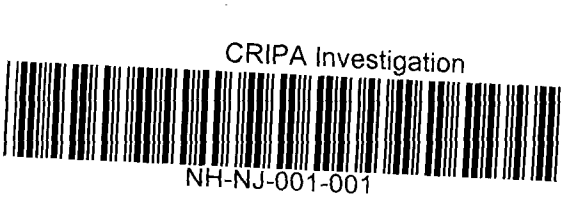
Memorandum



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DJ 168-48-47

Subject	Date
Recommendation to Investigate Bergen Pines County Hospital Paramus, New Jersey	November 1, 1996

To

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

From

RF Robinsue Frohboese
Deputy Chief
Special Litigation Section

We recommend that the Department initiate an investigation into the conditions of resident care and treatment in the nursing home and psychiatric care units of the Bergen Pines County Hospital ("BPCH") in Paramus, New Jersey, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. BPCH is the largest nursing home in the State of New Jersey. Its long-term residential care units serve 700 people who are elderly or who have disabilities. An additional 320 people with mental health needs are confined to BPCH's psychiatric treatment units.

The information we have obtained indicates that residents of BPCH are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and federal statutory rights. In particular, BPCH residents are not being provided with adequate medical and nursing care, are not being protected from harm, are being subjected to excessive physical restraint, are not being provided adequate nutrition, and live in an unsanitary and otherwise unsafe environment. These deficiencies subject residents at BPCH to harm and risk of harm in violation of their constitutional rights. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). In addition, BPCH may fail to provide services to its residents in the most integrated setting, as required by the integration regulations promulgated pursuant to Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., 28 C.F.R. § 35.130(d). Moreover, because children live in the facility, we will be examining whether they are receiving services in accordance with the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400 et seq.

We received our information from a variety of sources, including State survey reports for the Health Care Financing Administration ("HCFA"), interviews with and documents provided by local attorneys, newspaper articles, and a discussion with the Deputy Chief of the Civil Division in the United States Attorney's Office for the District of New Jersey.

Background

BPCH has a long history of providing inadequate care despite serious sanctions for the facility's deficiencies that various State and Federal agencies have imposed or threatened to impose over the years. In 1995, State investigators found widespread problems and ordered the facility to halt admissions to the long-term care unit.1/ Three years earlier, in 1992, BPCH was threatened with the loss of $24 million in Federal funds after State investigators found similar problems with care and recordkeeping.

This year, the New Jersey Department of Health ("DoH") recommended the facility be fined $112,000 because of the serious deficiencies in care at the facility. The DoH also threatened to halt admissions to the nursing care wing of the hospital because health care inspectors found residents being neglected and treated in unsanitary conditions.2/

Following a March 1996 inspection, a DoH official was quoted as saying the inspection findings were "a stark and graphic reminder of what happens when health care workers let standards slip."3/ The same official was quoted as saying that most of the problems "arose when staff members did not follow procedures or ignored the special needs of specific patients."4/ Specifically, DoH inspectors found that BPCH had failed to monitor and treat residents' dietary problems; to detect and treat bedsores; to diagnose and treat fractures and lesions in a timely manner; and to develop suitable care plans based on the special needs of individual residents.5/

Factual Allegations

I. BPCH fails to meet residents' basic care needs and to provide adequate medical and nursing care.

State surveyors have documented repeated instances of BPCH's failure to meet residents' most basic human and health care

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1/ The Record, Northern New Jersey, June 11, 1996, at p. 1.

2/ The Record, Northern New Jersey, April 18, 1996, at p. A1.

3/ Id.

4/ Id.

5/ Id.

needs. This neglect has resulted in serious harm to BPCH residents. For example, in March of this year, surveyors documented that an elderly resident was found:

> "in need of grooming, her hair oily, nails dark and soiled, and an odor [was] detected in the room. The patient was in a plastic diaper, wet with urine and soiled with feces... [and had] multiple open lesions with bright red blood dripping."6/

During the same survey in March, HCFA surveyors observed a nurse removing a bandage from open, bleeding lesions on a patient's buttock without gloves. The nurse then handled medical materials on a cart that were to be used for treating other patients, thereby risking serious spread of infection among patients.7/ This situation highlights not only deficient care of residents; it also presents dangerous infection control practices. Such health hazards are not new to BPCH. In 1995, surveyors concluded that nursing practices placed residents at serious risk of cross-contamination. One of the many incidents the surveyors cited to support their conclusion was a nurse who reused a medical instrument immediately after it had touched the drainage of another patient's wound.8/

HCFA surveyors have documented other serious infection control problems at BPCH. For example, HCFA surveyors observed an aide gathering linens soiled with feces and then handing a patient a straw for a drink without first washing her hands.9/ A staff member was also seen "picking up garbage off the floor with her bare hands."10/ She then "touched residents' plates and handled bread," without first washing her hands.11/ These incidents document BPCH's failure to implement infection control procedures necessary to prevent the spread of disease among residents. As a result of BPCH's failure to follow basic infection control procedures while dressing patients' wounds, disposing of human secretions and excrement, and feeding residents, staff expose residents to constant risk of cross-infection and disease.

6/ The Record, Northern New Jersey, April 18, 1996, at p. A1 citing HCFA survey report, March 8, 1996, p. 13.

7/ HCFA survey report, March 8, 1996, pp. 20-21.

8/ HCFA survey report, February 3, 1995, at p. 39.

9/ Id. at 22.

10/ Id.

11/ Id.

Several residents have developed pressure sores at BPCH as a result of substandard medical care. This has been an issue at BPCH for a long time.12/ For example, the pressure sores of one paraplegic resident were not "discovered" until this March, when they had already advanced to a serious state -- "stage III 2 x 1.5 cm with drainage and foul smelling odor."13/ In February 1996, a nurse failed to treat another resident's pressure sore, claiming that she was "unable to see the heel due to cast in place."14/ According to the resident, the unit nurses, and the physical therapist, the heel had never been covered by a cast. Although an orthopedic consultant noted the beginnings of a small ulcer on the resident's heel, BPCH staff failed to treat it until one month later when it had progressed to a serious decubitus ulcer covering the resident's entire heel.15/ A HCFA inspection released in June 1996 continued to find problems in resident care, including pervasive bed-sores, that HCFA surveys concluded were preventable and improperly treated once detected.16/

BPCH residents also often have to wait for days or weeks to receive treatment for skin tears, fractures, or other injuries. On several occasions during the January 1996 inspection, HCFA surveyors had to call nurses' attention to cuts, scrapes, and bruises which had not been treated.17/ The majority of BPCH's nursing home residents are cognitively impaired and rely completely on BPCH staff to diagnose and treat their injuries and other medical problems.

Staff have even failed to respond to residents' calls for help. For example, during their February 1995 inspection, HCFA surveyors saw an aide ignoring a newly admitted blind resident, who was lying in bed calling for assistance. When questioned why she was not assisting the resident, "[t]he aide stated, 'I don't usually work on this unit so I don't know the resident.'"18/ The surveyors observed that other residents received no response to their calls for help, and at least one

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12/ HCFA survey report, February 3, 1995, at pp. 37-38.

13/ HCFA survey report, March 8, 1996, at pp. 17-18.

14/ HCFA survey report, March 8, 1996, at p. 16.

15/ Id.

16/ The Record, Northern New Jersey, June 11, 1996, at p. 1.

17/ See, e.g., HCFA survey report, January 9, 1996, at pp. 15-17.

18/ HCFA survey report, February 3, 1995, at p. 14.

resident could not access his call button because of his disability.19/

BPCH's repeated failures to meet residents' basic care needs and to provide minimally adequate medical and nursing care have caused both mental deterioration and serious physical harm to residents in violation of their constitutional rights to receive adequate care.

II. BPCH fails to protect patients from harm.

During the past several years, New Jersey State surveyors have investigated and found repeated instances where BPCH has failed to protect its residents from undue risks of harm. For example, in 1995, the State DoH assessed fines against BPCH, citing lapses in care that contributed to the hanging death of a 13-year-old girl and the suicide of a 47-year-old man.20/ According to the state DoH report, BPCH failed to implement a one-on-one program designed to ensure the girl's safety.21/ In a DoH letter to the facility, officials said probes into the deaths of the two psychiatric patients revealed multiple violations of minimum standards of care that "represent a serious threat to the health, safety, and welfare of the patients in your facility."22/

Several months later, BPCH found numerous deficiencies in care when it investigated yet another suicide at the facility involving a 14-year-old boy who died by hanging himself. Specifically, the facility's own report concluded that BPCH:

> . . . failed to follow several state guidelines in caring for the teenager, including lapses in recordkeeping and timeliness of psychiatric evaluations, a slow response by emergency medical personnel, and failure to follow through on a doctor's order to increase [the boy's] anti-depressant, orders issued two days before the suicide.23/

The 1995 DoH inspection team found serious deficiencies in other aspects of BPCH's failure to protect residents from harm.

19/ HCFA survey report, February 3, 1995, pp. 16, 29.

20/ The Record, Northern New Jersey, December 19, 1995, at p. 1. This local newspapers also reported that, during a six-month period in 1995, three BPCH patients committed suicide.

21/ Id.

22/ Id.

23/ Id.

Early one morning in January of 1995, a cognitively impaired resident was found lying on her "right side with profusely [sic] bleeding from the mouth, [a] laceration noted on the bridge of the nose."24/ One staff member "remarked that the resident. . . 'looked like she had been hit in the face by a bat.'"25/ Those who had allegedly been caring for the resident had no idea what might have happened to her. The incident was reported to the local Long Term Care Ombudsman only after the resident's grandson intervened.26/

In October of 1994, a blind, mentally impaired female resident was sexually assaulted by a male resident.27/ The alleged aggressor was known to have verbally and physically assaulted other residents for several months. BPCH was cited for failure to make any effort to protect residents or to address the aggressor patient's behavior.28/ This incident was not reported to the Long Term Care Ombudsman as required by State regulation. In their January 1996 inspection, HCFA surveyors found that BPCH continues to fail to report injuries of unknown origin to the local Long Term Care Ombudsman for further investigation.29/

BPCH has also been the target of lawsuits resulting from the hospital's failure to protect residents from harm. In March of this year, a local attorney filed a lawsuit against the hospital accusing a BPCH doctor of sexually assaulting a mentally-impaired 25-year-old woman. The woman was an inpatient at BPCH's psychiatric unit at the time of the alleged assault.30/ In June of this year, a former patient also filed suit against BPCH alleging she was assaulted by a fellow patient and that the facility failed to provide proper patient supervision.31/ The lawsuit alleges that BPCH failed to protect the victim from

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24/ HCFA survey report, February 3, 1995, at p. 10.

25/ Id.

26/ Id.

27/ HCFA survey report, February 3, 1995, at pp. 5-6.

28/ Id. at pp. 7-8.

29/ HCFA survey report, March 8, 1996, at pp. 3-4.

30/ September 20, 1996, telephone conversation with Sheldon Liebowitz. Mr. Liebowitz is the attorney representing the victim.

31/ The Record, Northern New Jersey, June 14, 1996, at p. A16.

serious injury, even though BPCH staff were aware the alleged assailant had attacked other residents.32/

Clearly, BPCH's failure to supervise residents, to address problem behaviors, to report and investigate serious injuries, and to prevent untoward incidents results in significant harm and violates residents' constitutional right to live in a safe environment.

III. BPCH subjects residents to the undue and improper use of physical restraints.

BPCH's excessive use of restraints has also been an on-going problem. HCFA surveys from 1996 and 1995 document that BPCH has excessively and improperly restrained residents.33/ A follow-up DoH inspection in June of this year revealed that some patients continue to be "unnecessarily restrained."34/ The following examples from recent HCFA surveys are typical:

> One resident was constantly slipping out of his wheelchair because his wheelchair seat pad did not fit properly. An occupational therapist had recommended a new seat pad for the resident six months earlier, but none was provided. Rather than replacing the ill-fitting seat pad, BPCH staff strapped the resident down in a seat belt to prevent him from falling. Because of BPCH's failure to implement its own care plan, the resident "remained sitting slumped down in a wheelchair with an egg-crate cushion and a seat belt in place."35/
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> Another resident was observed sitting at a chair with a locked table top during a music activity. Staff told HCFA surveyors that it was more convenient to leave the resident's lap-tray on, "because the chair is too big and too high to fit under the table."36/
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> A third resident was observed wearing mittens at all times during the April 1996 survey. Nurses told investigators that the restraints were necessary to

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32/ Id.

33/ See, e.g., HCFA survey report, February 3, 1995, at pp. 1-6.

34/ The Record, Northern New Jersey, June 11, 1996, at p. 1.

35/ HCFA survey report, January 9, 1996, at pp. 5-6.

36/ HCFA survey report, April 30, 1996, at pp. 3-4.

prevent the woman from pulling out her tubes. However, the doctor's note indicated, and the resident's husband and several nurses aides confirmed, that the woman only needed restraints at night. Surveyors found no evidence that BPCH had made any effort to formulate an appropriate plan of care for this woman.37/

Out of neglect or for convenience of staff, BPCH has continuously relied on the excessive use of restraining devices rather than developing more appropriate, less restrictive means of caring for its residents. As a result, BPCH's residents have long been and continue to be unnecessarily deprived of their independence and basic constitutional rights.

IV. BPCH fails to monitor and treat residents' dietary and nutrition problems.

In both 1995 and 1996, HCFA surveyors found that BPCH failed to address its residents' special dietary needs. As a result, several residents lost large amounts of weight at alarmingly rapid rates.38/

During the January 1996 HCFA survey, for example, a cognitively impaired resident was observed on three different days sitting alone without touching her food. Although a three-month-old dietician's note indicated that the resident needed to be fed, BPCH failed to implement an adequate care plan.39/ This resident lost 12 pounds in less than two months.40/

Another resident with contractures and tremors of both hands was not given special weighted eating utensils during mealtimes as ordered by an occupational therapist. The resident "had to try several times before he could get a fork full of food" and was about to give up on his meal when the surveyor intervened and summoned staff to assist him.41/ Although the resident's care plan documented his difficulty eating, the resident told surveyors that he had not had feeding devices for some time. As

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37/ Id.

38/ HCFA survey report, January 9, 1996, at p. 4.

39/ HCFA survey report, January 9, 1996, at p. 5.

40/ Id.

41/ HCFA survey report, January 9, 1996, at p. 7.

a result of BPCH's inadequate care, he was denied the opportunity "to improve and maintain his independence in eating."42/

In March of this year, HCFA surveyors found that BPCH had not corrected this problem and continues to ignore the special dietary needs of its residents. One tube-fed resident was severely undernourished. As a consequence, her wounds were not healing properly. BPCH staff disregarded a three-week-old dietician's note indicating that the resident's daily protein and fluid needs were not being met.43/ Another resident with a poor appetite "showed a steady weight loss."44/ Despite a note indicating a "need for encouragement and direction at meals," the assessment team made no effort to develop an effective plan of care to implement this recommendation and the resident continued to lose weight.45/

BPCH's failure to assess and meet the nutritional needs of its residents is chronic. In 1995, a resident's weight dropped to seventy-two pounds. Although a gastronomy tube was inserted, State surveyors found that BPCH staff did not document her meals and supplemental feeding, did not re-evaluate her intake "in light of increased digoxin levels which can cause anorexia," and did not develop an interdisciplinary plan of care to adequately address her nutritional needs.46/ Another resident lost fifteen pounds in one month. State surveyors concluded that the one-and-a-half year-old care plan, recommending that the resident "will gain one pound per month," was obviously ineffective and inappropriate.47/ In 1995, a resident with a swallowing disorder did not receive thickened liquids as recommended by the dietician.48/ In January of this year, DoH surveyors also found staff feeding dangerously hot food to cognitively impaired residents, thereby posing a serious risk of scalding or burning the residents.49/

42/ Id. at p. 6.

43/ HCFA survey report, March 8, 1996, at p. 19.

44/ HCFA survey report, March 8, 1996, at p. 7.

45/ Id.

46/ HCFA survey report, February 3, 1995, at pp. 31-32.

47/ HCFA survey report, February 24, 1995, at pp. 3-4.

48/ HCFA survey report, February 24, 1995, at p. 4.

49/ HCFA survey report, January 9, 1996, p. 18.

As the above examples illustrate, BPCH has repeatedly failed to ensure that its residents receive adequate nourishment. Consequently, several BPCH residents have suffered weight loss and diminished capacity to eat independently.

V. BPCH subjects residents to an unsanitary and unsafe physical environment.

BPCH has been cited numerous times in past years by HCFA surveyors for sanitation problems and safety hazards.

The 1994 HCFA survey of BPCH reflected widespread sanitation problems in the BPCH kitchen and food storage areas.50/ For example, surveyors noted that:

-- meat and dairy products were stored and served at unsafe temperatures;51/

-- cupboards and refrigerators were "soiled with dried up food substances" and "covered with patches of mildew;"52/

-- in one refrigerator, "[t]wo plastic containers were noted on the floor underneath the food racks with foul-smelling, brown-colored liquid;"53/

-- staff was sweeping and toxic cleaning supplies were stored in the same area that foods were being prepared;54/

-- a room where food preparation equipment was cleaned was noted to have a "heavy, foul-smelling odor";"55/ and

-- "[s]everal dead and live brown insects were noted in the dry storage room and on the floor in the cook's area."56/

BPCH has also been cited for fire code violations for the past two years. In 1995, surveyors watched as staff members

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50/ HCFA survey report, January 13, 1994.

51/ Id. at 1-4.

52/ Id.

53/ Id.

54/ Id. at 6.

55/ Id.

56/ Id. at 6-7.

ignored a sounded fire alarm.57/ In March of this year, HCFA surveyors were concerned about the presence of wooden child safety gates that prevented residents from exiting in the event of a fire.58/ Moreover, smoke detectors were not functioning,59/ sprinklers were not in place,60/ and cigarette butts were found carelessly tossed on the floor, in non-ventilated, non-smoking areas.61/ BPCH's failure to observe fire safety regulations poses a particular threat to BPCH nursing home residents, the majority of whom are mentally and/or physically impaired.

VI. BPCH's compliance with the ADA and IDEA should be evaluated as part of the investigation.

Bergen Pines County Hospital serves individuals who are elderly as well as non-elderly individuals with chronic care needs. It is very likely that some of the residents could be more appropriately served with attendant care services in their own homes or in other community services. If, in fact, BPCH is failing to make this determination and thereby failing to ensure that BPCH is serving qualified disabled individuals in the most integrated setting appropriate to their needs, the county would be violating the ADA's prohibition of disability-based discrimination. 28 C.F.R. § 35.130(d) (ADA integration regulation); Helen L. v. DiDario, 46 F.3d 325 (3d Cir.), cert. denied, ___ U.S. ___, 116 S. Ct. 64 (1995). Given the many other failings occurring at BPCH, we believe it necessary to review BPCH's practices in this area to ensure that residents are not being unduly exposed to these dangerous institutional conditions if residents could be better served in an alternative setting. Moreover, because of the presence of children at the facility and the recent hanging suicides of both a 13-year-old girl and 14-year-old boy, we will evaluate whether children at the facility are receiving services required by IDEA.

Conclusion

The allegations presented above clearly demonstrate that BPCH residents suffer injury and harm as a result of numerous deficiencies in care and treatment at BPCH. In light of the information presented here documenting the constitutional and

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57/ HCFA survey report, February 24, 1995, pp. 12-13.

58/ HCFA survey report, March 8, 1996, p. 2.

59/ HCFA survey report, March 8, 1996, pp. 6-7.

60/ Id. at 7.

61/ Id. at 8-9.

potential federal statutory violations of the rights of the residents, we recommend the Department initiate an investigation pursuant to its authority under the CRIPA into BPCH. This proposed investigation is consistent with the Special Litigation Section's initiative to focus on nursing homes with seriously deficient conditions that violate residents' fundamental rights. The United States Attorney's Office for the District of New Jersey has been apprised of this recommendation and has offered its support in the investigation. In fact, the Deputy Chief of the Civil Division of the U.S. Attorney's Office resides in Bergen County and told us she has heard of "bad things" happening at BPCH, including the above-noted suicides. She said she was "glad" the Department would be investigating conditions at the facility.

Attachments

Approved: JL for DCP. 12/19/96

Disapproved: _____

Comments: