Robert D. Prunetti
County Executive
640 South Broad Street
P.O. Box 8068
Trenton, NJ 08650-0068

Re: CRIPA Investigation of Mercer County Geriatric Center

Dear Mr. Prunetti:

On December 10, 2001, we notified you that we were investigating the Mercer County Geriatric Center (MCGC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. Consistent with statutory requirements, we are now writing to advise you of our findings, supporting facts, and recommended remedial measures, pursuant to 42 U.S.C. § 1997b(a)(1).

Unfortunately, Mercer County officials declined to cooperate with this investigation. They refused to turn over any documents, allow access to the facility, or permit any on-site witness interviews. Mercer County's conduct is unusual in this regard. Most government officials cooperate with CRIPA investigations because they recognize that protecting the rights of institutionalized citizens warrants a thorough and impartial review.

We met promptly with County officials to explain the reasons for our investigation and its procedures. We then also communicated repeatedly with County officials in an effort to convince them that cooperation was in the public interest and could only improve the fact-finding process. If the County had agreed to our proposed investigation procedures, County officials would have had an early opportunity to work directly with our experts and staff. They also would have had an opportunity to address any identified problems on a voluntary basis at an early stage of this investigation. County officials declined, however, to provide even the most basic policies and procedures, access to staff, or even exculpatory documents. Most recently, County officials, through their attorney, Harry G. Parkin, interfered with our access to the residents themselves. These residents are all independent witnesses, and your counsel offered no legal basis for such an unusual act.

As we repeatedly advised you and your counsel, however, our investigations proceed regardless of whether officials choose to cooperate. Indeed, when CRIPA was enacted, lawmakers considered the possibility that local officials might not assist a federal investigation. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. We now draw such an adverse conclusion. The County's non-cooperation is, however, only one factor that we have considered in preparing our statutory findings and recommendations. We have also considered federal and state survey information, news articles, medical records, family interviews, private attorney and advocate interviews, and publicly available data.

According to our information, MCGC houses approximately 200 residents and has a 240-bed capacity. MCGC participates in both Medicare and Medicaid and provides nursing home services for an elderly population with significant medical problems. Approximately 57% of the residents are incontinent, 26% have restricted joint motion, 38% need help in eating, and 35% have behavioral symptoms.[(1)]

Under the United States Constitution and federal law, nursing home residents have a right to reasonably safe living conditions, adequate health care, restorative and rehabilitative care services, freedom from unreasonable restraints, and a treatment setting that is the most integrated and appropriate based on individual resident needs. See United States Constitution Amendments I, XIV; Youngberg v. Romeo,

457 U.S. 307 (1982); Olmstead v. L.C., 527 U.S. 582 (1999). Federal statutes governing the operation of nursing homes and their implementing regulations create similar rights. See, e.g., Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. (ADA); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. § 794 (Section 504); Grants to States for Medical Assistance Programs (Medicaid) 42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare) 42 U.S.C. § 1395i-3; 42 C.F.R. § 483 Subpart B.

Based upon our investigation, we find that Mercer County has violated the federal rights of MCGC residents.

I. MCGC residents are exposed to unsafe living conditions.

Mercer County does not maintain sanitary and safe living conditions at MCGC.

First, the facility does not maintain sanitary living conditions. Family members report finding feces on the fingernails of their relatives, unchanged diapers, a stench in living areas, and dirty sheets. On more than one occasion, state surveyors cited MCGC for failing to serve food at temperatures that are safe from food-borne pathogens. Surveyors have also noted concerns with staff hand-washing practices, disinfection techniques, tuberculosis prevention, and infection control investigations. For instance, surveyors observed improper cleaning of an incontinent resident. The surveyors noted that the resident's sacrum and buttocks were covered with feces. Staff changed a wound dressing and rinsed the area with some saline solution. They did not, however, use soap and water to disinfect. This resident had only recently been hospitalized for septic shock and dehydration. These types of problems have appeared in a number of surveys and been identified by a number of sources.

Second, the facility fails to ensure residents' personal safety. Staff have left residents, including those with mobility and mental impairments, completely unattended for long periods of time. Staff inattention in general results in serious accidents, falls and unexplained injuries. For example, one visiting family member repeatedly found her relative lying on the floor of the facility. On at least one occasion, the resident wandered out of the facility itself. From the time another resident entered the facility to the time of her discharge, she suffered from numerous falls, bone fractures, and unexplained injuries. One time, the resident was dropped on her head while being moved. How this could happen if staff had been attentive was never explained satisfactorily to the resident's relatives. In a third example, a family member used to visit at odd hours, only to find her unattended relative lying in urine, with parts of her naked body exposed. This family member also noted unexplained skin bruises.

These types of personal safety problems extend beyond mere resident neglect. MCGC also has problems with staff verbal abuse and the unexplained disappearance of residents' personal belongings. Residents' glasses, dentures, bedding, and other personal possessions reportedly disappear, and then the facility staff fail to investigate adequately or remedy the situation. Visitors have observed that staff inappropriately berate residents who rely on those staff for their daily care.

II. MCGC residents do not receive adequate medical and mental health care.

MCGC medical staff fail to assess and treat residents properly for potentially serious medical and mental health problems. When basic medical care is not provided, fragile geriatric residents often face increased risk of harm from their medical conditions and inappropriate medication practices.

For instance, during a recent inspection, surveyors reported that MCGC staff did not obtain information required to develop individualized, comprehensive treatment plans to address resident weight loss and

dehydration. Another survey found problems with treatment and prevention of bedsores. A number of sources report residents with deep, bleeding bedsores, infections, and other potentially life-threatening conditions. In a nursing home, it is essential that staff take vigorous action to prevent and treat such conditions.

MCGC's weakness in assessing and treating serious medical conditions also includes the treatment of mental health problems. Many nursing home residents have dementia, schizophrenia, and other psychiatric diagnoses. Where warranted, appropriate mental health care and review should be closely integrated into the resident's general care plan. We noted deficiencies at MCGC in the documentation and drug practices associated with treating such mental illnesses. For instance, a resident was kept on the same drug regimen for an extended period of time without adequate justification in the resident record. A state survey suggests that the facility staff fail to appreciate how resident mental health issues may act as a contributing factor to other medical problems. In one case, a resident with possible depression lost approximately 22% percent of her body weight. MCGC social services recommended a psychiatric evaluation, but the facility staff failed to respond in a timely manner. In a second case, a resident also exhibited symptoms of weight loss and depression. Yet, in both cases, MCGC staff apparently failed to follow-up on the symptoms of depression by conducting prompt, comprehensive causal assessments and appropriate professional intervention.

Inadequate medication practices contribute to problems with medical and mental health care. MCGC staff have failed to provide adequate pain medication to some residents; provided medications without adequate monitoring of their effects; and prescribed or terminated medications to residents for reasons that are not supported by resident medical data. A number of examples illustrate this problem. For instance, staff prescribed Zyprexa to one resident for restlessness, delusions, and self-injury. Yet, when asked by surveyors, staff could not explain what delusions the resident actually experienced, nor could they identify any examples of resident self-injury. If the medication was for restlessness only, that would be an inappropriate reason in this case for prescribing an anti-psychotic medication. In another example, a resident had to take medications through a gastrostomy tube. Inspectors noticed however that the medication nurse administered medications and food to this resident without properly checking that the tube was actually in place. This failure was cited as a departure from basic standards of practice. In a third example, surveyors discovered medical staff were giving a resident two different medications on a daily basis, despite a physician's order to the contrary.

III. MCGC residents are denied rehabilitation, restorative care, and freedom from unreasonable restraints.

When a facility lacks comprehensive assessment, rehabilitation, and restorative treatment programs, residents are more likely to lose their living skills. When treatment options are limited and as a resident's condition deteriorates, nursing home staff sometimes rely on inappropriate restraints as a substitute for treatment. MCGC denies residents rehabilitation and restorative care, and instead relies on inappropriate restraints.

While MCGC residents may have access to some recreational programs, the facility does not always develop the individualized restorative care and rehabilitation programs needed to maintain or improve resident functioning. For example, a resident entered the facility able to walk, eat, and use the bathroom with little or no staff assistance. Within a few days of his admission, however, MCGC staff obtained a physician's order to keep the resident in bed with side rails and a bed alarm. No assessment was made to justify the use of these measures. Even as the resident's physical condition declined, the treatment team failed to develop a plan to try to help the resident regain his former functional level. In the month after his arrival, the resident lost seventeen pounds and developed pressure sores. Shortly afterwards, the resident had to be hospitalized.

Second, staff sometimes rely on inappropriate restraints instead of providing appropriate, individualized, interdisciplinary care. Data reported by MCGC itself suggests restraint usage rates at least two times the State average. Staff routinely restrain residents while the staff engage in various tasks. For instance, one resident was frequently tied to his chair. He apparently beat on the arms of the chair so often that his arms were constantly bloodied. In addition to physical restraints, some reports indicate the inappropriate use of medication as restraints. Both physical and chemical restraints are inappropriate when they are used for the convenience of staff.

IV. MCGC mealtime assistance, nutrition, and hydration practices are not adequate.

MCGC's own data suggests that some 38% of MCGC residents are very dependent on staff for mealtime assistance. A breakdown in the facility's system for feeding residents therefore exposes large numbers of residents to serious risk of harm. While feeding issues are often complicated in a geriatric population, MCGC has failed to develop consistent and appropriate nutrition and hydration plans.

Thus, we have reports of residents losing ten percent or more of their body weight after just a month's stay in MCGC. Even as they lost such large amounts of weight, staff failed to develop appropriate intervention and feeding assistance plans. We have reports of residents who could not get a drink of water because staff failed to assist with their hydration.

MCGC administrators and staff have long been aware of deficiencies with the facility's nutrition and hydration practices. State surveyors have repeatedly advised Mercer County officials of a number of incidents. For example, there have been at least two hospitalizations identified in recent state survey reports regarding residents who suffered from dehydration and other problems. Our own review of resident deaths found signs of improper nutrition and malnourishment in some cases. Separately, one of our sources reported the case of a resident with an improperly positioned feeding tube. This resident slowly starved without adequate MCGC staff intervention.

In one particularly serious incident, staff fed a resident so quickly, she aspirated and died. Emergency room hospital physicians pumped a significant volume of food from the resident's lungs. If staff are properly trained in feeding practices and sensitive to residents' mealtime assistance needs, it is difficult to explain how such an incident could occur. This incident took place in January 2002, just weeks after we met with County officials to request their cooperation in our CRIPA investigation. County officials have continued to ignore all of our requests for information pertaining to such resident deaths.

V. MCGC residents are not treated in the most integrated setting appropriate to individual resident needs.

Under federal law, MCGC residents have the right to be treated in the most integrated setting appropriate to their individual needs. At MCGC, however, staff make little effort to identify options for providing more integrated treatment settings. When combined with a failure to develop restorative treatment programs, MCGC's failure to address the integration issue may result in the unnecessary institutionalization of some residents. Alternatively, it may result in excessively segregated treatment within a nursing home setting.

Our sources report little discussion by treatment teams regarding resident discharge issues, and the treatment meetings themselves do not include family members on a regular basis. Treatment plans also reflect the lack of an interdisciplinary approach.

When discharge and hospitalization decisions take place without adequate planning, inappropriate and

potentially dangerous situations may arise. For instance, in one case, lack of thorough discharge planning may have resulted in the premature discharge of a resident whose medical condition was still very fragile. After this resident was sent home, a visiting nurse complained that the resident needed emergency hospitalization. In another example, MCGC delayed providing a highly-functional resident who was deaf with interpreter services for nearly a year. If that resident was a candidate for services at home or in another community setting, this failure to accommodate a disability effectively resulted in the lengthy and improper segregation of the resident from society.

VI. Staffing, administration, and policy deficiencies contribute to inadequate care.

Our concerns about deficiencies with respect to resident care are heightened by a number of other systemic issues.

First, MCGC has staffing issues that contribute to deficiencies in care. Nurse staffing is a particular weakness at this facility. Our data indicates that MCGC registered nurse staffing levels fall well below the state average. Complaints about inadequate nurse response times, gaps in physician and psychiatrist oversight, and the County's unwillingness to share staffing data all evidence significant staffing problems.

Second, the County's policy towards residents' civil rights also causes us concern. While we recognize that jurisdictions may have legitimate reasons to monitor access to their facilities, Mercer County has gone one step further. They recently have denied us access to the residents themselves. As we have explained to the County in separate correspondence, interfering with communications between residents and federal officials is a violation of both federal law and state policy. See United States Constitution Amendments I, XIV; In re Quarles 158 U.S. 532, 535-36 (1895) (discussing right of citizens to communicate with federal law enforcement officials regarding violations of federal law); Lutz v. City of York, 899 F.2d 255, 263-266 (3rd Cir. 1990) (noting strict limits on State's ability to interfere with transactions between United States government and its citizens); see, e.g., Johnson v. Avery, 393 U.S. 483, 485 (1969) (institutionalized persons retain freedom to petition government for redress of grievances); see, also, New Jersey Rules of Professional Conduct Rules 3.4, 4.4. Residents do not lose their civil rights simply because they rely on the County for care. The County's approach towards the residents and their families is problematic. Such an approach can reflect or result in an institutional environment that places institutional interests over resident rights.

MINIMUM REMEDIAL MEASURES

In order to remedy the identified deficiencies and to protect the constitutional and federal rights of MCGC residents, MCGC should implement, at minimum, the following measures:

I. Resident safety and living conditions.

A. Regularly provide pre-service and in-service training for staff on resident care procedures. Such training must address general resident supervision, wound treatment, resident hygiene, and infection control. Facility management and medical administrators must begin direct and vigorous monitoring of the direct care staff's actual resident care practices and policy compliance. More particularly, training and procedures must address implementation of individualized resident care plans, cleaning and prevention of bedsores, communicable disease prevention, catheter use, hand-washing, facility maintenance, resident grooming, and prevention of injuries.

B. Ensure that individual staff are specifically trained on the needs and treatment of residents in their care. Staff must be evaluated in part on their compliance with care plans, and competency-based training must be incorporated into facility policies.

C. Ensure that staff routinely assist residents with their personal hygiene needs as necessary under their treatment and care plans. Where professionally indicated, such services must include assistance with toileting, dressing, and bathing.

D. Develop and implement meaningful incident review, peer review, and quality improvement procedures to allow investigation and follow-up of significant nursing home incidents. Issues to be targeted specifically, but not exclusively, include resident deaths, abuse, neglect, falls, unexplained injuries, property loss, medication errors, infectious disease transmission, and training failures. Injury, abuse, death, and infection trends must be fully investigated, and emerging issues must be identified and addressed. While individual staff accountability is a component of any staff oversight and quality improvement process, any such process must also identify systemic deficiencies and facility-wide remedies to address such deficiencies.

II. Medical and mental health care.

A. Provide nursing home residents with comprehensive, clinically defensible, and individualized treatment for their medical and mental health conditions.

1. Base medication prescriptions, behavioral interventions, and other treatment on thorough resident assessments, valid and reliable data, clearly established goals, and professionally justified diagnoses.

2. Develop comprehensive treatment plans that are individualized for each resident. Such plans must address residents' medical, mental health, nursing, disability, communication, discharge planning, and daily activity issues. Plans must be developed by an interdisciplinary team that has representatives from all appropriate disciplines, including physicians, psychologists, psychiatrists, nurses, therapists, direct care aides, nurses, and social workers. This treatment planning process must be an ongoing one for each resident. Staff must monitor the effectiveness of treatment and update treatment plans regularly.

3. Document treatment plans, behavioral programs, progress notes, medical orders, and other information in resident medical records as required by professional standards. Reliable, valid data must underlie treatment and behavioral planning decisions, and staff must be trained on proper documentation and data collection.

B. Conduct mortality reviews on all deaths that have occurred at MCGC in the last three years. Mortality reviews must be conducted by qualified, independent medical professionals. Mortality reviews must also be conducted regularly as part of any staff oversight and quality improvement program. MCGC must take appropriate corrective action based upon those reviews.

C. Conduct regular, comprehensive audits of medication use at MCGC. Qualified, independent medical professionals must be retained to target specifically any inappropriate

poly-pharmacy, clinically indefensible prescriptions, or problems with medication distribution and monitoring.

III. Rehabilitation, restorative care, and freedom from excessive restraints.

A. Develop rehabilitation and restorative care programs to help residents improve or maintain levels of functioning, ensure resident safety, and protect against excessive restraints. These programs must be part of an integrated, individualized treatment process, and must reflect interdisciplinary planning.

1. Develop rehabilitation and restorative care planning, policies, and protocols through structured procedures that allow facility-wide adoption and participation.

2. Tailor treatment plans to a resident's individual treatment goals, desires, interests, and lifestyle preferences.

3. As with resident treatment in general, monitor rehabilitation and restorative care plans for effectiveness and update regularly.

B. Implement policies to prevent inappropriate restraints. These policies must include safeguards against clinically indefensible restraint orders, prohibition and deterrence of unauthorized restraint use, development of behavioral support programs, and improved monitoring of individual and system-wide restraint use.

1. Consistent with professional standards, make every reasonable effort to reduce the use of restraints at MCGC. Restraints must never be used for the convenience of staff.

2. At a minimum, limit restraints only to emergency situations as permitted by professional standards. If restraints are required, staff must promptly obtain necessary physician authorization. Physicians and nursing managers must also personally and frequently review such orders during the period a resident is restrained.

3. Document properly all restraint usage at MCGC. Such documentation must include records on how often a resident was checked and the reasons for placing the resident in restraints. The documentation must also include clear criteria establishing when a resident should be released from restraints. Aggregate and trend data must be collected and incorporated into facility staff oversight and quality improvement processes.

4. Require treatment teams to review and address causal factors, including behavioral issues, that result in the restraint of a resident.

5. Develop policies and procedures to prevent the inappropriate use of medications as restraints. Oversight of inappropriate staff restraint usage must include review of physicians who prescribe psychotropic and sedative medications without professional justification.

6. Prohibit use of any restraint methods that do not meet professional standards and have not been approved in advance by qualified medical management staff.

IV. Mealtime assistance, resident nutrition, and hydration practices.

A. Regularly assess residents for dehydration, weight loss, and swallowing difficulties. Appropriate mealtime assistance, nutrition, and hydration plans must be developed and implemented. Necessary therapeutic positioning and functional seating programs must be developed for residents to facilitate feeding.

B. Carefully train and supervise staff in the implementation of nutrition and hydration plans. Training must include competency-based training on mealtime procedures, supplemented with quality monitoring of mealtimes. Only staff who have demonstrated competency with an individual's mealtime plan may provide assistance to that individual.

C. Ensure that the kitchen prepares and serves meals in a safe manner.

V. Community integration and ADA.

A. Assess residents to determine whether placement in the facility constitutes placement in the most integrated setting appropriate to individual needs. These assessments must be conducted in a manner consistent with a facility-wide policy and professional standards. Assessments must occur at admission and periodically during any resident's stay. If a more integrated setting would appropriately meet an individual's needs, MCGC must develop promptly a transition plan that includes clear target dates, measurable goals and outcomes, training and transition strategies, and responsible staff. Discharge and transition planning must be closely integrated into individual treatment plans. MCGC must identify barriers to discharge, make reasonable efforts to address such barriers, and follow-up on discharged residents in order to improve the quality of the discharge process.

B. Make a greater effort to include re

sidents and family members in the treatment and discharge planning process.

C. Provide reasonable accommodations for disabilities to ensure meaningful participation in treatment and activities by residents with disabilities.

VI. Staffing, administration, and policy.

A. Retain sufficient numbers of qualified registered nurses, aides, licensed practical nurses, therapists, nutritionists, social workers, psychologists, psychiatrists, and physicians to provide adequate care.

B. Develop and implement accurate and reliable systems for identifying problems with individual resident care, problems with facility-wide practices, and root causes for serious incidents. Incidents must be reported accurately to all appropriate federal, state, and local officials.

C. Maintain accurate, current, complete, and organized records on resident care. The quality assurance procedures must address the quality and accuracy of records.

D. Fully protect residents' legal rights, including their First Amendment right to communications with government officials. Mercer County must allow residents to meet with governmental and legal representatives.

We invite the County to discuss with us these remedial recommendations, with the goal of remedying the identified constitutional and statutory violations without resort to litigation. In the event we are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or otherwise protect the rights of MCGC residents, 49 days after the receipt of this letter.

42 U.S.C. § 1997b (a)(1). Accordingly, we will soon contact County officials to discuss in more detail the measures that the County must take to address the deficiencies identified in this letter.[(2)]

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: Harry G. Parkin, Esq.
Chief of Staff
Mercer County Executive's Office

Sylvia Mulraney
Acting Director of Human Services
Mercer County Department of Human Services

Donald E. Lynch
Mercer County Geriatric Center
Hospital Administrator

Christopher J. Christie
United States Attorney
District of New Jersey

---

1. While we presume these figures are correct, they are based principally on self-reported data. Because MCGC has demonstrated an unwillingness to assist with fact-finding and may not have in place the systems necessary to identify accurately residents with serious needs, we are concerned that problems are under-reported.

2. We understand that Mr. Parkin, your Chief of Staff, is serving as counsel due to the fact that your County Attorney, Alfred Vuocolo, has a conflict of interest in this matter.