APPENDIX A

DECEMBER 6 AND DECEMBER 10, 1995

LETTERS TOTHE COURT

HARRIET A. FIELDS, Ed., R.N.
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1722 19th Street, N.W.
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Message: (202) 234-7142

December 6, 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:

I am writing to inform you of a situation relating to vendor payment at DCV which is having a direct impact on the operations of administration and the nursing department in terms of the amount of time spent trying to put corrective systems in place. If this situation continues, there will be a direct negative impact on resident care by Sunday.

The situation is the following. National Nurses, Inc. is among the many vendors who have not been paid within **"forty-five days from the date of a legitimate invoice is received."** Stipulated Order, July 6, 1995.

As a consequence, as of 11pm last night and again tonight, National Nurses has threatened to withdraw their services. Thus, the District of Columbia would be out of compliance with **"needed goods and/or services procured for the benefit of the DCV residents shall not be terminated due to...non-payment or delinquent payment of...vendors."** Stipulated Order, July 6, 1995.

National is a particularly important vendor. DCV has two contracts with National, one is for as needed staffing, which will only increase as more DCV employees leave relating to closing. The second contract, implemented in the beginning of October with another phase in on November 6, is for management level nurses.

This second contract provides for the 16 FTE permanently assigned nurses to serve as replacement unit clinical coordinators on three of the units where DCV employees have left. In addition, this second contract provides for the permanently assigned quality assurance and staff development education personnel to work at the unit level in conjunction with the two Associate Directors of Nursing (ADONs). It is this activity that is so critically needed for continuity of care, improvement in care, development of the interdisciplinary discharge care plans described in the Monitor's November Status Report, and required under federal and District law and regulations and the Court Orders.

Under the first contract, National supplies within a twenty-four hour period, five to six nurses for the evening and night shifts combined. Coverage for these positions has been arranged through other contract nurse staffing vendors through Saturday. However, as of Sunday, December 10, 1995, the nursing department projects much difficulty filling these slots with other vendors, who have also not been paid. It is non-payment of this first contract that is out of compliance.

The Court Monitor, late this afternoon, was able to convince Mr. Ronald Messenheimer, President of National Nurses, not to withdraw the services of the management nurses, since technically the payment of their invoices is not yet out of compliance. Of course, it is certainly within Mr. Messenheimer's business prerogative to do so.

It is my understanding from Ms. Gladys Fountain, Interim-Administrator for Long Term Care, Commission of Public Health, District of Columbia, from information she received from Janette Michaels, Consent Decree Coordinator for the District of Columbia, that as of late this afternoon, Mr. Garland Pinkston of the Office of the Corporation Counsel will hand deliver a voucher for payment to Mr. Williams, the Chief Financial Officer for the District of Columbia.

As of 7:30pm this evening, the vice-president for National Nurses, Inc., Mr. Grant, has told me that they will continue to provide services tonight, but the payment situation must be resolved tomorrow morning or the threat to withdraw all staff will occur.

The scenario described above must not be allowed to occur month after month, the residents are coming painfully close to suffering.

I want to briefly share another lack of payment example and how pitifully it has affected one resident, Mr. L.R. It also provides another example of how critical the vendor payment list with phone numbers is to the Court Monitor in order to help prevent needless violation of residents rights and needless pain

and suffering of the frailest of District of Columbia residents.

Mr. L.R., a young man, is a total quadriplegic. That is he has no use of his arms or legs. He also has complete use of his mind. Mr. L.R. has been in bed for a month because the right foot rest of his wheelchair is broken. The physical therapy department has not been able to get a response from the vendor which repairs wheelchairs, Rehabilitation Equipment Professionals (REP). The Court Monitor spoke with the vendor today and was informed by REP that they have an outstanding bill for payment for repair to Mr. L.R.'s wheelchair of $587.50 from April 27, 1995. It is my hope that by reading this, the able-bodied decision makers of District will be shamed into improving the life of the able-minded artist, who is imprisoned in his bed because of this negligence.

The payment to these two vendors, especially National Nurses, will be closely monitored, and the Court Monitor will inform the Court on a daily basis of progress.

Once again, Judge Hogan, it is a privilege to serve the Court and to 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

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December 10, 1995

The Honorable Thomas F. Hogan
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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:

I am writing the Court now, before the next Status Hearing in January, because of four areas of concern which must be addressed immediately. I am also in this letter to the Court, recommending further data gathering and remedies to rectify what I have now identified as patterns detrimental to residents well-being.

The four areas I will address are the following: (1) update on Mr. L.R. profiled in my December 6, 1995, letter to the Court; (2) the process of procuring purchase orders for vendor services, whereby there is now no stock of normal saline used as a treatment modality for decubitus ulcers; (3) chronic non-compliance of payment of vendors, whereby there is now no duoderm in house for treatment of decubitus ulcers and no payment to National Nurses profiled in the Court Monitor's December 6, 1995, letter to the Court; (4) residents' being denied their own funds from their Personal Needs Allowance (PNA).

Each of these four areas are indicative to me of a common thread of similar patterns. These patterns are what I believe to be a misuse of government funds, passivity and lack of advocacy on the part of staff for residents' needs and the acceptance of the bureaucratic inertia described in the Court Monitor's October Status Report under C. Payment of Vendors (p. 22), and needless and unconscionable delays in issuing purchase orders from the Procurement Office of the Department of Human Services, District of Columbia.

A description of these patterns in action is profiled in the Court Monitor's November Status

Report under III. Stipulated Court Order, July 6, 1995, B. Measures to Remedy Shortages, 1. Food and Drink (pp. 29-31.)

However, I want to assure the Court, there are some staff who are true advocates for residents rights. The two Associate Directors of Nursing (ADONs) are implementing proactive steps to improve the standard of practice and care and are also openly, constructively, and professionally implementing the Court Monitor's recommendations.

Each of the four areas listed above will be profiled. At the end of the profiles will be recommendations and remedies needed to rectify the patterns reflected in all the areas profiled.

(1) Update on Mr. L.R. profiled in December 6, 1995 letter to the Court.

On December 8, 1995, Mr. L.R. was out of bed and up in his wheelchair and resumed his usual place at the entrance to DCV, where there is day light, activity, and other human contact. Mr. L.R.s situation reveals a pattern of passivity on the part of the staff and also a non payment of vendor problem.

The internal problem revealed by this resident scenario is the following. To be sure, the nursing staff did contact physical therapy when Mr. L.R.'s wheelchair first broke. However, a systems failure set in whereby no one rectified the problem until the Court Monitor was notified by the ombuds person and the President of the Residents' Council, immediately stepped in and called the physical therapy department and the wheelchair repair vendor, and alerted the Court. Daily rounds by nursing and administration would have uncovered this negligence.

The external problem revealed by this scenario is that a previous repair to Mr. L.R.'s wheelchair has gone unpaid since April, 27th of this year and the vendor was unwilling to service DCV again as a result of this neglect in payment.

Not maintaining resident equipment is a violation of federal regulations and the Court Orders.

(2) Process of Procuring Purchase Orders (P.O.) for Vendor Services

Last week at the time of writing of the Court Monitor's November 30 Status Report to the Court, this problem was reflected in a shortage of food supplies to the residents. This week this problem is reflected in an inadequate supply on hand of treatment modalities for decubitus ulcers, specifically, normal saline to cleanse the site and duoderm to apply to the wound. (Duoderm will be discussed under vendor non-payment.)

For about a week sterile water from treatment kits for other uses has been used to cleanse wounds. Sterile water is an appropriate substitute, however, normal saline is preferred. Normal saline is an item that should be routinely on hand in any nursing facility, and is also necessary for the sterile cleansing of other equipment, such as catheter and tracheostomy tubing.

While making rounds with the treatment nurse on Thursday evening, December 7, 1995, the Court Monitor discovered there was no normal saline in-house. On unit 4A, at Mr. C.F.'s bedside while dressing Mr. C.F.'s stage III decubitus ulcer on his left hip, the treatment nurse told me that they have been out of normal saline for about a week. This reminded me of a camping expedition, where ingenuity in substituting routine supplies saves the day. However, this is a human being with a gaping whole in his body. At times DCV is operating like an underdeveloped country, when in fact this is the nation's capital.

On October 10, 1995, DCV submitted a "request for purchase order" to the Procurement Office, Department of Human Services, District of Columbia. Among the items listed on the purchase order were normal saline and duoderm. The request for purchase order was marked "Urgent per Court Order." Once purchase orders are sent from the Procurement Office and received by DCV, they are sent by DCV to the vendor for delivery of supplies. If the vendor has been paid, supplies will be delivered.

DCV received the requested purchase order on December 6, 1995. Prior to receipt of the P.O., the staff person from DCV submitting the "request for purchase order" called Ms. Cheryl Perkins of the Procurement Office and stressed to her the urgent need for receipt of the P.O. for care of the residents and that priority should be given to DCV which is under a Court Order. Apparently, Ms. Perkins' response was that there are many District of Columbia agencies under Court Orders. I believe the analogy the DCV staff person used is a good one: "Ms. Perkins needs to know that DCV cannot be run like a stationery store, where you run out of pens or something: residents lives are at stake."

In a nursing facility it is not always possible to anticipate needed supplies months in advance. For example, the size of bandages needed will depend on whether a wound develops (which should not be happening), the site, and the anatomy of the resident.

According to staff and administration at DCV, receiving purchase orders in a timely fashion from the Procurement Office has been a chronic problem. (Recommendations to the Court are at the end of the profiles section.)

Lack of adequate supplies for resident treatment and care is a violation of federal regulations and the Court Orders.

(3) Chronic Non-Compliance of Payment of Vendors

As of Saturday, December 9, 1995, DCV is out of supply of one treatment modality for decubitus ulcers, duoderm. Treatment nurses are using a substitute which they believe is not quite as effective. One treatment nurse does have a limited supply of duoderm only because, through her wisdom and experience, she secreted supplies anticipating this scenario. There is no duoderm, although I am informed emergency supplies are on the way, because District Healthcare, the vendor, has not been paid. District Healthcare is owed approximately $42,000.

Update on National Nurses, Inc., profiled in December 6, 1995, letter to the Court: On Thursday evening, December 7, 1995, Mr. Ronald Messenheimer, President of National Nurses, Inc., left a message for the Court Monitor, that he had received "confirmation from the Chief Financial Officer's office (for the District of Columbia) that National will be payed in the next check run on Friday or Monday. I will continue services pending receipt of check on Friday or Monday."

On Friday afternoon, December 8, 1995, Ms. Barbara Mann of the Corporation Counsel's office for the District of Columbia, left a message for the Court Monitor concerning National Nurses Inc., that "we are not aware of any termination prior to the weekend or immediately thereafter, it is our understanding a check will be delivered to them not later than Thursday of next week. We are covered for the weekend at DCV." This information is in conflict with the information Mr. Messenheimer was told the day before from the Chief Financial Officer's office.

The Court Monitor will inform the Court on a regular basis. Within the past week, the Court Monitor has begun to notice shortages of staff, primarily of nurse aides. Contract nurse staffing vendors are supplying nurses. However, none of them have been paid. Most recently in a letter dated December 6, 1995, to Mr. Vernon Hawkins, Director, Department of Human Services for the District of Columbia, CUP HealthCare Services has indicated they will terminate services on Thursday, December 14, 1995. CUP HealthCare Services is owed $93,102.86, ($11,935.77 of which is from December 1994.)

Nurse aides are District of Columbia government employees, are unionized, and are opting to take annual leave before DCV closes and they loose their benefits. Further monitoring is needed to determine why there are not nurse aide replacements and where there may be a potential source. Apparently, through the Personnel Department of the District of Columbia, there is difficulty securing staff for a limited term employ.

DCV receives one of the highest Medicaid reimbursement rates in the continental United States, approximately $240 per resident per day. This amounts to approximately $87,600

per resident per year. When the Court Monitor first arrived at DCV on August 28, 1995, there were 270 residents. That is a total reimbursement rate of approximately $24,000,000 per year. Approximately half of this total is federal funds and approximately half is District funds. According to DCV administration, as mentioned in the Court Monitor's November Status Report to the Court, DCV is funded through fiscal Year 1996. Where are these funds?

The same vendor non-payment problems profiled in the affidavits of June 1995, which led to the Stipulated Court Order of July 6, 1995, are the same problems today. (Remedies needed to rectify this situation are at the end of the profiles section.)

(4) Residents Denied Personal Needs Allowance (PNA)

Residents are to receive their Personal Needs Allowance (PNA) on the first of each month. As of today, the residents have not received their December funds, nor can anyone tell them when they will receive their money. The residents have a Holiday shopping trip planned for Friday, December 15, 1995.

The Personal Needs Allowance is residents' money and in the District of Columbia amounts to $70 per month. The source of the PNA is two-fold. One is for the "categorically needy." These are residents with no other source of income and who receive Supplemental Security Income (SSI). This amounts to a federal minimum share of $35 per month and in the District of Columbia a matching share to equal the $70 per month. (I believe the ratio in the District is federal contribution of $40 and the District of Columbia contribution of $30.) The second source of PNA is the "medically needy." That is residents with social security, disability, and or public or private pensions. From these sources of income, $70 per month is withdrawn and to be put into the residents PNA. The remainder of these sources of income contribute to the residents Medicaid reimbursement rate.

In an interview with the teller at DCV on Friday, December 8, 1995, the teller told me that he has not received money in two and a half months, what he has been using to give to residents as their PNA is money remaining in the fiscal budget (I believe last year's.), and that he normally receives funds every week to two weeks. The teller also told the Court Monitor that the PNA is from the District of Columbia Treasury.

It is a violation of federal law and regulations to co-mingle resident funds with any other account. Resident funds in excess of $50 are required by federal regulations to be in an "interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account." [42 CFR Part 483.10 © (1) through (7)].

Judge Hogan, I cannot tell you how sad and pitiful it is to see the residents hovering around

the window of the teller, across the hallway from the administration offices. There is a steady stream of residents throughout the day. The residents have not reached the justifiable anger stage yet, although some are close to it. In their eyes you can see that they are stunned, bewildered, and hurt. On Thursday, December 7 the staff was paid. The residents are acutely aware of this and the fact, that there is no money to pay them their own funds.

The residents have so little in life, it is their dignity that is being robbed from them as well as their money. Being deprived of their PNA adds to the stress of the impending loss of their homes, and the stress of institutionalization at the Holiday season.

Recommendations and Immediate Remedies Needed

I believe all the above situations will continue unless the recommendations and remedies that follow are immediately put in place. As DCV continues to approach closing, I can foresee operations unraveling, as it has already begun to do so in the areas profiled above: nurse staffing, dressings for the treatment of decubitus ulcers, wheelchair repairs, and the residents' Personal Needs Allowance. I foresee the non-payment of vendors becoming out of control.

I believe the primary issue is the misuse of and lack of accountability for government funds earmarked for the operations of D.C. Village Nursing Home and for the direct care of the residents of D.C. Village Nursing Home - the most vulnerable and frail of the District of Columbia population. Non-payment of vendors is symptomatic of this larger issue and is manifested in the culture of tolerance for and acceptance of bureaucratic inertia. The behaviors surrounding this culture are manifested internally at DCV by the acceptance of and tolerance for lack of supplies for basic humane care, and externally among DCV government officials, by the tolerance and acceptance of needless delays in the procurement process.

Therefore, in order to prevent the further dissolution of residents' rights the following immediate remedies are needed: (These remedies are not to supplant my recommendations in my Status Reports to the Court, the remedies identified here specifically relate to the concerns identified in this letter.)

(1) An **independent audit**, under the Court's auspices, of the government funds earmarked for DCV. (For over a month now the Court Monitor has requested the Budget and Annual Costs Reports of DCV, most recently in the November Status Report.);

(2) Since there are dedicated federal and District matching funds earmarked solely for the operations and direct care of the residents at DCV, there is no need for requests for purchase orders to enter the bureaucratic maze of the D. C. Government process. And since DCV has a scheduled closing date of the end of March, 1995, **all requests for necessary purchase orders will be filled within a two week turn around**;

(3) An **accounting of Resident Personal Funds;**

(4) Establishment immediately of a **separate account for residents' personal funds** including the residents' Personal Needs Allowance.

Judge Hogan, I look forward to serving the Court in monitoring the implementation of these recommendations and immediate remedies needed for the best interests of the residents of D.C. Village Nursing Home.

Sincerely,

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

REPORT OF THE EVALUATION OF FOOD AND NUTRITION SERVICES OF THE D. C. VILLAGE NURSING HOME

REPORT OF THE EVALUATION OF FOOD AND NUTRITION SERVICES OF THE D.C. VILLAGE NURSING HOME

Submitted by

Mamie W. Byrd, R.D., L.D.

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Department of Nutritional Sciences

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January 17, 1996

REPORT OF THE EVALUATION OF THE FOOD AND NUTRITION SERVICES AT THE DISTRICT OF COLUMBIA VILLAGE NURSING HOME

The food and nutrition services components of the D.C. Village Nursing Home were evaluated at the request of Dr. Harriet Fields, Registered Nurse, the Court Monitor, during the period of December 20, 1995 through January 5, 1996, by two (2) Howard University faculty members: Mrs. Mamie Byrd, Registered/Licensed Dietitian, Instructor, and Project Director of the Howard University Health Promotion Institute, and Mrs. Jewel Lewis, M.Ed., Registered/Licensed Dietitian, Assistant Professor, Department of Nutritional Sciences.

Mrs. Byrd has an extensive background in nutritional care management and Long-Term Care services, as well as teaching Clinical Nutrition at Howard University. Mrs. Byrd conducted the evaluation of clinical nutrition services.

Mrs. Jewel Lewis teaches Food Service Systems Management and Quantity Food Production Management at Howard; served as the state agency nutritionist for the D.C. Office on Aging for five (5) years; former Food Service Director of the Washington Center for Aging Services, and has practiced dietetics for 26 years. Together this teams' experience exceeds 40 years of clinical nutrition care and foodservice administration and management. Mrs. Lewis performed the evaluation of foodservice administration, management, production, and service.

This report addresses the findings from the evaluation according to the following:

Court Order: To 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 nutritional needs.

FOOD SERVICE DEPARTMENT ADMINISTRATION

Three problems were identified in the policies and procedures area:

1. The policies and procedures manual was incomplete and outdated.

2. There were no apparent policies to cover the following critical areas of patient care and foodservice management:

   a. Decubitus ulcer protocol
   b. Documentation of food consumption
   c. Hydration schedule
   d. Addressing unplanned weight loss
   e. Menu Analysis
   f. Menu Substitutions
   g. Staffing pattern
   h. Job descriptions
   i. Employee Scheduling
   j. Employee Orientation
   k. Purchasing procedures
   l. Emergency food/beverage supplies
   m. Re-assessment of post-hospitalized residents

3. Lack of uniformity in patient care management

RECOMMENDATIONS

1. Prepare policies and procedures for each of the critical areas of patient care and foodservice management, including the above listing. Procedures should be adequately detailed to ensure the desired treatment out outcome for the policy written.

2. Conduct in-service training to acquaint staff with the policies and procedures developed.

FINANCIAL ANALYSIS/BUDGET ISSUES

Documentations were not provided for this area. The Food Service Director had promised to meet with me at 8:30 a.m. on January 4, 1996 to provide data to support the above, as well as other materials requested. However, I was kept waiting in her office for 1 hour and she never showed up though I was told that she was in the building. I left the building at 9:35. She had informed me earlier that she would not be in the office the following day. I was told that she had complained to the Corporation Council regarding the request for documents and was later asked by the Court Monitor not to collect any more data.

RECOMMENDATIONS

An audit of financial activities at D.C. Village be conducted by an independent auditor.

FOOD SERVICE SYSTEMS

In order to ensure compliance with the above court order, the following foodservice systems must be in existence and rigorously adhered to:

First, there should be an effective procurement system which includes a purchasing manual that incorporates statements of objectives, scope, authority, and relationships. A good manual can provide continuity and consistency, which are difficult to maintain otherwise.

Receiving, storage, and inventory control are some of the critical elements of procurement.

Receiving

Receiving can be defined as an activity for ensuring that products delivered by suppliers are those that were ordered in the purchasing activity.

The receiving process involves more than just acceptance of and signing for delivered products. It also includes verifying that quality, size, and quantity meet specifications.

When procedures are not systematized, a number of problems may arise, such as losses due to carelessness, failure to assure quality and quantity of goods delivered, and pilferage. Competent personnel with specified responsibilities, well written specifications, procedures for critical control, adequate supervision, scheduled receiving hours and procedures to ensure security are desired elements of the receiving activity.

Storage

Storage is the holding of goods under proper conditions to ensure quality until time of use.
Only those personnel authorized to store goods, issue goods, check inventory levels, or clean the areas should have access to storage facilities since prevention of theft and pilferage is a major concern. Both have impacts on the availability of adequate food supplies.

Inventory Records

Inventory is a record of food, supplies, and materials owned by the facility. Inventory records have four basic objectives.

1. Provision of accurate information on food and supplies in stock
2. Determination of purchasing needs
3. Provision of data for food cost control
4. Prevention of theft and pilferage

Inventory control is the technique of maintaining food, food supplies, and materials at desired quantity levels. The major objectives of this control are to maintain quality of goods and supplies, to minimize inventory costs, and to ensure that adequate quantities of food are on hand for production and service needs.

A periodic physical count of food and supplies in storage is an important requisite of any inventory control system.

D.C. Village failed to provide documentation of:

1) Inventory
2) Storeroom requisition files
3) Existence of a purchasing manual
4) Policies and procedures regarding purchasing, including receiving, storage, and inventory control

RECOMMENDATIONS

1. Develop an effective procurement system, including a purchasing manual, statements of objectives, scope, authority, and relationships, including a section for each of the elements of the procurement system.

3. A periodic physical count of food and supplies in storage be conducted and records be retained according to the required legal period.

4. Appropriate staff receive in-service training in numbers 1,2, and 3 above.

The second critical area in the foodservice system is production or the preparation of menu items in the needed quantity and with the desired quality, at a cost appropriate to the foodservice operation. While quantity deals with numbers, quality should include not only the aesthetic aspects of a food product but also the nutritional value and the microbiological safety of the product.

The basic tool for the production system is the production sheet which translates the menu into a plan of operation and is the single most important, available production control. This form should contain as a minimum the following information:

- *census
- menu item
- *recipe
- *portion size
- total portions
- *amount to prepare
- distribution of portions
- *overproduction and underproduction
- special instruction and comments
- preparation
- *menu substitutions

Six (6) of the above eleven (11) elements of minimum information were omitted on the production sheet used at D.C. Village (identified by asterisks). This discussion is limited to three (3) of those six (6) items since they impact directly on the court order.

Recipe

Standardized recipes must be used in order to verify yield, or number of servings, compute food costs, and ensure consistent quality. Recipe numbers and titles need to be indicated in order to avoid any confusion by the production staff, including cooking utensil(s) and service equipment.

Portion Size

This is needed for use in calculating quantities to prepare and for communicating to food service personnel the standards on which production is based.

Quantity of Food to Prepare

Should be indicated in pounds, etc. for meat and dry ingredients; the size and number of cans, etc. for canned items ; and the number (#) of pounds for frozen foods, etc.

While some of the information was available it was not always being used appropriately. Production sheets listed the number of servings to produce, but the quantities of food required to be produced to achieve these numbers were omitted. Other irregularities included:

1. Recipes were not being used by foodservice personnel to determine portion sizes.

2. Improper serving utensils were being used for four (4) food items during a luncheon meal: three (3) ounce serving utensils were being used where 4 ounce portions were required.

3. Portion sizes were omitted on menus, production sheets, and recipes. Therefore the nutritional status of residents is at risk.

RECOMMENDATIONS

1. Develop a system for food production and service including policies and procedures for effective production controls.

2. Modify, update or adopt a recipe system to include (a) portion sizes, (b) specifications of cooking equipment to be used to prepare the food item, (c) type(s) of serving utensil(s) to ensure the desired portion size is achieved.

3. Modify and update production sheets to include portion sizes and quantities to be prepared.

4. Include portion sizes on all menus, including nourishment sheets.

5. Conduct in-service training for appropriate management and staff to familiarize them with items 1, 2, 3, and 4 above.

6. Adopt a comprehensive and systematic program for trayline quality assurance and monitoring, including the designation of appropriate staff to check each station on the trayline for proper serving utensils prior to the beginning of each meal.

7. Documentation of menu substitutions on the menu as served and on the production sheets. Residents should be notified of necessary changes through an approved and effective mechanism.

8. Purchase an appropriate nutrient analysis computer software package to analyze all menus.

   The entire menu system should be reviewed. The diet manual indicates that the facility provides eight (8) different routine diets, excluding test diets, but records indicate that 20 different types of diets have been prescribed for the residents, varying in complexity and compositions and similar to those found in a an acute care hospital diet manual.

   Many of the diet prescriptions are very restrictive. Generally this type of situation lends itself to noncompliance with the diet order on the part of the resident such that food intake is diminished, plate waste is prevalent, and residents become extremely dissatisfied with the meal service. Geriatricians, especially geriatric dietitians and nutritionists, advocate and recommend a more liberal dietary pattern for nursing home residents.

Greater satisfaction and improved food intake have been demonstrated through the use of a more liberal diet. The use of nutritional supplements are usually decreased as a consequence and often results in tremendous costs savings to the facility.

Residents at D.C. Village were very vocal about expressing their dissatisfaction with the food served at the facility, including complaints about "receiving the wrong food item(s); "unattractive meals"; "tasteless food"; "small servings", " the same foods served for Christmas as any other day".

RECOMMENDATIONS

1. Adopt a more liberal dietary pattern consistent with the dietary practices of most nursing homes to improve the dietary intake of residents.

2. Advise physicians of the need to use the facility's diet manual as a guideline for ordering diets for their patients in order to achieve the goals of the facility.

CLINICAL NUTRITION CARE MANAGEMENT

The Court Monitor, Dr. Harriet Fields, Registered Nurse, requested that this portion of the evaluation be focused on the nutritional care management for three (3) categories of residents: (1) those with decubitus ulcers(pressure sores), (2) those who had experienced significant unplanned weight changes, and (3) and those who had experienced frequent hospitalizations. A sample of twelve (12) residents was randomly selected from a list of twenty-four (24) residents provided to the evaluator by the Court Monitor.

The twelve (12) charts were reviewed to assess the quality of residents' care and to determine the degree of compliance with federal and local regulations. Findings were as follows:

1. One hundred percent (100%) of the records lacked documentation of food consumption, that is, no record was available which documented the amount or percentage of food, beverages and dietary supplements consumed by the resident. The use of food consumption records is a standard nutrition care management practice. With only an occasional notation, it is virtually impossible to assess the nutritional adequacy of a resident's food and fluid intake.

2. Sixty-seven percent (67%) of the records contained prescribed dietary supplements. Frequency of use and volume prescribed is of concern due to the fact that excessive use of dietary supplements has been demonstrated to suppress appetite and decrease the amount of food ingested during the service of regular meals.

3. Forty-two percent (42%)of the records indicated that residents were to receive increased fluids based on assessed needs by the Registered Dietitian. However no distinct identifiable interventions were observed on the charts or resident's meal trays in comparison with those residents who did not have recommended or prescribed interventions.

4. Twenty-five percent (25%) had experienced significant, unplanned weight loss or gains which were not aggressively and sufficiently addressed by dietary interventions. In three (3) cases no follow-up strategies were suggested or implemented, eg., re-weighing of residents to verify changes in weight and to rule out scale errors; calorie counts; meal observations; visitation of residents during meal hours to validate food consumption; review and update food preferences or perhaps consultations with the attending physicians, nursing aides or family members, etc..

Case Study:

A. Mr. B.T., a resident of unit 2B, is a quadriplegic with multiple decubiti who has recently experienced significant weight changes as well as a relatively recent hospitalization. The resident's weight history is as follows :(8/95) 149 lbs., (9/95)164.5 lbs., (10/95) 132 lbs. During the months of (11/95) and (12/95) resident refused to be weighed. The dietitian documented her awareness of his weight problem in her progress note of 10/24/95. However there was no documented effort to explain the loss; changes in appetite; adequacy of intake; acceptance and tolerance of diet; and no plan of care or intervention strategies were proposed. A later consultation with the Nursing Coordinator for this unit revealed that Mr. B.T. had experienced a hospitalization for urinary retention which was probably the reason for his unusual pattern of weight changes. However, the 10/95 weight still represented a significant weight loss from this resident's usual weight. Further, the nursing records revealed his refusal of the prescribed supplements, yet this was not addressed in the dietitian's progress notes or the care plan. The supplements were not discontinued and no other dietary interventions were proposed.

Other nutrition related problems noted regarding this resident include a moderately depressed serum albumin level of 3.3 mg/dl per 6/95 lab results and no follow up was done or recommended. In view of the problem with severe weight loss, decubiti and poor oral intake this indicator can serve as a predictor of malnutrition. An albumin level of less than 3.5 mg/dl frequently reflects protein-calorie malnutrition.

Nursing was also the verbal source of other very pertinent information such as the resident's non-compliant behaviors refusal to be turned, refusal to do ADL's and refusal to eat anything if he did not get what he had specifically requested from the dietary department. While this resident has a long history of being a very "picky eater", none of these facts was noted in the dietary or nursing progress notes nor in the resident's interdisciplinary care plans.

Finally, an interview, with a Registered Nurse who stated that she has had a twelve (12) year history of caring for this resident, revealed that he had recently exhibited signs of "giving up" and depression. She explained that she believed this may have something to with the recent changes in his behaviors, as well as his mental and emotional outlook on life. Yet none of these observations or suspicions had been documented. The writer inquired about a psychiatric consult or if there was anyone who was
emotionally close to resident who could possibly coax or encourage him. The response was that she had hoped that he was scheduled to be seen by an outside group of consultant psychiatrists who were currently making rounds. The chart review was performed on 1/5/96 and none of this was reflected in the resident's chart at that time. The Head RN stated her intention to adjust the IDT patient care plans to reflect more detailed and relevant aspects and issues surrounding the management of his care.

5. Seventeen percent (17%) of resident's care plans did not reflect the current resident status and care or simply did not adequately address the care needed.

6. Thirty-three percent (33%) of annual nutrition assessments omitted significant data regarding the resident's progress as it related to residents' nutritional status and the nutritional care plan goals. Current issues of resident care were also omitted.

Meal Observation and Tray Accuracy

During this review several meal rounds and tray line observations were conducted, including meal trays of those residents who were included in the patient sample of for charts reviewed. However observations were not limited to those alone.

During and throughout the visitation a pattern of tray inaccuracies became evident.

1. On 12/28/95 Mr. CF of Unit 3A who has a diet prescription for a High Fiber diet received white bread which was even marked on his tray card. Apple juice was on his tray, also. Reviewing the dietary department's carded file revealed that he should have received wheat bread and cranberry juice, according to physician's order.

2. On 1/3/95 JB's chart on Unit 3A indicated that he was to receive a 2 gram Sodium Pureed diet, but he was served a dental soft diet. Fortunately, this resident was able to tolerate the diet very well. However, the question arises regarding the need for re-evaluation by the dietitian to recommend an upgraded diet for this resident. A pureed diet probably would not have been acceptable to this resident. However, the diet sent to the resident did not correlate with the diet order or tray ticket.

Other examples of tray inaccuracies were noted, and are available upon request.

RECOMMENDATIONS

1. The development and implementation of a comprehensive system for nutritional care management of the residents at D.C. Village nursing home.

2. The development and implementation of a uniform system for documenting the nutritional care management of residents at D.C. Village nursing home.

3. Establish policies, procedures, goals, and objectives for training management and staff in tray accuracy and tray line monitoring, including outside conferences, courses, seminars, work shops, and/or professional consultants.

4. Routine updating and documentation of residents' food preferences, dislikes, and allergies.

5. Establishment and implementation of an effective and consistent program of hydration, including a Hydration Policy to ensure uniform approaches in the prevention and treatment of dehydration. Both Nursing and Dietary Departments will need to collaborate to devise a policy and procedures.

6. Institute a mechanism or method for assessing and documenting food intake.

7. Comply with residents' rights by developing a policy to post menus on each unit and follow through with the same.

8. Comply with the facility's policy for the re-admission of residents after hospitalization.

9. Implementation of a more uniform and aggressive approach to addressing significant unplanned weight changes.

10. Adoption of a uniform and systematic interdisciplinary care program to reflect a more integrated approach to patient care and describe the plans in writing.

11. Evaluate use of commercial nutritional supplements.

12. Establish a program of quality assurance monitoring which includes the following areas:

    a) tray accuracy

    b) analysis of all menus for nutrient content

    c) timeliness, accuracy, uniformity and quality of nutritional care documentation.

    d) interdisciplinary care plans, treatment protocols, and client surveys and/or questionnaires.

APPENDIX C

PAYMENT OF VENDORS

DC VILLAGE NURSING HOME VENDOR REPORT

Vendor Name	Person Contacted	What Supplied?	Outstanding Invoice	Dates & Services Rendered	Payment Status	Continue to Ship/ Provide Service?
Allied Medical Consults	Donna Thompson	RN's, LPN's	Yes	10/3/95 12135.41 10/3/95 4365.55 10/6/95 954.56 11/2/95 460.24 11/2/95 8993.48 11/3/95 260.56 12/7/95 7014.12	DCV claim check in mail 12/29 for $17,000	Yes, if they can find nurses to go. Many will not go because they have not been paid by the agency. Soon to be none who will go.
District Healthcare	Monique Foster		Yes	Still awaiting info		Awaiting info from vendor, but vendor indicated future as supplier is uncertain
SRT Premier Nursing Serv.	L. Duvall	RN's., LPN's	Yes	approx. $20,000 over 90 days	Per Jeanelle Michael, check cut as of 1/10/96 still not rec'd	Possibly not, if check not rec'd very soon
Hill-Rom	*Richard Hughes*	*Specialty Med. beds*	No			*Yes, only because after extensive collection efforts for prior past due balance, DCV overpaid by $4,000 which vendor considers deposit.*
J.P. Food Service	A/R Dept.	Food	No			COD ONLY
John Sexton Continental Foods	Mr. Leonard	Various food items	Yes	Nov., Dec., Jan., $16,319.50	now due	Yes
SYSCO	Terry in credit	Various food	No			Account not open now, would have to be reevaluated if order placed. May 1995 last order.
Southern Int'l Corp	Jose Abraham	Food	Yes	$1,140.60	Current, Jan shipment	Yes
Calico Industries	Finance dept.	Kitchen and janitorial supp.	No			Account suspended, might still ship
EECO	Brenda	Kitchen exhaust serv.& supp.	No			P.O. has expired. If new P.O. issued
Galliher & Huguely	Cindy, A/R	Lumber	Yes	*$182.34 finance ch	Sept inv. pd Dec. finance chg now due	Account on hold
Pameco Corp.	John Wood	Refrigeration supplies	No			Yes
Pro-Ed	Pam, A/R	*Educational material*	No			*Yes, nothing ordered since 1992*
A & A Hearing Center	Sharon Poehland	Hearing aids	No			Yes, but probably COD or with deposit. Bad time collecting Fall 1995
Technical Sales & Services	Dean, A/R	Computer repai	Yes	August inv. $25 bal		Yes, vendor seems to think just a misunderstanding

Vendor Name	Person Contacted	What Supplied?	Outstar Invoice	Dates & Services Rendered	Payment Status	Continue to Ship/ Provide Service?
CUP	Dianne Johnson	Nurses	Yes	12/5/94 $11935.11 8/8/95 $1874.81 9/1/95 $7042.58 9/5/95 $1915.26 9/19/95 $2139.87 10/3/95 $15059.46	DCV claims still trying to process. Vendor has been paid for more recent inv.	Still sending nurses now, but Mr. Harris, owner, is planning to send a letter indicating termination of nurses if old invoices not paid.