Memorandum

DLP:AEP:RF:VH:EMS:cmw
DJ 168-70-25

Subject	Date
Recommendation to Investigate Hamilton County Nursing Home Chattanooga, Tennessee	September 13, 1996

To	From
Deval L. Patrick Assistant Attorney General Civil Rights Division	Arthur E. Peabody, Jr. Chief Special Litigation Section

We recommend that the Department initiate an investigation into the conditions of resident care and treatment at the Hamilton County Nursing Home ("HCNH") in Chattanooga, Tennessee, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. HCNH is a 676-bed nursing home operated on behalf of Hamilton County, Tennessee.1/ The information we have obtained indicates that residents of HCNH are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. In particular, HCNH residents are not being provided with adequate medical and nursing care, are not receiving adequate treatment of their behavioral problems, are subject to excessive physical restraint, are not protected from harm, and live in unsanitary conditions. These deficiencies subject residents at HCNH to harm and risk of harm in violation of their constitutional rights. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). In addition, HCNH fails to provide services to its residents in the most integrated setting, as required by the integration regulations promulgated pursuant to Tile II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., 28 C.F.R. § 35.130(d).

We have obtained information regarding HCNH from a variety of sources including: survey reports prepared by the Health Care Financing Administration ("HCFA"); interviews with several local contacts, among them an attorney with Southeast Tennessee Legal Services and the current and former local Long-Term Care Ombudsmen of Tennessee; along with newspaper articles relating to a Hamilton County Grand Jury probe of HCNH. The Grand Jury found

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1/ By State statute, operation of HCNH has been given to a seven member Board of Trustees that is appointed by the Hamilton County Commissioners. Hamilton County also pays for the operation of HCNH. As such, it meets the definition of a publicly operated facility under CRIPA.

conditions at HCNH to be "deplorable" and recommended that certain units at HCNH be closed.

Background

HCNH is the only government operated nursing home in Hamilton County and provides 85 percent of the Medicaid beds in the area.2/ The 676-bed facility is divided into two units. There is a 530-bed intermediate care unit and a 146-bed skilled care unit for residents who need more intense medical and nursing care.

Two of our sources, the former Long Term Care Ombudsman of Hamilton County and an attorney with Southeast Tennessee Legal Services, told us that many residents of HCNH and their relatives are afraid to speak out about conditions at HCNH for fear of staff retaliation.3/ The Legal Services attorney told us that HCNH has such a bad reputation in the local community for providing inadequate care that many of the elderly live "in fear" of ever having to move to HCNH.4/

Factual Allegations

I. HCNH residents are being subjected to the excessive and inappropriate use of physical restraints.

HCNH has been cited numerous times in recent years by HCFA surveyors for subjecting residents to undue bodily restraint as well as using inappropriate restraint devices, such as tying residents in their bedsheets.5/ The local Long Term Care Ombudsman also told us she has observed the improper use of restraints at HCNH.6/

Specifically, HCFA surveyors observed several situations where residents were kept in restraints for excessive periods of

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2/ HCFA report, July 15, 1996.

3/ Telephone interviews with Paula Faustus, a former Long Term Care Ombudsman, July 22, 1996 ("Faustus interview") and Lynn Dechman, an attorney with Southeast Tennessee Legal Services, July 11, 1996 ("Dechman interview").

4/ Dechman interview.

5/ HCFA survey report, August 23, 1993, p. 3; HCFA survey report, November 22, 1995, p. 8.

6/ Telephone interview with Long Term Care Ombudsman Kelly Drayer, July 15, 1996 ("Drayer interview").

time.7/ Residents were also observed by surveyors in restraint devices other than those prescribed by their physicians. Residents were observed restrained with bed sheets when they had specific orders for less restrictive types of restraints. Another resident was observed restrained with her hands tied to a bed with a bed sheet even though she had a physician's order to be up out of bed in a chair with adequate safety precautions.8/ One resident was observed restrained with a bed sheet in her chair for two separate days of the survey. Two other residents were observed restrained for almost three and a half hours and were only released when surveyors intervened.9/ HCFA also found that HCNH failed to evaluate the effectiveness of the prescribed restraint and to try less-restrictive alternatives.10/

Currently 378 of HCNH's residents (61.2 percent) are being physically restrained. Of these, only 152 came to the facility with orders to be restrained.11/

The local Long Term Care Ombudsman recently visited the facility to respond to a complaint regarding the misuse of restraints.12/ Specifically, she received a complaint from the Department of Health Services that a woman was being unduly restrained in her gerichair. The Ombudsman visited the woman and did, in fact, find her restrained in the chair by the tray table that was to be used only during meal times. The Ombudsman observed the woman restrained in her chair for the duration of her more than two hour visit. These and other documented incidents of restraint indicate that HCNH residents are being restrained in ways that do not comport with professional standards in violation of their Fourteenth Amendment Rights.

II. HCNH residents are being subjected to inadequate medical and nursing care resulting in actual physical harm.

We have gathered information from several independent sources alleging widespread substandard medical care at HCNH that is detrimental and harmful to residents. Specifically, HCNH is failing to: adequately treat decubitus ulcers; to diagnose

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7/ HCFA survey report, November 22, 1995, pps. 8 - 9.

8/ HCFA survey report, November 22, 1995. pps. 8 - 9.

9/ HCFA survey report, August 26, 1993. p. 3.

10/ HCFA survey report, November 22, 1995, at pps. 8 - 9.

11/ HCFA report, July 15, 1996.

12/ Drayer interview.

fractures in a timely manner; to develop comprehensive care plans that adequately identify and address residents' needs; and to adequately evaluate residents' need for assisted living devices.

A. HCNH fails to provide adequate care of decubitus ulcers.

The supervisor of Adult Protective Services in Chattanooga told us that HCNH fails to provide its residents with adequate nursing care, which has lead to numerous residents developing decubitus ulcers (bedsores). This failure has been so egregious that residents have been required to have limbs amputated.13/ HCNH has an extensive history of inadequately treating bedsores that dates back several years, including a well-publicized case in 1989 involving a man who developed ulcers the size of "salad plates."14/

A local attorney told us about the 1989 case that involved a resident who was placed in HCNH after having a severe stroke. It was determined that he had little or no skin breakdown problems at time of admission. However, within 30 days of being admitted to HCNH he was taken to a local hospital and was declared "within an hour of death." He had bed sores the size of salad plates that went down to the bone over his body with the worst on his hips. He was also malnourished and had anemia.15/ In a court proceeding resulting from this incident, the attorney representing HCNH admitted to the Court that other HCNH residents suffered from bedsores. Soon thereafter, nine residents were admitted to the hospital from HCNH for treatment of decubitus ulcers ranging from minor to severe.16/ As a result of the case, the facility's medicaid admissions were temporarily suspended.17/

13/ Telephone interview with Bobbie Tyler, Supervisor of Adult Protective Services, Chattanooga, Tennessee, July 15, 1996 ("Tyler interview").

14/ Telephone interviews with Glenna Ramer, Chattanooga, Tennessee, July 15, 1996 ("Ramer interview"). Ms. Ramer was the attorney who brought the suit against HCNH and two of its attending physicians on behalf of the family of the resident involved.

15/ Ramer interview.

16/ Tyler interview.

17/ Telephone interview with Rita Bollinger, Public Health Regional Regulatory Program Manager, July 16, 1996.

In a draft letter to the Chairman of the Hamilton County Commission in 1989, the Supervisor of Adult Protective Services wrote: "the team is continually confronted (emphasis added) with alleged neglect of the elderly residents at Hamilton County Nursing Home especially the 'Skilled Care Unit.' The following concerns are the most prevalent [sic] (1) Severe decubitus ulcers 3cm at stage 3...."18/ The letter also identified this as a problem that has been widespread since 1987.

We have received information that inadequate care at HCNH continues to cause bedsores in residents and, once they occur, HCNH does not treat them properly. For example, the Adult Protective Services Supervisor also told us while HCNH did improve conditions for a short time after the 1989 case, she felt that they soon began to deteriorate and she still sees residents with bedsores that are not being adequately treated.19/ As recently as July 1996, HCFA reported that almost all of the residents with decubitus ulcers had developed them while at HCNH.20/

B. HCNH fails to diagnose and treat fractures in a timely manner.

HCFA has documented in its surveys, including the most recent survey, that fractures and other injuries to HCNH residents have not been diagnosed in a timely manner.21/ The supervisor of Adult Protective Services also identified HCNH's failure to diagnose and treat fractures as an area of concern, telling us that in some cases, residents do not receive treatment until family members intervene.22/ Unfortunately, many residents of HCNH are without immediate family to advocate on their behalf and, as a result, those residents may suffer further delays in getting medical treatment.23/

18/ Draft letter from Clara Sawyer and Bobbie Tyler (Supervisor of Adult Protective Services), representatives of the Adult Protective Services Multi-Disciplinary Team to Attorney Rheubin McG. Taylor, Chairman of the Hamilton County Commission, August 15, 1989.

19/ Tyler interview.

20/ HCFA report, July 15, 1996.

21/ HCFA survey report, November 22, 1995.

22/ Tyler interview.

23/ Id.

For example, on September 27, 1995, a female resident was found lying on her back with wounds and skin tears.24/ She was treated for a broken left arm. Subsequently, however, she began to complain of pain in her back, chest and right arm. HCNH's only response to her complaints was to increase her level of Ativan. On October 17, 1995, at the request of a nursing supervisor, she was finally X-rayed and found to have three broken ribs. HCFA also documented the case of another resident who, although he had an order for a vest restraint at all times, was found on the floor with wounds. He had sustained a hip fracture that went undiagnosed for two days.25/

Further, HCFA also identified the case of a resident whose only treatment after sustaining a hip fracture was to be placed on bedrest.26/ After being confined to her bed, she continued to be in distress, yelling for "help" and complaining of pain. Due to a lack of communication between the orthopedist and staff, staff were unsure how to address the resident's condition or complaints. HCNH's only response to the resident's distress was to increase her psychotropic medication. Further, HCFA surveyors noted that while the resident was on bedrest she developed a pressure sore on her coccyx, suffered a decrease in appetite, developed a urinary tract infection that was not adequately treated, and became dependent upon staff for her feeding.27/

C. HCNH fails to meet residents' nutritional needs and uses invasive medical techniques inappropriately.

In its 1995 and 1994 surveys, HCFA also identified that HCNH was not adequately addressing residents' nutritional needs. There were numerous cases of residents with these nutritional needs that were not being addressed or even noted on the care plan.28/ For example, one resident had a 17 percent weight loss over a six month period and was being evaluated for invasive G-tube placement for feeding without any input from the nutritional department.29/ HCFA also identified other

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24/ HCFA survey report, November 22, 1995, p. 12.

25/ Id. p. 12

26/ HCFA survey report, October 31, 1994. p. 9.

27/ Id.

28/ HCFA survey report, October 31, 1994, p. 7

29/ Id.

situations where residents' care plans did not reflect significant changes in residents' conditions.30/

The Adult Protective Services Supervisor told us that she believes that HCNH fails to adequately explore less-intrusive alternatives before the facility makes major health care decisions regarding residents.31/ For example, she told us that so far this year, her office has received a large number of requests from Hamilton County for permission to insert G-tubes into HCNH residents. According to the Adult Protective Services Supervisor, this is reflective of HCNH's over-reliance on such devices without first exploring less invasive alternative methods.

HCNH has also been cited for using medical devices such as Foley catheters inappropriately. In the 1994 HCFA survey, a resident was admitted with a stage II pressure sore on her right buttock, but could ambulate with the help of two staff members.32/ She was placed on bed rest and given a Foley catheter to allow the ulcer to heal. This is not a prescribed use of a Foley catheter.33/ In 1993, HCFA found that none of the HCNH residents with Foley catheters were adequately assessed for the use of these catheters.34/

III. HCNH fails to provide appropriate and adequate treatment for residents who have behavior problems.

For several years, HCFA has cited HCNH for failing to provide comprehensive care plans for its residents. This deficiency has been particularly true for residents with behavioral problems who need psychological services.35/ For example, HCNH has identified 228 residents (36.9 percent of its population) as having behavioral disorders. According to HCFA data, this is twice the national average for a nursing home.36/ However, not even half of these residents who have

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30/ HCFA survey report, November 22, 1995, p. 23

31/ Telephone conversation with Bobbie Tyler, Supervisor Adult Protective Services, July 15, 1996.

32/ HCFA survey report, October 31, 1994, p. 9.

33/ Id.

34/ HCFA survey report, October 15, 1993. p. 6.

35/ HCFA survey reports August 26, 1993; October 31, 1994; November 22, 1995.

36/ HCFA report, July 15, 1996.

been identified as requiring behavioral treatment are receiving it.37/

The failure to provide behavior management programs has compromised the safety of other residents. For example, during its most recent survey, HCFA found HCNH deficient in identifying residents that display aggressive or injurious behavior towards other residents and developing programs to abate these behaviors and protect the victims.38/ One resident had documentation in his nurses' notes of daily yelling and frequent episodes of combative behavior, but there was no behavior plan in place to address this or even a notation on the care plan that this behavior existed.39/

In another example, HCFA surveyors identified a male resident who displayed sexually inappropriate behavior towards several female residents.40/ Even though HCNH identified the problem behavior, the facility failed to take any constructive action to address this man's behavior problem. He had no care plan in place that the HCFA surveyors could identify even though he was still displaying behaviors dangerous to the other residents.41/

HCNH also fails to effectively implement those care plans it does have in place to address dangerous resident behaviors. Even though HCFA noted a male resident with a care plan to address his wandering behavior into female residents' rooms, HCNH staff failed to consistently implement these interventions. Residents reported to the surveyors that the behavior problem continued to be especially problematic at night when he would wander into the females' rooms displaying threatening or vulgar behavior.42/

The former Ombudsman told us "that no one wanted to go to the building" that housed mentally ill residents because people "pull on you and grab at you," referring again to HCNH's failure

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37/ Id.

38/ HCFA survey report, November 22, 1995, p. 22.

39/ Id.

40/ HCFA survey report, October 31, 1994, p. 11.

41/ Id.

42/ Id.

to provide adequate management and care to people with severe behavioral problems.43/

In October 1995, the former Ombudsman received a call regarding a resident at HCNH who was threatening other residents and was running a "scalping" operation.44/ He would steal coffee and cigarettes designated for specific residents and then sell the items to residents for whom HCNH did not provide such items. For those residents who were not allowed a lighter, he would charge them a fee to light their cigarettes. The Ombudsman felt that HCNH did not address this man's behavioral problems.

A year earlier in 1994, HCFA identified the same resident engaging in the same behavior and found HCNH deficient in providing adequate security to residents. Specifically, HCFA found that when behaviors were identified or observed by staff, there was no definite care plan in place to address those behaviors; if there was a care plan, it was not consistently administered.45/

In addition to inconsistently implemented behavior plans, HCFA surveyors noted that, in many instances, HCNH's only planned intervention for residents' behavior problems was psychoactive medications.46/ For example, HCFA surveyors found a resident who had frequent episodes of combative behavior, however there was nothing in his care plan addressing the behavior other than a psychotropic medication.47/ HCFA also found another HCNH resident who exhibited behaviors had a care plan that only called for the use of psychoactive drugs.48/ These facts, coupled with an over reliance on mechanical restraints indicate that HCNH residents are being subjected to chemical and physical restraints in lieu of less intrusive behavior management plans, in violation of their Fourteenth Amendment rights to receive appropriate treatment and to be free of unreasonable restraint.

IV. HCNH does not provide a safe physical environment for its residents and it does not provide an atmosphere that allows for basic resident dignity.

43/ Faustus interview.

44/ Faustus interview.

45/ HCFA survey report, October 31, 1994. p. 11.

46/ HCFA survey report, November 22, 1995, p. 22.

47/ Id.

48/ Id.

A. Physical Plant

HCNH continues to place its residents in danger by not properly maintaining its physical facility. In April 1995, a Hamilton County grand jury toured the facility and, without notice to HCNH officials, extended its tour into areas of HCNH other then those they previously announced.49/ According to local newspaper reports, the grand jury "discovered the facility was dirty, understaffed and shabby." It also found a resident "in a wheelchair with her hands in a large container of soiled linen, which was one of several containers which cluttered the hallway."50/ Permitting residents access to soiled linen poses serious infectious disease problems.

HCFA also identified problems with the physical plant that could ultimately be dangerous to residents. For each of the surveys in 1995, 1994, and 1993, HCFA found that HCNH was deficient in providing a safe and hazard free environment. Specifically, resident equipment, such as wheelchairs, were soiled with dirt and had food stains on the chair and foot rests. Soiled linen in the utility room was not bagged or contained as required by standard infection control procedures. Surveyors also found a dark liquid solution resembling Betadine in a plastic mouthwash bottle with its original label in an unlocked, unattended locker in the men's shower room.51/ They observed live roaches crawling on one resident's bedclothes and on another resident's breakfast tray.52/ HCFA also found bathrooms in several units that were not safe and sanitary with dirty bathtubs and broken floor tiles. Flies and live roaches were also observed in dining rooms and resident rooms.53/ The former Ombudsman, who toured the facility on a weekly basis until recently, also told us there were similar problems with the physical facility.54/ These deficiencies pose serious risks of spreading infection and disease among HCNH's residents whose health is already compromised.

49/ Article, "Shut unit of home, jury says: Intermediate nursing is called deplorable," The Chattanooga Times, Judy Frank, April 27, 1995.

50/ Id.

51/ HCFA survey report, November 22, 1995, pps. 16-26.

52/ HCFA survey report, August 26, 1993. p. 11.

53/ HCFA survey report, October 31, 1994, pps. 5, 19.

54/ Faustus interview.

B. HCNH fails to provide adequate measures to ensure resident privacy.

HCNH fails to consistently provide an environment that protects the privacy rights of its residents. HCFA has identified on numerous occasions over the past several years that residents were changed in front of their roommates. Residents were also observed walking down the hall exposed or coming to the table for a meal half-exposed.55/ Staff also do not treat residents with respect, in some cases yelling at them and frequently not knocking on doors before entering.

V. HCNH is failing to assess residents to determine whether they are being served in the most integrated setting appropriate to their needs.

Hamilton County Nursing Home serves individuals who are elderly as well as non-elderly individuals with chronic care needs. We have information that some of the residents could be more appropriately served with attendant care services in their own homes or in other community services. The nursing home, however, does not assess residents to determine whether they are being served in the most integrated setting appropriate to meet their needs. By failing to make this determination and thereby ensure that HCNH is serving qualified disabled individuals in the most integrated setting appropriate to their needs, the county is 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)

Conclusion

Hamilton County Nursing Home has been cited by HCFA for numerous deficiencies, has had its Medicaid admissions temporarily suspended, and has been the subject of criticism from numerous local sources, including the former Ombudsman, the Supervisor of Adult Protective Services, an attorney with the Southeast Tennessee Legal Services and a Hamilton County grand jury. In light of the information presented here documenting the constitutional and federal statutory violations against the residents at Hamilton County, we recommend the Department initiate an investigation pursuant to its authority under the CRIPA into HCNH. This proposed investigation is consistent with the Special Litigation Section's initiative to focus on nursing homes with seriously deficient conditions that violate residents'

55/ HCFA survey reports, October 31, 1994 and November 22, 1995.

fundamental rights. The United States Attorney's Office for the Eastern District of Tennessee has been apprised of this recommendation and has offered its support in the investigation.

Attachment

Approved: 

Disapproved: _____

Comments: