specialty clinics is a model necessary for the appropriate outplacement of the remaining 12 residents with mental retardation at DCV. Mr. Butler is in conversations about this team plan with Mr. Hubbard at Mental Retardation and Developmental Disabilities Administration (MRDDA), District of Columbia.

- I believe the model for a consultation team to serve as a resource to outplacement sites at the residents new homes, identified in the Outplacement of Residents with Mental Illness section of this Report, would be appropriate for this population as well.

Recommendations

l) I therefore, recommend, the identification, development and implementation with all possible haste of a specialty consult team to serve as a resource to facilities and homes receiving DCV residents with mental retardation, to evaluate, train, serve, as resource to receiving facilities until staff is stabilized and competency is demonstrated.

2) GUCDC must become more proactive and actively involved in the discharge planning process for residents with mental retardation at DCV.

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

While GUCDC is present there is compliance. However, on numerous occasions on evenings and weekends, I have observed residents not engaged, in bed, and some positioned incorrectly as described above.

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