HAMILTON COUNTY NURSING HOME FINDINGS LETTER

Mr. Claude Ramsey
County Executive
Hamilton County
625 Georgia Avenue
Room 208
Chattanooga, Tennessee 37402
Re: Investigation of Hamilton County Nursing Home

Dear Mr. Ramsey:

On December 2, 1996, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, that we were investigating conditions at the Hamilton County Nursing Home ("HCNH") in Chattanooga, Tennessee. We conducted our investigation by reviewing facility records, including residents' medical charts and other documents relating to the care and treatment of HCNH residents; interviewing administrators, staff and residents; and conducting an on-site survey of the facility in January 1997, with three expert consultants. Consistent with CRIPA's statutory requirements, we are now writing to inform you of our findings.

HCNH is a public nursing home located in Chattanooga, Tennessee. It is operated on behalf of Hamilton County, Tennessee, by the Hamilton County Nursing Home Board of Trustees. There are approximately 600 residents at the nursing home, most of whom are above age sixty and have chronic medical problems.

Based on our investigation of resident care and treatment at HCNH, we have concluded there are a number of conditions and practices at the nursing home that violate the constitutional and federal statutory rights of HCNH residents, including: the failure to ensure safety of residents; the failure to provide adequate health care services, including medical and nursing care and nutritional and rehabilitation services; the failure to use restraints in accordance with professional standards; and the failure to provide residents with adequate activities. A major cause of many of these deficiencies is that HCNH has an insufficient number of staff across all clinical disciplines, including physicians, nursing staff, therapy and activity staff, and dietary staff. We set forth below the facts supporting our findings of unconstitutional and unlawful conditions and practices at HCNH and the minimum measures that are necessary to remedy these deficiencies.

Before addressing the substantive violations, we would like to express our appreciation to the HCNH administrators and staff, particularly Mr. Ed Brazil, Mr. Norman Haley, and Ms. Jocelyn Bryant for their assistance and cooperation during our January 1997 survey of HCNH. We hope to be able to continue to work with County and HCNH officials in the same cooperative manner to remedy the problems we found.

I. HCNH IS FAILING TO ENSURE THE SAFETY OF ITS RESIDENTS

Individuals residing in a publicly-operated institution such as HCNH have fundamental Fourteenth Amendment due process rights to live in reasonably safe conditions and to be provided the essentials of basic care. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982); Meador v. Cabinet for Human Resources, 902 F.2d 474 (6th Cir. 1990). Federal statutes governing the operation of nursing homes create similar rights. See, e.g., Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1351i-3; and their implementing regulations, 42 U.S.C. § 483 Subpart B. However, HCNH is failing to ensure that residents are not harmed or placed at unnecessary risk of harm. In addition, HCNH fails to notify state authorities and family members properly when untoward incidents occur.

Our investigation has revealed that residents of the nursing home have suffered harm because of the facility's failure to provide adequate supervision of residents. Moreover, Certified Nursing Staff ("CNAs" - direct care staff) have been falsifying documents that were designed to ensure that CNA staff were observing and checking on residents at shift change. Our nursing expert found that these documents were often filled out well in advance of the shift change, calling into question the integrity of HCNH's resident care documentation and exacerbating the problem of inadequate supervision of residents. Other shift change sheets to document residents' supervision were found blank or with incomplete data.

The facility's failure to supervise residents places them at risk of harm and has resulted in serious injuries to residents. On numerous occasions, incident reports describe residents as being "found" by staff or other residents after suffering injuries from falling out of their beds or wheelchairs. For example:

- A resident was found in the doorway of his room sitting with his back against his bed and with "[b]lood on floor bright red." The resident's Foley catheter was still attached to the bed with the bulb still inflated and the patient was bleeding internally from his penis. A dressing that had been on his coccyx was lying on the floor beside the resident's bed.
- A resident was found with his torso on the floor, lying in his own vomit, with his feet "tangled in between split side rail."
- A resident was found on the floor next to his bed "covered with feces." The resident had freed himself from his vest restraint and had fallen to the floor.
- Within the space of several minutes, two residents in adjoining rooms were discovered to have "black eyes." HCNH's own investigation reports cites the CNAs for failing to properly check on residents during shift change.

In addition, the facility's failure to supervise residents adequately has resulted in residents wandering away from their buildings unsupervised and without staff knowledge. In one incident, a resident was "found face down" on the ground behind one of the resident buildings. Another resident has eloped three times in the space of a few months. On one occasion, this resident left the grounds of the nursing home and was found wandering down a busy road. Another time he eloped from the facility and slipped on ice, dislocating his finger. A third time he was found off the grounds and, according to the incident report, "walking toward the interstate." Moreover, HCNH administrative and medical staff told us they were unaware of these elopements. This lack of knowledge makes adequate medical or administrative response to the events impossible.

There also are fire safety concerns stemming from residents smoking in violation of the nursing home's own policy regarding resident smoking. This access to flammable materials is a particularly dangerous circumstance given the unsteadiness of many residents and the proximity of flammable materials, such as newspapers and nightclothes.

Taken together, these facts demonstrate that HCNH residents are at serious risk of harm and have suffered harm, in violation of their basic rights, due to the facility's failure to provide adequate safety and supervision of residents.

II. HCNH IS FAILING TO PROVIDE RESIDENTS WITH ADEQUATE HEALTH CARE SERVICES

Residents of publicly-operated institutional facilities such as HCNH have a Fourteenth Amendment due process right to adequate health care. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982); Meador v. Cabinet for Human Resources, 902 F.2d 474 (6th Cir. 1990). See also 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide for medical, nursing and specialized rehabilitative services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"). HCNH fails to provide its residents with adequate medical and nursing care, which has resulted in harm and has contributed to the untimely death of HCNH residents.

A. Medical Care

Serious deficiencies exist in medical care at HCNH. It is our consultant physician's opinion that many of the medical care failings at HCNH exist because the facility's physicians do not take a primary role in addressing the medical care needs of the HCNH resident population. Instead, the physicians have developed a style of practice that, in our consultant's opinion, amounts to a "wanton disregard" for the medical needs of HCNH residents. The nursing home has too few physicians to care adequately for its residents and the physicians it does have are not providing needed medical services to residents. We identified numerous failings in the health care delivery system at HCNH including:

Delays in seeking and providing acute care: We reviewed a number of cases where there were significant delays in responding to serious medical conditions of residents. For example, our consultant physician reviewed the record of one female resident who was in respiratory distress with an elevated temperature for several days before being transferred to an acute care hospital where she subsequently died. It is our consultant's opinion that the delay in transferring this resident to an acute care facility was a contributing factor to her death. In another incident reviewed by our consultant physician, a resident had stopped breathing for thirty minutes before 911 was called. It is our consultant's opinion that the lack of timely action by the nursing home staff was a direct cause of this resident's death.

One contributing factor to HCNH's failure to provide timely and appropriate acute care is that the nursing home's physicians do not respond in a timely fashion to critical laboratory results and do not adequately examine residents with acute medical needs. As a result, the residents do not receive needed medical attention, including timely transfer to acute care facilities. At the time of our tour, our medical consultant was so concerned about one current resident, who had multiple Stage IV pressure sores (the most serious, advanced stage of pressure sores) and was malnourished, he alerted HCNH's administrator to this resident's condition and the need for immediate physician attention. It was our medical consultant's opinion that this resident should have been in an acute care facility receiving intensive treatment and not in HCNH.

There is also inadequate access to acute psychiatric care. We were told that the psychiatric crisis response team takes approximately five to twenty-four hours to respond to crisis psychiatric situations. Our consultant physician found this "absolutely inadequate and dangerous to the health, safety and welfare of the residents and staff of HCNH."

Inadequate review of untoward events and deaths: HCNH physicians do not perform appropriate medical follow-up assessments of untoward events, such as injuries or fractures of unknown origin. We reviewed numerous incident reports involving injuries, where the medical staff conducted little or no

follow-up to determine the cause of the incident, its effect on the resident, or how similar incidents might be avoided in the future. In addition, HCNH physicians advised us that after a patient falls, the physician generally only reads the nurse's incident report and may never personally examine the resident. This is a troubling admission given the number of residents whose fractures or other injuries following a fall are not discovered for days or weeks after the fall was reported. The lack of follow-up of these and other incidents represents a substantial departure from accepted standards of medical care and practice.

Further, the facility conducts no routine mortality reviews. Given the many problems with the health care delivery system at HCNH, the failure to conduct routine mortality reviews is a serious deficiency because such reviews may reveal issues that require remedial attention. Currently, the nursing home does not make a consistent effort to obtain cause of death reports from the hospital where the resident died, or to have the Hamilton County Medical Examiner review deaths at the nursing home.

Inadequate policies: The facility is also operating with outdated, inappropriate, and in some instances, dangerous, policies, procedures and protocols. For example, the HCNH seizure management policy permits the use of intramuscular Valium to treat emergency situations where a resident experiences prolonged seizures, known as "status epilepticus." Current accepted professional standards require intravenous or rectal treatment when this emergency condition develops because intramuscular treatment is inadequate to stop the seizures.

Inadequate systems of preventive care: Comprehensive assessments of residents' health care needs are a critical requirement for nursing home facilities receiving federal funding. 42 U.S.C. § 1396r(b)(3). HCNH, however, does not perform adequate initial assessments of residents' health care needs. Without such assessments, it is not possible for the facility to plan for maintaining or increasing the health status of residents. For example, the medical staff does not adequately order or assess the need for specialized therapies for residents with special needs such as non-healing decubitus ulcers, speech and swallowing problems, or range of motion limitations. The nursing home also fails to identify and address the medical needs of post-menopausal women, e.g., the facility does not provide for mammograms, pap smears, or estrogen replacement therapy. Medical care is generally only provided for acute needs and little is done to prevent medical conditions from deteriorating. In sum, there are no systems in place at HCNH stressing preventive health care.

Inadequate pressure sore care: Deficiencies at HCNH in assessments and preventive care are particularly evident in its treatment of pressure sores. It is the opinion of our experts that the facility had an unacceptable pattern of clinically avoidable, facility acquired pressure sores among its resident population. We observed one resident who had multiple pressure sores over his body, including several large Stage IV sores. The resident was in such distress that he would literally scream in pain whenever he was turned or moved.

There is no system of preventive measures in place at HCNH for residents at risk of developing pressure sores. Staff do not adequately perform basic care tasks, such as range of motion exercises, to help prevent residents from developing pressure sores. Rather, range of motion is performed only every other day "with bathing," which our consultant physician found to be inadequate. Further, once those sores do develop, the nursing home's treatment response is inadequate. For example, our consultant physician identified several residents with Stage III or IV pressures sores (i.e., wounds that had developed to a serious stage) who could benefit from specialized beds, yet those beds were not being provided. One resident had had a Stage IV pressure sore for two years, yet had not been referred for plastic surgery -- which is standard practice in such instances. Further, our physician noted at least two residents who had doctors' orders in place to stay off their backs while in bed because they had pressure sores on their backs. Yet, we observed these residents during our tour lying on their backs in their beds, exposing them to further danger from the pressure sores. The facility's failure to implement orders by its own physicians places HCNH residents at risk of harm and is a substantial departure from accepted professional standards and Medicaid/Medicare regulations. We also observed instances of residents being bathed and then put to bed with their skin still wet, further exposing them to the risk of skin breakdown.

Inadequate integration and communication among clinical staff: As we toured the nursing home and reviewed records, it became clear to our expert consultants that a major failing in the health care delivery system at HCNH is a lack of coordination and communication between physicians, nurses, and therapistsregarding the medical needs and status of residents. The medical, nursing and therapy staff at HCNH do not act in an interdisciplinary way to identify, plan for, and treat the

specific needs of residents. The Medical Director is also not actively involved in the development of the facility's policies and procedures, contrary to federal regulation. This lack of interdisciplinary communication is a basic failing that negatively affects practically every aspect of resident care at the nursing home. For example, nurses might note a resident in distress, but that information is not conveyed in a timely manner to a physician. In other situations, therapists believe that a resident could benefit from a specific therapy, yet that information is not conveyed to the physician responsible for the resident's care. Even when information is related to the physicians by the nursing staff, follow-up is often inadequate.

Similarly, the nursing home does not communicate adequately with local hospitals when residents are transferred to and from the respective facilities. HCNH also does not monitor the quality of outside medical services being rendered to its residents, or even consistently obtain residents' hospital records upon their return to the nursing home. This failure results in a lack of continuity of medical treatment and care for HCNH residents.

B. Nursing Care

As with medical care, nursing services at HCNH are deficient due to many factors. A major failing with nursing care at HCNH is that the nursing staff do not follow the basic nursing process of adequately assessing the nursing care needs of HCNH residents, developing and implementing nursing care plans to meet those needs, and monitoring the efficacy of the plans. Our nursing expert found that HCNH's admission and routine annual nursing assessments do not adequately identify or evaluate residents' health care needs. In fact, our nursing expert found that the vast majority of HCNH nursing staff have not received any training in physical assessment. As noted earlier, the failure to perform adequate assessments is a crucial deficiency. Without an adequate assessment of a resident's health care needs, there can be no individualized care plan that meets those needs. Failure to meet the nursing care needs of the HCNH population results in unnecessary deterioration of residents. For example, the extremely high number of residents who experienced unplanned weight loss in 1996, discussed further below, is directly linked to inadequate assessment of residents' acute and chronic illnesses and injuries.

HCNH nursing staff are not adequately trained in providing many other basic components of nursing care, resulting in deficiencies in these areas. Particular problems exist in such vital areas as medication administration and side effects monitoring, wound care, restraint application, evaluation of laboratory findings and their implication for nursing care, and identification and management of seizures. For example, when our nursing expert asked six different staff about the type of seizure disorder a particular resident had, not one knew. This information is important for staff to know because the appropriate response to a seizure is dependent upon staff being able to identify the type of seizure. This same resident suffers from recurrent Dilantin (an anti-seizure medication) toxicity, but there were no nursing notes in her medical chart of the effect that Dilantin toxicity had on her appetite, mental status, or seizure activity. Further, this resident experiences recurrent decubitus ulcers, is one of the many residents identified as having experienced significant weight loss, and has had pneumonia in the past. These factors should have alerted the nursing staff that further assessment was needed in order to develop a plan to treat the resident's ailments and prevent their recurrence. Our nursing expert found that this was not being done.

Moreover, the nursing staff is inadequately trained in infection control and does not follow routine universal precautions to prevent the spread of infection. This deficiency is particularly evident in the treatment and housing of residents with Methicillin Resistant Staphylococcus Aureous ("MRSA"). According to accepted infection control procedures, these residents should be isolated in a separate area to prevent the spread of this highly contagious condition. At the time of our visit, however, our nursing expert noted that the eleven cases of MRSA at the nursing home were scattered throughout the facility. At least one resident was transferred from a unit where people with MRSA lived to a unit where no previous cases of MRSA had been identified. The nursing staff's only justification for this transfer was that it helped to distribute caseloads evenly. This is an unacceptable reason for exposing individuals in the new unit to an increased risk of acquiring MRSA**.**

Our experts found a number of other deficiencies in HCNH's nursing care practices including: inadequate supervision of certified nursing assistants and licensed practical nurses by registered nurses; repeated failure to detect critical changes in residents' health care status; and failure to perform basic nursing services, including nursing staff not responding in a timely manner to resident call bells. Exacerbating these nursing care deficiencies is the fact that there are no quality assurance mechanisms in place to monitor the delivery of nursing care services.

Finally, nursing documentation is grossly deficient, fails to reflect resident progress or status and, as noted above, is sometimes fraudulent. Our nursing expert found numerous examples of inadequate nursing documentation. According to our expert, nursing notes are the "mainstay of assessment for the appropriateness of interventions." A

lack of thorough and accurate nursing notes makes it nearly impossible to provide adequate care to the nursing home's residents.

In sum, deficiencies in nursing care at HCNH outlined above pose serious risks to the health and safety of HCNH residents in violation of their federally-protected rights.

C. Nutritional Services

Nutritional and dietary services at HCNH are deficient and violate federal standards. See 42 U.S.C. § 1396r(b)(4)(A)(iv). Our survey team was particularly concerned with the high number of HCNH residents who have suffered significant, unplanned weight loss during the past year. Specifically, the nursing home's own records showed that of the 950 to 1008 individuals residing in the nursing home between January 1996 and January 1997, at least 225 suffered significant, unplanned weight loss, as those terms are defined by federal regulations. Our consultant administrator concluded this rate of significant weight loss to be "outrageously high." HCNH's own staff admitted to us that the great majority of the instances of weight loss were clinically avoidable. The high rate of serious and non-healing pressure sores, as discussed above, is also linked to inadequate nutritional and dietary services.

Our nursing consultant observed staff feeding residents without following care plans and safe feeding practices. Residents are fed too rapidly and in unsafe positions, and signs above residents' beds regarding precautionary feeding techniques are often ignored. In other situations, we observed nursing staff not providing assistance to residents who need help eating their meals. For example, our physician consultant observed one resident with a half-eaten breakfast. When the physician asked a CNA why no feeding help was offered, the CNA responded that "the family brings in food." No effort is made to normalize meal time or the eating process. Food is often served cold, bland and tasteless, and there are few opportunities for socialization during mealtimes. Most residents are being forced to eat meals in their beds or alone in a chair in the hall. Simple tasks that will make eating more enjoyable, such as taking a resident to the bathroom or providing the resident with clean bed clothes prior to eating, are not done. There are little to no attempts made to encourage residents to eat or to provide a therapeutic dining atmosphere for residents.

There are inadequate assessments of the nutritional status and needs of residents. Further, HCNH staff do not keep the dietitian timely informed of the status of residents with pressure sores, so that the diets of those residents can be adjusted accordingly.

Additional problems include inadequate communication between dietary and food service staff, inadequate therapy screening and services for residents with eating disorders, inadequate oral hygiene for residents, the lack of adaptive eating equipment for individuals who would be able to feed themselves given such support, and the high number of individuals being fed by feeding tubes.

It is the opinion of our consultants that the lack of adequate nutrition and dietary services contributes greatly to the deterioration of HCNH residents and is a leading contributor to the unacceptably high number of significant weight loss, infections, falls, aspirations, pressure sores, amputations, deaths and other untoward medical outcomes among the HCNH resident population.

D. Specialized Rehabilitation Services

Most HCNH residents need physical, occupational or speech therapy, but fewer than one-quarter of HCNH residents receive any therapy services. Moreover, only a fraction of HCNH's residents have even been screened by rehabilitation services to determine whether they might benefit from rehabilitation. Numerous HCNH rehabilitation staff readily admitted to us that residents who could benefit from such services were not receiving them. Nursing staff is inadequately trained regarding the benefits of rehabilitation for nursing home residents, decreasing the nursing staff's ability to contribute to the identification of residents who may benefit from rehabilitation. Even those residents whose need for therapy is clear after minimal direct observation are not being assessed for therapeutic need. For example, one resident "never gets out of bed" because "he's too stiff." He is fed by direct care staff and our nursing expert observed him coughing throughout the meal. He also has a problem with weight loss. Yet this resident has not been assessed by any of the therapists or nursing staff for either his stiffness or choking at mealtimes. In sum, nursing, nutritional, and rehabilitation staff do not adequately communicate to provide a comprehensive approach to resident needs.

HCNH residents are suffering harm from the lack of therapy services. For example, HCNH staff admitted to us that residents have developed clinically avoidable contractures due to the lack of physical therapy services, including such basic therapy as routine range of motion. The need for rehabilitative services is compounded by the lack of activities and exacerbates the already high number of residents with inappropriate weight loss and skin breakdown. According to our expert consultants, this lack of adequate rehabilitation is likely to result in more residents being confined to a wheelchair or bed, thus increasing the workload of and the need for more nursing staff. In addition, it results in higher mortality rates.

We also observed numerous residents in ill-fitting and poorly maintained wheelchairs. For example, we noticed many residents in wheelchairs without footrests where their feet were dangling. The failure to provide adequate foot support to persons who use wheelchairs is a substantial departure from accepted professional standards. Our physician consultant observed one resident with a painful right heel ulcer wheeling himself in a wheelchair unequipped with footrests. Another resident complained that he had asked for a wheelchair with footrests innumerable times, but had given up on obtaining such a wheelchair. Individuals with a diagnosis of peripheral vascular disease ("PVD") were frequently found in wheelchairs without foot rests and their legs dangling down for hours -- a dangerous and professionally unacceptable practice. We observed one resident with PVD who already had one leg amputated sitting in a wheelchair with his remaining leg hanging down. His leg was cyanotic and cool to the touch. He had a pressure sore on the leg which, because of his diabetes and PVD, was healing poorly.

In sum, based upon their observations, review of records and interviews with therapy staff, our experts concluded that HCNH does not provide adequate rehabilitation services to its residents.

III. HCNH'S RESTRAINT PRACTICES ARE PROFESSIONALLY UNJUSTIFIABLE AND DANGEROUS TO RESIDENTS

Nursing home residents have constitutional and federal statutory rights to be free from physical or chemical restraints imposed for convenience of staff and without medical justification. Youngberg v. Romeo, 457 U.S. 307 (1982); 42 U.S.C. § 1396r(c)(1)(A)(ii). HCNH uses restraints on its residents in violation of accepted standards of practice and in ways that threaten the health and safety of residents.

At HCNH, it is common practice to put a vest restraint on a resident and then secure the restraint to a bed with split siderails with the rails up. This is a dangerous and professionally unacceptable practice that violates the manufacturer's warnings on the vest restraint. In the facility's incident reports, we came across several examples where residents had become entangled in restraint straps and in the split rails on the bed and were found literally hanging from the sides of their beds. It is also a violation of basic standards of care to use siderails without padding whenever a vest restraint is concurrently employed, which is also common practice at HCNH. There is a lack of documentation that residents are being released from restraints or monitored in accordance with professional

standards of practice. The ability of many residents to get out of vest restraints, as documented by HCNH's incident reports, indicates that restraints may not be properly sized or applied. We also found instances of safety restraints not being applied, even though a physician had ordered them.

Further, HCNH residents are subjected to restraints without adequate and specific medical justification. There is no identification of the specific reason for restraints and the specific times for the restraints to be applied. It is common to find physician orders to restrain residents because of "confusion" or "unsteadiness", which alone are not appropriate justifications for restraining a resident. Less restrictive alternatives are not considered, nor are residents re-evaluated for the continuing need for restraint on an appropriate and routine basis. Our consultants found it likely that the vast majority of bedrail-restrained residents would not need such restraints if appropriate assessments had been done. We observed no use of commonly accepted alternatives to restraints while residents are in their beds, such as rolled bumper cushions, added mattresses on the floor adjacent to the bed, bed alarms or wedges/pillows, or half-rails in lieu of full rails. HCNH is also not routinely seeking informed consent regarding restraint application from cognitively-impaired residents' responsible parties. These practices violate the constitutional and federal statutory rights of HCNH residents and subject them to the risk of harm.

IV. HCNH RESIDENTS DO NOT RECEIVE ADEQUATE STIMULATION ANDACTIVITIES

Nursing home residents have the right to be provided sufficient activities to maintain their physical, mental and psychosocial well-being. 42 U.S.C. 1396r(b)(4)(A)(v). Throughout our week-long tour of HCNH, we saw numerous examples of the dearth of activities provided to residents. Our survey team noted the substantial amount of time residents spend in their beds. For example, it was not uncommon to find at least half, if not the majority, of residents still in their beds at 11:00 a.m. on certain units. Further, in at least one building, it is routine practice to put residents back into bed at 2:00 p.m. and leave them in bed until time for the evening meal, at about 4:30 p.m. Although nursing staff reported that this practice is used because residents get tired in the afternoon, we witnessed enforced bed rest in situations where residents did not require it. For example, we observed one resident asking to get up, only to be told by a nursing administrator, "you're going to rest today."

There were little or no activities scheduled in the evenings or on weekends. HCNH staff admitted to us there was a need for more group activities as well as more individualized activities for residents who could not get out of bed. We were told that the activities staff is only able to provide services to one-half of HCNH's bedridden residents (approximately 100 people at the time of our visit); the rest receive no activities at all. For those residents who do receive one-on-one therapy services, the sessions are limited to only one or three five-minute visits a week, and sometimes amount to no more than turning on the resident's television or radio. We also found that a building's activities are not accessible to residents from other buildings, even if the residents are able and eager to attend a specific activity in another building.

This lack of activities has a negative effect on the health and well-being, including psychological well-being, of HCNH residents. It is the opinion of our consultants that the lack of activity at the nursing home is "destroying the ability of residents to enjoy life" and "is a direct and immediate threat to the mental and psychosocial well-being of Hamilton County Nursing Home residents." Our consultants were also concerned about the general lack of devices that would allow residents to have control over their own environment. Devices such as eating equipment, pressure switches to turn off the televisions, and modified clothing to facilitate independent dressing, were not present in the nursing home. These types of tools are important to the maintenance of residents' independence and their emotional and physical health.

We observed several additional problematic issues at the nursing home. There is no consistent effort to keep track of resident property as a protection against loss or theft. We spoke with several residents and family members of HCNH residents who told us that residents' clothing and other items frequently disappear. We were also told that

residents' clothing is often lost after being sent to the facility's laundry. In addition, we noted poorly maintained, unstable and ripped furniture, which poses various risks to residents, including falls, cuts, and skin breakdown.

Finally, it was apparent to our experts as they traveled throughout the nursing home, that some residents did not appear to require "nursing home" level care and could be served more appropriately in community-based placements. Failure to serve those HCNH residents who are "qualified individuals with a disability" in the most integrated setting appropriate to their needs is a violation of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; 28 C.F.R. § 35.130(d); Helen L. v. DiDario, 46 F.3d 325 (3d Cir.), cert. denied, __ U.S. __, 116 S. Ct. 64 (1995).

V. MINIMAL REMEDIAL MEASURES

In order to remedy these deficiencies and to protect the constitutional and federal statutory rights of HCNH residents, HCNH should implement promptly, at a minimum, the following measures:

1. Provide a safe environment for HCNH residents. Staff members should monitor and safeguard the residents adequately, particularly those residents in vest restraints in their beds.

2. Provide residents with adequate preventive, chronic, routine, acute and emergency medical and nursing care in accordance with generally accepted professional standards. In order to accomplish this, HCNH should ensure adequate and appropriate interdisciplinary communication among relevant professionals, and HCNH physicians and nurses must follow professional standards of practice in writing orders and in general recordkeeping practices. The Medical Director should be involved in the ongoing development, implementation and review of all policies and procedures. Further, HCNH physicians and nurses should:

a. Conduct comprehensive evaluations of all residents forwhom they are responsible;

b. Determine what specialized services are required for residents and ensure that such services are provided in a timely manner whenever necessary to address residents' medical and nursing care needs;

c. Ensure that each resident has an integrated plan of medical and nursing care to address any chronic medical and nursing care need;

d. Ensure that each resident's health status is adequately monitored and reviewed and that changes in a resident's health status is responded to in a timely manner;

e. Ensure that all HCNH staff, including physicians, nurses, therapists and direct care are adequately

trained in current standards of practice in all relevant areas of health care delivery;

f. Provide adequate therapy services (including physical, occupational and speech therapy) to HCNH residents who can benefit from such therapies;

g. Provide effective preventive systems for pressure sores and provide adequate care for residents with pressure sores;

h. Ensure adequate and appropriate communication, including access to residents' hospital records, between HCNH and local hospitals concerning the health status of residents as they are transferred to and from the respective facilities;

i. Ensure that HCNH residents in need of acute hospital care are transferred promptly to an appropriate facility and are not inappropriately discharged to or admitted to HCNH;

j. Conduct mortality reviews for residents who die either at HCNH or at an acute care hospital following transfer from HCNH to determine whether appropriate care was provided and develop and implement any necessary changes in services at HCNH based upon the review;

k. Provide adequate medical services for post-menopausal women in accordance with accepted standards of practice; and

l. Provide for adequate emergency response to residents' acute psychiatric needs.

3. Provide adequate nutritional management services, including adequate nutritional assessments of individual residents' specific nutritional needs, and ensure that residents receive appropriate diets and food that is served in a safe and timely manner and in appropriate amounts. HCNH must also ensure that residents who need assistance in eating are assisted by adequately trained staff. In addition, HCNH must assess and treat residents with swallowing problems and residents who are unable to eat orally in accordance with accepted professional procedures and federal law.

4. Establish and maintain an adequate, unified record for each resident that comports with accepted professional standards and federal law. In particular, the records should contain all relevant information, including hospital records, with respect to the resident's care and medical and nursing status. Further, HCNH must ensure that records are accurate and take appropriate disciplinary actions against employees found to be falsifying records.

5. Employ and deploy a sufficient number of physicians, registered nurses, licensed practical nurses, certified nurses' aides and therapists, including physical therapists, occupational therapists, speech therapists, and other specialized rehabilitation therapists, and dietary staff to provide adequate supervision, safety, health and treatment to each HCNH resident.

6. Ensure that bodily restraints are used only pursuant to accepted professional standards and federal law and that they are never used for convenience of staff or as punishment. Comprehensive assessments should be performed prior to restraint application, physicians' orders should be followed, and restraints should be used appropriately when in place. The facility should ensure that residents are monitored, exercised, and released from restraints in accordance with professional standards of practice and federal law, and that the need for the continuing use of restraints is re-evaluated on a timely basis.

7. Provide sufficient, meaningful activities for all residents and make all due efforts to get residents involved in activities.

8. Take sufficient measures to ensure the protection of resident property against loss or theft.

9. Develop and implement policies and procedures that provide adequate investigation of and remedial action for instances of alleged resident abuse, neglect and/or mistreatment.

10. Identify residents who could be served in more appropriate, alternative settings and seek placement for residents in those settings.

11. In order to ensure compliance with the remedial measures, HCNH should develop an effective monitoring and quality assurance mechanism.

We hope to be able to resolve this matter amicably and cooperatively. As such, we will contact counsel for the Board of Trustees to arrange a meeting to discuss in greater detail the issues raised in this letter. We look forward to working with you to resolve this matter in a reasonable and practical manner.

If you have any questions, please contact the attorneys assigned to this matter, Verlin Hughes (202-514-6260) or Christy López at (202-616-3197).

Sincerely,

Isabelle Katz Pinzler
Acting Assistant Attorney General
Civil Rights Division

cc: Mr. Heman McDade
Chairman, Hamilton County Nursing
Home Board of Trustees

Rheubin Taylor, Esquire
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Mr. Ed Brazil
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