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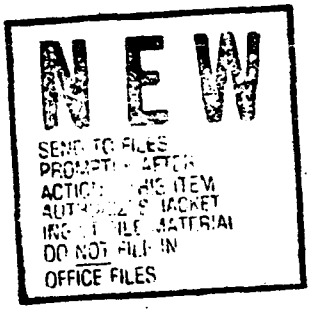

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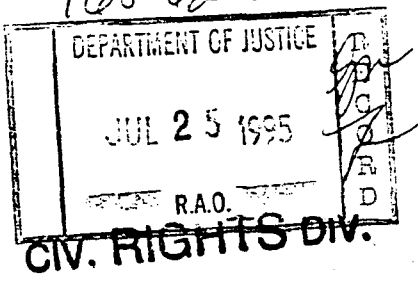

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CRIPA Investigation

NH-PA-004-001

U.S. Department of Justice

United States Attorney

Eastern District of Pennsylvania

DRH:kjh
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Philadelphia, Pennsylvania 19106

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July 20, 1995

Via Federal Express
Richard J. Farano
Trial Attorney
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
10th & Pennsylvania Avenue, N.W.
Washington, DC 20530

RE: Philadelphia Nursing Home

Dear Mr. Farano:

Enclosed please find the Memo to Deval L. Patrick regarding Philadelphia Nursing Home. If you need anything further, please feel free to contact me.

Very truly yours,

MICHAEL R. STILES
United States Attorney

DAVID R. HOFFMAN
Assistant United States Attorney

Enclosure

U.S. Department of Justice
United States Attorney
Eastern District of Pennsylvania

615 Chestnut Street
Suite 1250
Philadelphia, Pennsylvania 19106-4476
(215) 451-5200

July 20, 1995

MEMO TO: DEVAL L. PATRICK
ASSISTANT ATTORNEY GENERAL
CIVIL RIGHTS DIVISION

FROM: JAMES G. SHEEHAN
ASSISTANT UNITED STATES ATTORNEY
CHIEF, CIVIL DIVISION

DAVID R. HOFFMAN
ASSISTANT UNITED STATES ATTORNEY

RE: PHILADELPHIA NURSING HOME

I am writing to request the immediate intervention of the Department of Justice in the Philadelphia Nursing Home (PNH), Girard and Corinthian Streets, Philadelphia, Pennsylvania. An investigation by the Department into the conditions at PNH, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., is necessitated by recent findings at the facility as well as concerns raised by advocates of those residing in the facility. PNH is a city-owned facility which has delegated managerial functions to Episcopal Long Term Care, a subsidiary of Episcopal Hospital. There are approximately 360 individuals currently residing at PNH.

BACKGROUND

PNH is the only city-owned nursing facility in the City of Philadelphia. PNH has a population mix of elderly, developmentally disabled, HIV/AIDS patients, accident victims and those suffering from mental impairments. The residents range in ages from 21 to over 90 years of age.

From July 1994 until December 1994, the census increased by 150 residents, to over 480. There are, however, only 2 attending physicians to care for the entire resident population with the exception of one other physicians who is treating only one resident.

A survey of the facility was performed on the following dates; June 1-2, 5-16. On June 13, 1995, the Commonwealth of Pennsylvania Department of Health found that there is a "serious and immediate threat to residents." On July 14, 1995, the Health Care Financing Administration, based upon a revisit by the state's Department of Health found that the immediate threat to resident health and safety had been removed but that 9 level A deficiencies remained. These deficiencies involved Quality of Care, Quality of Life, Nursing Services, Dietary Services, Infection Control, Resident Behavior and Facility Practices of the nursing home.

As a result of the survey, the census at PNH dropped to approximately 360 residents from over 480. Based upon information supplied by the Long-Term Care Ombudsman Program, it is estimated that approximately **100** residents of PNH were transferred to local hospitals from PNH based upon their medical condition as discovered by the Department of Health surveyors.

THE JUNE SURVEY RESULTS

The nursing home survey conducted in June found multiple serious deficiencies including, but not limited to:

Resident to Resident Abuse:

(a) The rape of a 89 year old resident;
(b) The infliction of cigarette burns on two residents;
(c) An elderly diabetic resident was hit in the face and eye.

Even more disturbing was the fact that there were no reports filed by the facility nor was there any intervention by the facility in any of these cases.

Quality of Care:

(a) Residents with decubitus ulcers were not identified by staff, i.e., 14 out of 29 targeted residents had Stage II decubitus ulcers found by the surveyors that were never noted by the facility;

(b) One resident, who was critically ill, was observed lying in bed on his right side without being turned and repositioned

for almost three hours. Additionally, pressure relieving devices between the resident's knees and legs were not provided. The resident was also incontinent of bowel, had not been bathed and a strong body odor was present. Within a two week period, the resident had developed four Stage II decubitus ulcers;

(c) Reports of pressure sores were incomplete or inaccurate so proper tracking and cause of pressure sores advancing from the Stage II to the Stage IV level was impossible;

(d) One resident had abnormal laboratory values evidencing acute renal failure that was never communicated to physician. Upon learning of the lab values, the resident was immediately hospitalized;

(e) Residents are at nutritional risk. One resident had an unexplained loss of weight of over thirty (30) pounds in less than three months while another resident lost over 21 pounds in 2 months. Additionally, one resident did not have food served even though the resident was in the restorative feeding program. This resident has bilateral gangrene of the lower extremities, at least 5 decubitus ulcers on both legs, including 4 Stage IV pressure sores. Protein and food consumption, critical elements in good wound healing, were unable to be reviewed since the documents were inaccurate and missing information;

(f) The nursing staff failed to turn and reposition residents, provide incontinence care, and release residents from restraints in a timely fashion.

Quality of Life:

Residents throughout the facility were observed with genitals, buttocks, thighs and backs exposed to other residents, staff and visitors.

Residents wore soiled and torn clothing.

Residents were not regularly bathed.

CONTINUING NATURE OF DEFICIENCIES:

The survey noted that "all deficiencies cited during the July 18, 1994, Medicare, Medicaid and State Licensure Survey remained in noncompliance on this survey."

Additionally, as of July 14, 1994, <u>all</u> Level A deficiencies remained after the facility was re-surveyed in July.

JULY MEETING WITH ADVOCATES

On July 18, 1995, a meeting was held at the U.S. Attorney's Office in Philadelphia, Pennsylvania that included representatives from advocacy groups for the elderly (Long-Term Care Ombudsman Program), developmentally disabled, and AIDS patients. The meeting was convened to gather information as to the day-to-day occurrences at PNH and the attempts made by the advocacy community to rectify the conditions at PNH. All of the representatives found the conditions at PNH to be inadequate, appalling and also emphasized that staff at PNH was overwhelmed.

In addition to the survey findings, a summary of the information supplied at the meeting evidenced the fact that:

(a) residents are being discharged to the community in a septic condition and that their discharge planning "almost killed a few people";

(b) residents are not receiving physical or occupational therapy and physician consultations are simply not occurring thereby jeopardizing residents' health;

(c) staff was unaware of psychiatric and/or psychological histories of residents thereby offering no proper treatment and endangering other residents;

(d) the vast majority of staff was temporary in nature thereby creating a lack of familiarity with resident needs and conditions;

(e) the nursing home administrator was extremely difficult to reach with complaints and was, in fact, non-responsive;

(f) the physicians responsible for the provisions of care do not know what is going on with the residents' medical conditions and therefore, proper medical care is not being provided;

(g) the food at PNH is inedible based on taste, preparation and delivery and as such, residents are at nutritional risk as evidenced by the survey results.

CONCLUSION

Based upon the information compiled to date, it is apparent that the inadequate provision of quality care to the residents of PNH necessitates an investigation by the Office of Civil Rights pursuant to the authority under CRIPA. I offer my continued assistance in attempting to rectify the intolerable conditions at PNH. The United States Attorney for the Eastern District of Pennsylvania has been apprised of the circumstances surrounding this request.