U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

The Honorable Sonny Perdue
Office of the Governor
203 State Capital
Atlanta, Georgia 30334

MAY 30 2008

Re: CRIPA Investigation of the Georgia Regional Hospital in Atlanta

Dear Governor Perdue:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness or developmental disabilities who are treated in public institutions. The findings discussed in this letter apply particularly to the Georgia Regional Hospital in Atlanta, Georgia ("GRHA"). We will provide a supplemental letter describing any additional findings concerning the remaining hospitals in the state hospital system as soon as reasonably possible. However, as detailed below, we found conditions at GRHA to be so critically deficient that we write to you at this time to stress the urgency of necessary reforms.[1]

On April 18, 2007, we notified you that we were initiating an investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to CRIPA. The State agreed that the Department's inspection of four of the State's hospitals would stand as representative of all seven hospitals in the system. We began our on-site inspections with a visit to GRHA on

[1] We note that many, if not all, of the findings we make regarding GRHA are representative of conditions encountered at the two other hospitals we have inspected to date, the Northwest Regional Hospital in Rome and the Georgia Regional Hospital at Savannah.

September 17 through 21, 2007. Visits to the Northwest Regional Hospital in Rome and the Georgia Regional Hospital at Savannah occurred on October 29 through November 2, 2007, and on December 17 through 21, 2007, respectively. The visit to Central State Hospital in Milledgeville is tentatively scheduled for June 9 through 13, 2008.

We conducted our on-site review with the assistance of expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, and discharge planning and community placement. While on-site, we interviewed administrative staff, mental health care providers, and patients, and examined the physical plant conditions throughout most, but not all, of the facility.[2] In addition to our on-site inspection of GRHA, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and grave concerns about GRHA to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation pertaining to GRHA, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set

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[2] The State, asserting that CRIPA does not afford jurisdiction over admissions, intake, and "short-term outpatient" units, refused us access to such units at GRHA (and at the regional hospitals in Rome and Savannah). The State's position is incorrect. See, e.g., 42 C.F.R. § 483.20 (2006) (describing the State's duty to provide physician orders for immediate care at the time of admission and to perform comprehensive assessments within fourteen days of admission). By law, our investigation must proceed regardless of whether officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigations. See H.R. Conf. Rep. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. As we informed the State's attorneys, the State's decision to deny us access to these areas permits us to draw negative inferences about conditions and practices in those units. See id. While we did not draw negative inferences in making the findings described in this letter, we reiterate that we are authorized to do so if the State continues to deny us access to these areas in the future.

forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at GRHA violate the constitutional and statutory rights of its residents. In particular, we find that GRHA: (1) fails to adequately protect its patients from harm; (2) fails to provide appropriate mental health treatment; (3) fails to use seclusion and restraints appropriately; (4) fails to provide adequate nursing and health care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

We note, at the outset, three overarching concerns. First, the majority of the findings we have made have also been made by other agencies in the past. See, e.g., United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Survey of Georgia Regional Hospital at Atlanta (June 14, 2006) (describing failure to meet federal regulatory standards in protection from harm, mental health treatment, nursing and health care, and specialized needs services, resulting in injuries to patients, including death); Memorandum from Peter Buckley, M.D., and Nan Lewis, M.P.H., of the Medical College of Georgia to William P. Kissel of the Georgia Department of Human Resources entitled "Audit Summary - Georgia Regional Hospital - Atlanta" (May 3, 2007) (describing deficits in protection from harm, mental health treatment, seclusion and restraint usage, nursing and health care, and discharge planning, resulting in staff and patient injuries). Throughout this letter, we have included specific references to past findings by these entities, where appropriate. In addition, recent media coverage, including a series of investigative articles in the Atlanta Journal Constitution, has also reported that patients at GRHA are exposed to a significant risk of harm and often suffer preventable injuries and illnesses, some of which have been fatal. We found that these same conditions remain unabated, despite GRHA's notice of the deficiencies.

Second, GRHA is the very hospital where, nearly a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities violates the law. Olmstead, 527 U.S. 581 (1999). Olmstead involved two women with developmental disabilities who were inappropriately confined at GRHA. The Supreme Court held that states are required to provide mental health treatment to persons

in the most integrated, appropriate settings. In the wake of the Olmstead decision, Georgia commissioned numerous studies of deficiencies in its community mental health care system, including: a February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); a January 2005 Study of the CSB Service Delivery System (Phase II); and a May 2005 Georgia Mental Health System Gap Analysis. As stated in the Phase II Study by the State's Department of Audits and Accounts, these studies "point to accountability, oversight, management, and quality of care issues." Despite the mandate by the Supreme Court and the subsequent clear analysis and recommendations in Georgia's own reports, as indicated herein, our review of discharge planning at GRHA finds that Georgia still frequently fails to ensure that patients receive appropriate and sufficient services to enable them to live in the least restrictive setting consistent with their needs, and as required by federal law.

Third, the findings that we make about the Adolescent Unit are particularly disturbing. We observed several troubling incidents during our tour, including one where an adolescent tore the water cooler from the wall and had to be forcibly escorted by staff to a seclusion room. One week earlier, a disturbance on the same unit required the assistance of county police to subdue the adolescents on the unit. Moreover, we found the number of incidents on the unit of patient-on-staff abuse and patient-on-patient aggression to be extraordinarily high. The GRHA psychiatrist assigned to the Unit described the situation as "continuing clinical chaos." Another staff member candidly stated that the adolescent patients would be safer outside of GRHA. This is a highly dangerous situation that requires immediate attention.

I. BACKGROUND

Georgia Regional Hospital at Atlanta was established in 1968 and was the first hospital facility constructed in Georgia's regional hospital system. Located on 174 acres in DeKalb County, GRHA serves residents of metropolitan Atlanta and a section of Northeast Georgia. GRHA operates 352 licensed inpatient beds in four disparate program areas: adult mental health, adolescent mental health, forensic services, and services for persons with developmental disabilities.[3] The adult mental health unit is

[3] We note that the combination of populations at GRHA is unusual. Each population and the combination of these populations present unique health, safety, and treatment concerns.

comprised of 124 beds and serves the six counties of metropolitan Atlanta, a population of more than four million people. The adolescent unit, comprised of 28 beds, is the sole adolescent program statewide. The forensic unit, comprised of 90 beds, serves both persons charged with a crime who require evaluation before trial, as well as persons committed by the courts to the hospital for treatment after being found incompetent to stand trial or not guilty by reason of insanity. The unit for persons with developmental disabilities provides residential care to 41 patients. In addition, four beds are reserved for temporary care for individuals who are in crisis in the community. GRHA also operates 65 beds providing residential skilled nursing care to persons with developmental disabilities who are also medically fragile.

II. LEGAL STANDARDS

The Fourteenth Amendment due process clause requires state mental health care facilities to provide patients with "adequate food, shelter, clothing, and medical care," along with conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training, including treatment, as may be reasonable in light of their constitutionally-based liberty interests. Youngberg, 457 U.S. at 315, 319, 322.

In order to secure these liberty interests, individualized treatment must be provided that will give patients "a reasonable opportunity to be cured or improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975); D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997)(holding that the constitutional right to psychiatric care and treatment is triggered by the State's physical confinement of an individual with mental illness; the court noted the holding of former Fifth Circuit cases, including Donaldson (which are binding upon the Eleventh Circuit if decided before September 30, 1981)); see also Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23. Patients have a due process right to have all major decisions regarding their treatment be made in accordance with the judgment of qualified professionals acting within professional standards. Griffith v. Ledbetter, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989).

In addition, patients' constitutional liberty interests in security compel states to provide reasonable protection from harm

in mental health hospitals. Youngberg, 457 U.S. at 315-16. States are also compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, states may not rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188.

It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Thomas S., 699 F. Supp. at 1189. Seclusion and restraint should only be used as a last resort. Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980). Further, professional judgment should be exercised on a case-by-case basis regarding the most appropriate setting in which individual patients should be placed. See, e.g., Thomas S., 902 F.2d at 254-55.

Medicare/Medicaid regulations governing certified psychiatric hospitals, such as those in Georgia, require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483.

Furthermore, Georgia must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); see Olmstead, 527 U.S. at 607 (holding that states are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities).

III. FINDINGS

Significant and wide-ranging deficiencies exist in GRHA's provision of care. Certain conditions and services at GRHA substantially depart from generally accepted professional standards, and violate the constitutional and federal statutory rights of patients who reside there. In particular, we find that GRHA: (1) fails to ensure the reasonable safety of its patients; (2) fails to provide adequate mental health treatment; (3) engages in the inappropriate use of seclusion and restraints; (4) fails to provide adequate nursing care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. Many of these deficiencies stem from a system that does not have clear, specific standards of care or an adequate number of trained supervisory, professional, and direct care staff.

A. GRHA Does Not Adequately Protect Patients from Harm

Patients at GRHA have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. GRHA fails to provide a living environment that complies with this constitutional mandate. Specifically, individuals residing at GRHA are subject to frequent patient assaults that often result in serious harm, to unchecked self-injurious behavior, and to abuse and neglect. The harm GRHA residents experience is multi-faceted and includes physical injury; psychological harm; inadequate, ineffective, and counterproductive treatment; repeated hospitalizations; and excessively long hospitalizations. The facility's ability to address this harm is hampered by inadequate incident, risk, and quality management, including deficient investigative practices.

1. Incidents at GRHA Are Serious and Recurring

Our review of the incidents at GRHA revealed that they are serious, recurring, and frequently result in grave harm. We highlight three areas where the problems are particularly acute: patient aggression, accumulation of contraband, and suicide ideation and attempts.

a. Patient Aggression and Self-Injurious Behaviors Are Not Controlled

Patient aggression is not adequately controlled on many of the units at GRHA. A melee that occurred on the Adolescent Unit just one week prior to our visit is illustrative of the problems we found with uncontrolled patient aggression at GRHA:

- On September 8, 2007, six adolescents began throwing tables and chairs at the window protecting the nurses' station. Three of the adolescents forced the door to the lobby of the Adolescent Unit open by kicking and slamming it with their bodies. The patients broke tables and cabinets in the lobby area and attempted to force open the outside door. One patient held a piece of plexiglass to his neck, threatening to cut himself, and then cut his neck before staff was able to take the piece of plexiglass from him. Other patients not involved in the destructive behavior refused to stay in their rooms and began running around the unit. Staff and facility police were unable to restore order and had to call DeKalb County police officers to diffuse the situation.

Our review of patient incidents reveals troubling patterns in the patient aggression: repeat victims, repeat aggressors, and units where patient aggression is particularly uncontrolled. The frequent patient-on-patient assaults at GRHA often result in serious injury to the victim, including fractures, lacerations, and head wounds, many of which can not be treated at GRHA and require treatment at the local emergency room. These incidents are not merely fights between two patients. Rather, they often involve multiple assailants. For example:

- A.A.[4] was assaulted by two patients two days after he was admitted; his right eye was injured. Less than a week later, A.A. was again the victim of an assault by two patients; this time his left eye was injured.

- B.B. was attacked by three patients, and the following day he was attacked by two patients, one of whom participated in the first assault.

Assaults and patient aggression are particularly problematic on the Adolescent Unit. GRHA staff are unable to provide adequate security for the patients on that unit. Among the serious incidents that occurred during our visit[5] was one involving C.C., a 16-year-old patient experiencing his 13th

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[4] To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

[5] The DOJ team was not on the Adolescent Unit at the time of the incident, although we observed the debriefing following the incident.

psychiatric hospitalization in two years. C.C. entered a psychiatrist's office and refused to leave. His behavior became threatening, escalating out of control as he began destroying items in the office and banging on the locked door. The psychiatrist tried unsuccessfully to call for help and finally hailed a staff member in the vicinity who called an emergency code. C.C. left the doctor's office and damaged property in the front lobby before he was eventually calmed and placed in seclusion. In a debriefing following this incident, staff uniformly reported feeling unsafe on the Adolescent Unit. The psychiatrists asserted that lack of adequately trained staff resulted in "continuing clinical chaos" on the unit. Notably, GRHA staff asserted to the DOJ team that the adolescent patients would be safer outside of GRHA.

Staff as well as patients are often the victims of assault. Indeed, staff on the Adolescent Unit are repeatedly victims of patient aggression. Our review found at least 22 incidents of patient aggression against staff on the Adolescent Unit between January and August 2007, including kicking, punching, biting, and sexual assault. For example, on January 12, 2007, D.D. approached a female staff member from behind, covered her mouth with his hand, pushed her against the wall, and attempted to sexually assault her. In another incident, E.E. took scissors from a shelf and threatened to attack a physician. On March 18, 2007, when a staff member attempted to intervene in a fight between two patients, both patients began punching and kicking the staff member for intervening in the fight. Given these conditions, it is not surprising that staff expressed fear and concern for their own and patients' safety on the Adolescent Unit.

Sexual assaults are not limited to the Adolescent Unit. Staff members and patients on other units have been similarly assaulted. For instance, one female staff member was forced into the kitchen by a male patient who pushed his body against hers and attempted to sexually assault her. In another example, a female patient reported that a male patient had come into her room and attempted to remove her pants before she persuaded him to leave.

The repeated and significant level of violence on the units suggests a fundamental failure to address the root causes of patients' aggression and demonstrates a failure to intervene adequately to prevent future incidents. The case of patient F.F. is illustrative:

- One night in late January 2007, F.F. broke a light fixture and threw a couch across the East Unit's day room. The following afternoon, he punched another patient in the forehead. A few days later, he pushed his physician during an examination and broke furniture in the day room. Ten days later, F.F. pushed another patient to the ground, and the patient struck his head on a chair as he fell, lacerating his eyelid and eyebrow. The following day, F.F. threw chairs across the cafeteria, and then went outside and began shaking a staff member's vehicle. That evening, F.F. hit a patient in the face. Within the next few weeks, F.F. attacked a staff member, putting him in a choke hold and wrestling him to the ground. We found no indication that F.F.'s treatment team developed a behavioral support plan to address F.F.'s aggression.

b. Contraband Is Not Controlled

Contraband is frequently recovered at GRHA, and much of this contraband has been converted into weapons by patients. During the same time frame as the aggressive incidents described above, F.F. was discovered with two razors, a large pair of scissors, a broken plastic knife, and several other pieces of contraband. A.A. used a razor to cut arteries in his neck and arms, requiring emergency room treatment. Many other patients have been found with weapons, including knives and razors, and with toothbrushes and combs sharpened into shanks. Other patients have been able to hoard or smuggle numerous pills, which, if taken at one time, could cause grave illness or even death. Given the level of patient aggression and the psychological instability of many of the patients at GRHA, the amount of contraband accumulated by patients is indicative of inadequate care and supervision.

c. Suicidal Ideation and Attempts Are Not Addressed Appropriately

A significant number of patients are admitted to GRHA for stabilization and protection because of suicidal ideation or attempts. Our review revealed a troubling number of patients who obtained the means to attempt suicide and/or who inflicted serious self-harm despite being admitted because of suicidal ideation or after declaring an intent to harm themselves. Three examples are illustrative:

- G.G. is a 21-year-old woman first admitted to GRHA in August 2007 after running into traffic with a broken glass bottle in her hand, threatening to kill herself. GRHA professionals determined that G.G. was stable approximately

one week after her admission and discharged her to a homeless shelter. G.G. was readmitted to GRHA with suicidal ideation only three days after her discharge. Seven hours after arriving on a residential unit, and less than 32 hours after her admission, G.G. had both the means and the opportunity to make a serious suicide attempt. She was found lying face down in a pool of blood outside her bedroom doorway, unresponsive, with a cord wrapped tightly around her neck, and bleeding from her mouth and nose. Witness statements suggest that the cord was made of shoe laces and/or a robe belt from a bag given to G.G. on the admissions unit. GRHA records indicated that staff had not checked on G.G. for more than 30 minutes, although her observation level required that she be checked every 15 minutes.

- H.H. has repeatedly attempted suicide during her admissions to GRHA. In July 2006, she obtained a razor and made multiple cuts to her abdomen requiring suturing. Less than two weeks later, H.H. broke a ceiling light and swallowed the glass, requiring treatment at the emergency room. The following month, H.H. broke a light bulb and repeatedly lacerated her arms, again requiring attention at the emergency room. During a subsequent admission in March 2007, H.H. again broke a ceiling light, lacerated her arms, and allegedly ingested glass. These injuries once again required emergency room treatment.

- A.A. cut his neck and arms with a razor on May 8, 2007. He was rushed to the emergency room to stop the arterial bleeding. When staff initially entered his blood-spattered room, A.A. shouted "I told you I was suicidal."

2. <u>GRHA Provides Inadequate Incident and Risk Management</u>

To protect its patients in accordance with generally accepted professional standards, GRHA should have in place an incident and risk management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. Although policies and procedures describe such an incident and risk management system at GRHA, this system is not implemented, and the actual incident and risk management system falls significantly short of these

standards. As indicated above, GRHA has serious, recurring incidents and inconsistent incident reporting. Moreover, GRHA fails to identify risks and to implement corrective actions, and performs inadequate investigations. As a result, patients are routinely exposed to actual and potential harm.

a. Incident Reporting Is Incomplete

The first necessary step in addressing harm like that at GRHA is to ensure complete and accurate incident reporting. Although GRHA's incident reporting policy requires that all incidents be sent to the Compliance and Risk Management Department so that they can be entered into a centralized incident and injury database, this policy is not adequately followed. During our tour, we reviewed documents generated from GRHA's incident and injury database, including a facility-wide statistical summary of all incidents and injuries for the period between January and July 2007. This database summary indicated that the Developmental Learning Center ("DLC"), a 38-bed unit, reported only three incidents in this six month period. Records maintained on the DLC unit, however, indicated that 153 incidents occurred during that same period. Neither the DLC Director nor the Director for Compliance and Risk Management, who oversees the database, were aware that the DLC's incident reports had not been forwarded to the risk management department. Thus, from January 2007 until our consultant's review of the records in September 2007 -- a period of more than eight months -- records in the risk management department reflected a nearly complete absence of harm in the DLC, and no one noticed, investigated, or corrected this highly unlikely anomaly.

Failure to forward incident reports to the risk management department, and a corresponding failure to notice that these reports are missing, is not limited to the DLC. According to our review, GRHA's risk managers had also not received any incident reports from Secure Unit II for August or September 2007, despite this unit averaging seven incidents per month. Even if this lapse was attributable to a delay, and not a failure to report, the delay itself would be a critical failure to respond promptly to incidents of harm. Indeed, we found that GRHA has been repeatedly cited by State investigators for failing to report critical incidents in a timely manner as required by State policy.

The absence of reliable incident data, coupled with GRHA's inability to recognize this issue, indicates a grave deficit in the administration's operational oversight. Without reliable data regarding incidents and injuries, GRHA is incapable of

responding appropriately to prevent future harm. GRHA's failure to adequately report incidents and injuries significantly departs from generally accepted professional standards.

b. Risk of Harm Is Not Identified and Sufficient Preventive Actions Are Not Taken

Incident management focuses on the collection and aggregation of data that are meaningful to protect an individual from harm, while risk management focuses on identifying actual or potential harm from that data and taking timely action to prevent the harm from occurring or recurring. Generally accepted professional standards dictate that a facility's risk management program: (1) identify actual or potential risks of harm based on historical data, diagnoses, and co-occurring conditions; (2) develop timely and appropriate interventions designed to reduce or eliminate the risks of harm; and (3) monitor the efficacy of the interventions and modify them as necessary in response to further data. GRHA fails to provide adequate risk management in each of these areas.

Although GRHA's incident and injury data are significantly under-reported, trends in the existing data are nevertheless evident. These trends, however, appear to go unrecognized at GRHA. We found numerous examples of significant incidents or escalating patterns of incidents that remain unaddressed. For example:

- As discussed earlier, F.F. had at least seven incidents of aggression against peers and staff within a five-week period, and multiple incidents of seclusion and restraint. Notwithstanding these indications of continued crisis, F.F. does not appear on the facility's list of persons with a Behavior/Safety plan.

- I.I. was admitted to GRHA after he was found incompetent to stand trial on child molestation charges. In July 2007, I.I. reported to a nurse that he had inserted a bottle of deodorant in his rectum, and was sent to the emergency room to have it removed. The only intervention by GRHA staff appears to have been an instruction not to insert objects in his rectum again, and questioning from his psychiatrist about why he had done so, which I.I. declined to answer. I.I.' medical record does not reflect that his treatment

team either revised his treatment plan or otherwise addressed this issue.[6]

The failure to identify actual or potential risks to patients and respond with appropriate interventions is a significant departure from generally accepted professional standards. Even when risks are identified, however, GRHA inadequately addresses those known risks. For example:

- A Corrective Action Plan ("CAP") was developed after H.H.'s July 2006 suicide attempt but was not implemented at the time of her discharge. It was not implemented when H.H. was readmitted in March 2007 and made a similar suicide attempt, her fourth, while at GRHA.[7]

- I.I. was on "sexual protocol" which required both line-of-sight observation and a single bedroom to prevent I.I. from sexually assaulting other patients. On June 14, 2007, I.I. was assigned to the same bedroom as four other patients; that evening, I.I. sexually assaulted another patient in the room.

- J.J. was assigned to line-of-sight observation in February 2007. Having failed to maintain this observation level, a staff member went into J.J.'s bedroom only after hearing a loud noise from inside and discovered J.J. choking another patient. The victim required emergency room treatment. Had J.J.'s line-of-sight protocol been followed, this incident would not have occurred.

We discovered many other instances in which CAPs were not implemented in a timely manner. For example, in November 2006, several staff restrained a patient in a prone (face-down) position. The CAP involving this potentially life-threatening deviation from generally accepted professional standards was not initiated until three months after this incident. In another egregious example, K.K. attempted to strangle herself with a string in May 2006, while on line-of-sight observation. A CAP

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[6] I.I. was discharged to a personal care home several weeks later. There is no documentation of this incident in his progress notes, discharge summary, or aftercare plan.

[7] This is particularly troubling because of the great similarity between her suicide attempts; had a CAP been implemented, her March 2007 suicide attempt might have been prevented or the harm mitigated.

was not initiated until March 2007, 42 weeks after the incident. Moreover, we note that GRHA's failure to ensure that CAPs are completed and implemented in a timely fashion was raised in the Medical College of Georgia's May 2007 Report. The repeated failure to complete CAPs in a timely manner jeopardizes GRHA's ability to protect patients from harm. GRHA's continued failure to follow its own action plans, despite the identified risks, is a grave deviation from generally accepted professional standards.

c. Investigative Practices Are Inadequate

Generally accepted professional standards dictate that facilities like GRHA investigate serious incidents such as alleged abuse and neglect, serious injury, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures.

The investigative process at GRHA significantly departs from these standards, both because of irregularities in collection and preservation of evidence, and because we found instances in which serious allegations of abuse and injury were not investigated at all. Illustrative examples include:

- L.L. was admitted to GRHA on August 4, 2007. She was transferred from an acute care facility to GRHA because of suicidal ideation. During her 44-day stay at GRHA, L.L. was physically and sexually assaulted; her injuries included a 2-3 inch facial laceration. Neither assault was investigated or addressed. The failure to investigate assaults by a fellow patient during this time is especially troubling because the assaults, which were 20 days apart, were perpetrated by the same individual, and therefore, the second assault was arguably preventable. Moreover, the assaults L.L. suffered may have been the precipitating cause of a severe regression in her mental health recovery.

- On January 2, 2007, M.M. reported to staff that she had been sexually assaulted by her roommate, but there is no evidence that this incident was ever investigated.

GRHA's failure to investigate allegations of this magnitude is a significant departure from generally accepted professional standards.

In addition, we also found instances in which significant evidence was not properly identified, preserved, analyzed, and presented. The investigation surrounding the suicide attempt of patient G.G. in August 2007 illustrates the problems we found in this area. In the back of G.G.'s medical record, we discovered a manila envelope containing progress notes that related to G.G.'s attempted suicide, as well as statements by six patients who witnessed the incident. The outside of the envelope had a handwritten note stating that these documents were "removed from medical record." These additional progress notes and witness statements included relevant details about the incident that were not included in the progress note that remained in the medical chart. The additional statements describe several irregularities in G.G.'s care that may have played a significant role in the incident: (1) staff was meeting together during the incident and not observing G.G. at the 15 minute intervals required by her care plan; (2) at least one staff member had argued with the patient just before her suicide attempt (an argument that escalated to shouting, and may have escalated to pushing); and (3) staff were unable to locate emergency bags or scissors to cut the ligature from G.G.'s neck. The handwritten note on the manila envelope containing the removed materials also stated that staff had contacted the Director for Compliance and Risk Management regarding these documents.

The removal of documents from the medical record in these circumstances is highly irregular, and a significant departure from generally accepted professional standards. Equally disconcerting, however, is the fact that there appears to have been no investigation of the fact that documents were removed from the record. There is also no evidence that GRHA addressed any of the details raised in the additional progress notes and witness statements, or that the contradictory eyewitness statements were investigated and reconciled. Failing to investigate and reconcile these conflicting eyewitness statements is a serious departure from generally accepted professional standards in performing investigations.

Another example of GRHA's inadequate investigatory practices is the investigation and mortality review of the death of J.J. in April 2007. J.J. was admitted to GRHA from the Fulton County Jail on March 14, 2007 at 12:20 a.m. He spent the first two and a half hours in the Admissions Unit and was then transferred to the West Unit. At 7:00 p.m. that evening, staff found J.J. lying

on his bed with coffee ground emesis[8] on the sheets and the floor. He was promptly transferred to Grady Memorial Hospital, where he died five weeks later.

J.J.'s death certificate indicates that the medical examiner suggested that J.J. likely incurred an injury while at GRHA on March 14, 2007, apparently by ingesting a foreign substance. GRHA conducted an internal investigation into J.J.'s death, but this investigation was inadequate. For example, critical information was not gathered or analyzed regarding the intensity level of J.J.'s supervision, or whether he was supervised as required. GRHA investigators did not interview any of the staff who cared for J.J. during his brief stay at GRHA, nor determine whether he was examined by a physician after being placed on the West Unit. The investigative report is devoid of substantive information regarding the care J.J. received at GRHA. Nevertheless, the investigation concludes that: "Staff followed hospital and DHR protocol in ensuring that [J.J.] received appropriate care." There is no basis for this conclusion in the record. GRHA's investigation into J.J.'s death represents a gross deviation from generally accepted professional standards in mortality reviews.[9]

3. Quality Management Is Inadequate

Generally accepted professional standards require that a facility like GRHA develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of corrective actions taken in response to problems that are discovered.

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[8] Coffee ground emesis is the medical term for vomit that contains blood.

[9] When done properly, mortality reviews often raise programmatic issues that should be reviewed and evaluated. By failing to require adequate mortality reviews, to follow established procedures for conducting the reviews, and to follow up on the reviews conducted, GRHA is failing to identify the underlying causes of deaths and to correct deficiencies that may prevent deaths or similar harm from occurring in the future.

GRHA falls far below these standards. Instead, we found that GRHA's quality management system lacked accountability and oversight, resulting in corrective action plans and performance analyses remaining outstanding for months at time. For example, GRHA has a committee that is responsible for analyzing and addressing patient safety data and when necessary, conducting performance analyses to study and resolve adverse incidents or trends. At the committee's January 16, 2007 meeting, it noted that an analysis on sharps contraband for Central Unit remained outstanding for 25 weeks. By June 18, 2007, with the analysis still outstanding, more than 45 weeks after it had been initiated, another Central Unit patient had obtained a razor and attempted suicide.

B. Mental Health Care Is Inadequate

GRHA patients have a constitutional right to receive adequate mental health treatment. Donaldson, 493 F.2d at 520. The mental health services at GRHA, however, substantially depart from generally accepted professional standards. Psychiatric practices are marked by inadequate assessments and diagnoses, which in turn, lead to inadequate treatment planning and delivery of inadequate treatments and interventions. Psychology services and behavioral management services are particularly deficient. Medication management services are inadequate. Each of these failures affects the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Moreover, GRHA's failure to treat a patient's mental health needs while hospitalized has frequently led to failed discharges and to repeated hospitalizations.

In accordance with generally accepted professional standards, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. Treatment plans should define the goals of treatment, the interventions to be used in achieving these goals, and the manner in which staff are to coordinate treatment. The treatment plans should also detail an integrated plan designed to promote the patient's stabilization and/or rehabilitation so that the patient may return to the community. Taken together, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are critical to a hospital's ongoing efforts at quality improvement.

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant

clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

GRHA treatment planning substantially departs from these standards. From initial diagnosis and assessment, to the development of skills and functioning necessary for recovery and community reintegration, GRHA's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; patients are at increased risk of relapses and repeat hospitalizations; and patients' options for discharge are significantly limited, resulting in unnecessary prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

1. Psychiatric Assessments and Diagnoses Are Inadequate

Mental health treatment begins at the time of admission. The admissions work-up is an integral part of the course of hospitalization; it establishes the initial diagnosis and begins the course of treatment for the patient as he/she begins his/her hospital stay. We noted many deficiencies in the initial assessments we reviewed. Assessments were often not timely or thorough. Intake patient histories and medical status were often incomplete and inadequate. One example is N.N., who we witnessed having a seizure during a medical code. N.N. had been admitted to GRHA the day before. The code was poorly handled. There was considerable delay due to the lack of clarity in his chart regarding his medical status and whether his seizure medication had been continued upon admission. It was apparent that inadequate assessment and the resulting inadequate documentation contributed to poor management of this seizure.

An effective treatment plan begins with a diagnosis that is clinically justified. If mental health professionals do not correctly identify a patient's psychiatric condition before developing a treatment plan, the treatment interventions will not be aligned with the patient's needs. Thorough assessments are necessary to identify presenting problems and strengths and needs of the patient, and to identify potential risks from aggressive or self-injurious behavior, potential victimization, or high risks presented by substance abuse or certain medical conditions. Adequate assessments are essential to the development of a person-centered plan that can direct rehabilitation, treatment, and care while the patient resides in the hospital, and to formulate an adequate discharge and transition plan for the patient's return to the community. Psychiatry, medicine, nursing, psychology and social work each should contribute to the assessment in accord with generally accepted professional standards.

At a minimum, an initial assessment should include: (1) an adequate review of presenting symptoms and the patient's mental status; (2) a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the patient and others. As more information becomes available, the assessment must be updated to include: (1) a history of the presenting symptoms from the patient based on the patient's level of functioning and from collateral sources, as available; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's biopsychosocial functioning; (4) a review and critical examination of diagnostic conclusions made in the past in light of new information; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

In many cases, initial assessments at GRHA are cursory. The assessments used at GRHA fail to identify the strengths of the patient. They also frequently fail to assess substance abuse history, vocational and educational history, and history of community living and prior placements. A majority of psychiatric assessments contained rudimentary descriptions of current symptoms without examining in any depth the history of the symptoms and previous treatments. Each of these failings creates a serious impediment to the treatment team's ability to identify the services and supports a patient may need while in the facility and upon discharge.

GRHA patients are routinely given tentative and unspecified diagnoses (often referred to as "rule out" or "not otherwise specified" ("NOS") diagnoses) as a result of these flawed assessments. We found virtually no evidence of further assessments or observations to finalize the diagnoses. Because different psychiatric conditions can have similar signs and symptoms, it is important for mental health professionals to address rule out and NOS diagnoses to ensure that a patient's treatment is appropriate for his or her actual mental health needs. At GRHA, however, rule out and NOS diagnoses persist for months, with no sign of further diagnostic refinement. The prevalent use of the "NOS" diagnosis reflects an inadequate diagnostic evaluation process and contributes to the lack of specificity in treatment plans.[10]

O.O., who has a discharge diagnosis of Psychotic Disorder NOS, exemplifies the inadequacy of GRHA's assessments. O.O. has had multiple readmissions to GRHA and was slated for imminent discharge, notwithstanding discussion of her active psychosis in the treatment team meeting the day before her scheduled discharge. The absence of a definitive diagnosis has perpetuated a generic treatment approach that has repeatedly failed this patient.

GRHA's failures in the preliminary stages of assessment and diagnosis, as well as its failure to reassess patients to refine diagnoses, grossly depart from generally accepted professional standards. Patients receive, or are at risk of receiving, treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses. The result is that the actual mental illness is often unaddressed, placing patients at risk of prolonged institutionalization and/or repeated admissions to the facility.

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[10] The May 3, 2007 Medical College of Georgia Survey Report ("the MCG Report") also concluded that the prevalence of the NOS diagnoses at discharge (two of the top five discharge diagnoses in 2005-2006 at GRHA were Psychotic Disorder NOS and Depressive Disorder NOS) indicates a lack of thorough diagnostic evaluation. The MCG Report described one patient who carried an NOS diagnosis for over two years. The lack of diagnostic specificity remains a continuing problem. From July 2006 to July 2007, Psychotic Disorder NOS and Depressive Disorder NOS remained two of the top five discharge diagnoses at GRHA.

2. Treatment Planning Is Inadequate

a. Treatment Plans Are Not Individualized and Do Not Address Patients' Needs

Treatment plans, which at GRHA are called Individual Recovery Plans ("IRP"), or Individual Habilitation Plans ("IHP"), are, for the most part, inadequate and fall far short of generally accepted professional standards. They are frequently minimalist, generic, and reflect neither the true scope of patients' needs nor a coherent plan for treatment. When the treatment team fails to identify or address all of a patient's presenting concerns, that patient is deprived of treatment for those concerns, and frequently subject to a longer period of institutionalization or to a repeat admission when those conditions or behaviors become barriers to successful community integration. Multiple re-admissions are extraordinarily costly to patients and the system. Frequent relapses may cause a progressive worsening of a patient's mental illness and make the patient more intractable to treatment. Multiple re-admissions are also costly to the system of care, resulting in multiple assessments, care plans, and other treatments, where one adequate provision of these services would have sufficed. Examples of deficient IRPs include:

- P.P. had 21 readmissions to GRHA in the first nine months of 2007. Her treatment plans for each of these 21 stays at GRHA were identical.

- Q.Q.'s IRP included a single goal related to completing an evaluation of competency to stand trial. There were no goals or interventions to address his assaultive behaviors. As a result, after he assaulted his peers in the Adolescent Unit, he was transferred to an adult forensic unit in order to protect the other adolescents.

- R.R.'s IRP contained as his stated goal the phrase "incompetent to stand trial," which ended in March 2007, six months prior to our review. R.R. has no current treatment goals or interventions despite the fact that his psychiatric evaluation notes diagnoses of schizophrenia and substance abuse, and concerns with "chronic boredom, failure to accept responsibility for his actions, impulsivity, lack of remorse, lack of victim empathy, and poor behavioral controls."

- S.S.'s IRP calls for the psychologist to meet on an "as-needed" basis for cognitive behavioral therapy.

Cognitive behavior therapy requires a systematic, planned approach to psychotherapy sessions; providing it on an "as-needed" basis is contrary to the principles of the intervention and has virtually no chance of a meaningful treatment effect. Moreover, none of the treating or supervising clinicians on this case appear to have noticed this glaring incongruity, which suggests a deficit in professional knowledge, training, and/or supervision.

- T.T.'s IRP lists only his diagnoses ("Major Depressive Disorder, recurrent, severe; Alcohol Dependence") and four problems ("suicidal ideation, depressed mood, paranoid, substance abuse"); the remainder of the IRP is blank. The IRP fails to include any goals, objectives, or interventions to address his identified problems.

- U.U.'s IRP lists only his diagnoses ("Psychotic d/o, NOS; Cannabis abuse") and a single problem statement ("Paranoid, suspicious; h[istory] o[f] S[uicidal] I[deation] / H[omicidal] I[deation]"). The IRP does not include any goals or objectives nor any interventions to address the problems. The patient was discharged after one day with a single progress note which concludes: "Will d/c [discharge] him as he is stable now."

- V.V. has had 107 admissions to GRHA. Despite her continuing need to be hospitalized, V.V.'s treatment plan rarely varies across her more than one hundred admissions.

Inadequate assessments that fail to discern the reasons for multiple re-admissions, and treatment plans that fail to address relevant clinical presentations in a specific, individualized, strengths-based, recovery-oriented manner have resulted in repeated failures of treatment at GRHA and the subsequent failure to succeed in the community.

Treatment plans at GRHA often provide no clear alternatives if the initial, vague interventions prove ineffective, leaving staff with few alternatives to restraint, seclusion, and PRN (pro re nata or "as needed") medications to address challenging behaviors. Examples of vague or generic treatment plans include the following plans, which provide nearly identical goals for patients with very different diagnoses and treatment needs:

- W.W.'s diagnoses include Impulse Control Disorder, Post-Traumatic Stress Disorder, and moderate mental retardation. His IRP contains a single generic goal related to his mental illness: to "participate in developing a

realistic aftercare plan that can be followed in the community."

- X.X.'s diagnoses include schizoaffective disorder and borderline personality disorder. His IRP includes a goal identical to that for W.W.

The recurrence of identical goals and objectives for patients makes evident the non-individualized nature of GRHA's treatment plans.

The lack of meaningful treatment and habilitation services for residents on the DLC unit, where the majority of the residents may need behavioral supports but have no co-occurring psychiatric disorder, is particularly problematic.[11] A sense of complacency pervades the DLC, where patients' limited skills or challenging behaviors seemingly are accepted as unchangeable, and is reflected in the inadequate treatment plans and interventions for the residents of these units. For example:

- Y.Y.'s IHP does not provide for any skill training programs despite identified challenging behaviors. Y.Y. has a behavior plan that calls for increasing her verbal expression of needs and desires, but no program plan designed to accomplish this goal. Accordingly, Y.Y.'s behaviors have remained unabated, requiring intensive 1:1 supervision for over two months' time.

- Z.Z.'s "skill training" of learning how to hold a switch in an "on" position is inappropriate, meaningless, and will not enrich this person's life.

GRHA's failure to provide adequate treatment to DLC residents is exacerbated by clinically outdated and unsupportable opinions about patients with developmental disabilities. For example, the facility's speech therapist told us that an entire unit of residents in the DLC does not require communication skills programming because their level of development is too minimal to benefit from this training.

To conclude that challenging behaviors are an inherent and unchangeable part of the condition of mental retardation is a

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[11] As indicated earlier, the DLC, or Developmental Learning Center, houses residents with developmental disabilities, with the majority having no co-occurring psychiatric disorder.

gross deviation from generally accepted professional standards, and suggests a lack of training and competency regarding current practices. Because of this commonly-held view at GRHA, these behaviors are not addressed, patients are deprived of effective treatment, and these behaviors become a justification for continued institutionalization. This is an egregious violation of these patients' rights.

b. Failure to Address Repeated Admissions

GRHA's high rates of hospital re-admission are well documented. Audits commissioned by the Governor, including the 2005 Georgia Mental Health Gap Analysis study, concluded that a 30-day readmission rate 55% greater than the national average contributed to overburdening the State's Psychiatric Hospitals. These conditions persist. In the past year, several units at GRHA routinely exceeded 100% occupancy, and high 30-day readmission rates continued as well.

The work of admitting patients and providing the crisis stabilization necessary for new admissions leaves an already overburdened system with fewer staff resources to provide treatment planning, interventions, and supervision for patients. Moreover, frequent re-admissions are extremely detrimental to these individual patients, disrupting their recoveries and their lives in the community. Frequent relapses and re-admissions may progressively worsen a patient's serious and persistent mental illness and make patients more intractable to treatment. Thus, generally accepted professional standards demand that treatment teams routinely examine and address issues that cause individuals to be admitted repeatedly to the hospital. However, in multiple cases of repeated admissions we saw no evidence that the treatment team examined or addressed the factors that led to re-admission or altered the patient's treatment from a previous stay at the hospital. For example:

- As mentioned previously, V.V. has had 107 GRHA admissions, with little change in her treatment plans across admissions.

- P.P. had 21 GRHA hospitalizations in the first nine months of 2007, with no change in her treatment plans.

- A.B. has had 14 GRHA admissions, including twice in 2007, with virtually the same treatment plan upon each admission. Despite a diagnosis of substance abuse, he received no substance abuse treatment during his two 2007 admissions.

c. Treatment for Substance Abuse Is Inadequate

There is a stark lack of treatment and interventions for patients with co-occurring diagnoses of substance abuse. It was evident in a significant number of records that this issue was one of the most serious impediments to community placement and part of the reason for frequent re-admissions to the hospital. Examples include:

- A.C. has had 37 GRHA admissions, including twice in 2007. She has a diagnosis of substance-induced psychotic disorder with hallucinations, but has received no substance abuse treatment during her many GRHA admissions. In addition, GRHA discharged A.C. to the Union Mission night shelter without adequate planning for community substance abuse care.

- A.D. has had 41 admissions to GRHA. He has a dual diagnosis of schizoaffective disorder and substance abuse. After his last two admissions in 2007, he was discharged to a homeless shelter without adequate coordination with community substance abuse services.

- A.B. has had 14 GRHA admissions, with two admissions in 2007. He has a co-occurring diagnosis of mood disorder and substance abuse disorder. In the past year, A.B. was discharged to a homeless shelter after his first admission and returned to GRHA only ten days later. He received no treatment for substance abuse while at GRHA and no planning for substance abuse services when he returned to the community.

- A.E. has had 53 GRHA admissions, with four admissions in 2007. He has a diagnosis of schizoaffective disorder and substance-induced psychotic disorder. On her last two admissions, A.E. was discharged to a homeless shelter without adequate planning for substance abuse care in the community.

- A.F. is an adolescent with profound substance abuse problems noted in his record. His treatment plan says A.F. is to be enrolled in a substance abuse group, but there are no substance abuse services offered on the Adolescent Unit.

The lack of substance abuse programming and its deleterious effects on patients at GRHA is well known to hospital and state administrators. The GRHA administrator and the Director of the Division of Mental Health, Developmental Disabilities, and

Addictive Diseases both candidly admitted this deficiency and acknowledged that the deficiency was particularly acute for adolescent patients. This deficit was also cited in the MCG audit. Notwithstanding these admissions, and in a pattern that echoes the failure of accountability throughout this system, a draft of the hospital's Corrective Action Plan generated in response to the MCG findings (dated several months prior to our visit), proclaims that corrective actions to remedy the substance abuse deficit in adolescent programming at GRHA are "complete."

3. Behavioral Management Services Are Inadequate

Behavioral support plans ("BSPs") at GRHA are largely nonexistent, and those that exist are largely inadequate and not well integrated into overall treatment. Many patients who were repeatedly subject to seclusion, restraint, and/or administration of PRN medications - measures that should be reserved for emergency crisis intervention - have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Staff across the facility were unable to identify events that would trigger a referral for a behavioral assessment or a revision to an existing behavior treatment plan. For those few patients with behavioral management plans, treatment teams routinely fail to revise those plans, notwithstanding evidence of continuing or escalating problem behaviors. In addition, there are clearly too few skilled psychologists and behavioral specialists on staff to develop and monitor adequate behavior management plans for the many patients whose behaviors suggest a compelling need for such plans.

When performed, behavioral assessments depart substantially from generally accepted professional standards. The few attempts at functional assessments of behavior found in patient charts at GRHA typically do not consider antecedent, environmental, or health factors that influence a behavior, whether a behavior is situationally appropriate, or possible reinforcers. The assessments do not contain sufficient baseline data, do not hypothesize a function for the behavior, and do not select replacement behaviors. When questioned about these deficiencies, the clinicians who prepared these functional assessments or supervised these cases appeared unfamiliar with many of the essential components of a minimally-adequate functional assessment. The inadequacies in the assessments undermine any subsequent behavioral treatment planning. An example is Q.Q., who has a behavior plan that does not define target behaviors, shows no baseline data for those behaviors, and specifies no replacement behaviors other than compliance with staff directions. His chart contained only one partially completed

behavior plan monitoring checklist. Not surprisingly, Q.Q.'s disruptive behaviors continued, leading to his transfer from the adolescent unit to an adult forensic unit.

GRHA fails also to collect sufficient behavioral data on which to base treatment decisions. Generally accepted professional standards require a mental health professional to analyze objective data concerning symptoms or behavior, and not merely anecdotal information. In interviews, GRHA staff indicated that the "data" they use in assessing a patient's target behavior, replacement behaviors, or his or her progress in meeting goals comes from reviewing progress notes or from asking line staff. The lack of accurate behavioral data hinders accurate evaluation of the progress, or lack of progress, made by patients. Accordingly, actions by treatment teams are often based on inaccurate summaries of the limited data collected, leaving teams at risk of making decisions that are not clinically indicated. Examples include:

- A.G.'s progress notes and data sheets are inconsistent. A progress note for A.G. dated June 1 reported zero incidents of sexually inappropriate behaviors, agitation, or angry outbursts for more than two weeks; however, the data sheets indicated he was verbally abusive toward staff/peers on May 29, May 30, and June 1, the days immediately before the progress note. A note dated June 20 reported zero incidents of sexually inappropriate behavior "since implementation." Yet the data sheets documented sexually inappropriate behavior every day but one, from June 10 through June 17.

- A.H.'s behavior plan data monitoring sheets include many inconsistent gaps. The data revealed numerous instances where a reward was provided when the data indicated it had not been earned, and numerous instances where the reward was apparently earned but not provided.

The lack of reliable and complete behavioral data deprives treatment teams of essential information on which to make sound clinical decisions, denying patients timely and effective interventions and allowing harmful and dangerous behaviors to persist.

Specific examples of GRHA's inadequate behavioral management services include:

- S.S. is a resident of the adolescent unit with documented repeated instances of serious self-injurious behaviors in September 2007. A BSP was initiated on September 9, 2007,

primarily consisting of 1:1 supervision but no other intervention. A September 19 note in her chart acknowledges that the behavior plan is not helping, but no change is recommended. The following day, we observed S.S. repeatedly bang her head against a wall while the staff assigned to provide her with 1:1 supervision recorded these events without intervening.

- A.H.'s Treatment Plan Review Note dated August 6, 2007, states that he "did not have a good review period. He showed frequent agitation . . . He exhibited numerous episodes of object aggression . . . Due to worsened behavior, he was transferred on 7/17/07 to Forensics I unit . . . His impulse control remains poor . . . ." Despite this review documenting escalating problem behaviors, A.H.'s treatment team failed to recommend any change in his behavior plan.

- A.I.'s chart contains frequent progress notes indicating deteriorating behaviors, including assault on staff members. The sole intervention is repeated PRN medications for "agitation." Following three days of daily incidents of significant aggression, which is not addressed at all in A.I.'s treatment plan, the Treatment Plan Review Note dated August 27, 2007, reads: "All goals are current and appropriate, Treatment plan to continue." The following week's Weekly Note stated that he "has become more disorganized and aggressive . . . He is up and awake for most of the night. He is not fully compliant with his treatment plan. The percentage of 'met' is getting lower." Significant aggression continued to be documented through the time of our site visit more than two weeks later, yet no changes were made to his plan.

- A.J.'s monthly behavior plan monitoring report documented steadily increased monthly rates of "inappropriate sexual behavior," increasing from three instances in April 2007 to 36 and 22 incidents in August and September, respectively. Despite this substantial increase, there was no evidence of a change to the behavior plan.

C. Seclusion and Restraints Are Used Inappropriately

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, the State may not subject residents of GRHA to seclusion and restraint "except when and to the extent professional judgment

deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training." Id. at 324. Generally accepted professional standards require that seclusion and restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. GRHA's use of seclusion and restraints, including medication used as a chemical restraint, substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of seclusion and restraint, and the fact that these measures restrict patients' rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like GRHA reduce their use of seclusion/restraint by addressing behavior problems with less intrusive and restrictive strategies. Regrettably, this does not occur at GRHA. Instead, many patients at GRHA have endured frequent episodes of seclusion, restraint, and/or sedating PRN medications, without any indication that the team adequately assessed the patient, developed and/or reviewed the treatment plan, or considered alternative interventions. For example, none of the following patients, who received multiple crisis interventions, including seclusion, restraint, and PRN medications, appeared on a list of patients with BSPs between May 1 and July 30, 2007:

- F.F. had 25 instances of seclusion or restraint in the four-month period between January 11, 2007 and May 11, 2007.
- A.K. had 12 instances of seclusion or restraint in the 33-day period between May 7, 2007, and June 9, 2007.
- A.J. had 13 instances of seclusion or restraint in the six-month period between February 16, 2007, and August 17, 2007.
- A.L. received 12 psychotropic PRN medications in the ten day period between June 7 and June 17, 2007.
- A.M. received 7 psychotropic PRN medications in a single week beginning July 9, 2007.

- A.N. received 23 psychotropic PRN medications in the two weeks beginning May 4, 2007.

- A.O. received 28 psychotropic PRN medications in the month of May 2007.

- A.P. received 11 psychotropic PRN medications in the ten days between July 9 and July 19, 2007.

There is no effective data collection and monitoring system with respect to the use of restrictive interventions such as seclusion, restraint, and PRN medications. Typically, nursing and direct care staff on the units are responsible for this documentation, but there are no systems in place at GRHA to ensure that this information is gathered. As a result, patients who are in need of more intensive treatment, or an alternate approach to treatment, are not identified and targeted for treatment plan revisions.

In a significant departure from generally accepted professional standards, the facility does not ensure that seclusion and restraints, including manual holds and PRNs, are used only as a last resort and not in the place of active treatment, as punishment, or as a convenience for staff. In some cases, restraints are written right into the program. In addition, contrary to generally accepted practices, we also found insufficient review of restrictive programs by the facility's human rights committee. Representative examples include:

- A.Q.'s behavior plan specifies an escalating series of negative consequences for displays of physical aggression, culminating in the statement: "Manual Restraint may be used."

- A.R.'s behavior plan states that if his self-injurious behavior continues, a team of "trained staff may implement a two person hold."

- A.J.'s behavior plan states that if he does not withdraw to a quiet location to calm down, "staff (at least 2) using mandt[12] approved manual holds, may assist to a quiet location."

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[12] The Mandt System is a program designed to assist staff in de-escalating inappropriate patient behaviors while treating the patient with dignity and respect.

- Q.Q.'s behavior plan includes "a prescribed p.r.n. if necessary" for escalating behaviors.

Throughout the facility, staff effort is focused primarily on controlling dangerous patients rather than treating them and changing their behavior. The Adolescent Unit is particularly problematic, where a volatile mix of patients, insufficient staffing and supervision, and ineffective treatment create a dangerous environment. Untrained staff lack the skills necessary to handle the large number of very impaired patients who are dangerous to themselves or others or who have specialized needs. Not surprisingly, we found that in these difficult circumstances, staff resort to seclusion and restraint and secondarily, PRN medication, in lieu of appropriate treatment.

Restrictive interventions clearly are used in place of active treatment, as punishment, and for the convenience of staff at GRHA, contrary to generally accepted standards. The facility averaged over 200 episodes of PRN use per month in the first seven months of 2007. In addition, a sample of 77 recent seclusion or restraint monitoring forms contained frequent notations that a patient was "out of control and was a threat to himself and others." However, in not a single instance were specific behaviors recorded that supported the conclusion that the patient was a threat to self or others. Moreover, there was not a single instance in these 77 examples where it was documented that alternative measures were tried prior to the use of a restrictive device, as required by generally accepted professional standards.

Furthermore, we found no system is in place to audit medical records regarding episodes of seclusion, restraints, or manual holds. This is notwithstanding assurances in the GRHA Plan of Correction, developed in response to findings of deficient seclusion and restraint documentation in the MCG Report, that "quality management staff will monitor charts with seclusion and restraint documentation for completion."

D. Medical Care Is Inadequate

Although GRHA patients are entitled to receive adequate health care, see Youngberg, 457 U.S. at 315, the facility's basic medical care and nursing services substantially depart from generally accepted professional standards. Specifically, GRHA fails to provide basic medical care and has inadequate clinical oversight, staffing, nursing services, medication administration, infection control, physical and nutritional management, and emergency preparedness.

1. Inadequate Clinical Oversight

The major role of clinical oversight in any institution is to ensure that generally accepted professional standards of practice and accountability are maintained. Specifically, staff responsible for clinical oversight should respond, in a timely manner, to identified problems and offer stable, consistent administrative guidance and supervision. GRHA fails to provide such adequate clinical oversight. Staff responsible for oversight in all of the major disciplines appear to be overwhelmed and reacting primarily to escalating crises. Repeated failures by supervisory staff to implement timely appropriate corrective action plans have led to significant and numerous harmful situations.

Both the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and consultants from the Medical College of Georgia have chronicled grave deficiencies at GRHA, including inadequate staffing and programming, the excessive use of seclusion and restraint, and unsafe clinical situations that have resulted in injuries to patients, including death. Despite these clear findings of repeated deficiencies, these conditions remain unabated. Despite a "plan of correction" and the administration's verbalization of an understanding of the extant deficits, the system of care remains in disarray with no sense of urgency of the need for things to change. Patient and staff injuries continue to occur with an alarming regularity without adequate intervention by those responsible for clinical oversight. The critical incidents we witnessed on the Adolescent Unit reflect the egregious consequences of the failure to address burgeoning problems effectively.

2. Inadequate Staffing and Nursing Services

In addition to lack of appropriate clinical oversight, GRHA suffers from a chronic nursing shortage, which has caused a number of serious deficiencies in the nursing services provided to patients. Specifically, nursing staff: (1) fail to provide basic medical care such as monitoring vital signs and responding in a timely manner to changes in patients' medical status; (2) fail to participate actively in the treatment team process by providing feedback on patients' responses, or lack thereof, to medication and behavioral interventions; (3) fail to document and monitor properly the administration of medications; and (4) fail to implement adequate infection control procedures. These deficiencies expose GRHA patients to harm and a significant risk of harm, including death.

In order for GRHA's nursing administration to verify that these essential elements of care are routinely provided, the department should have a formal, comprehensive, and rigorous system of monitoring the process, quality, and outcomes of the nursing department. Data generated from this system should be regularly reviewed and analyzed for trends, and plans of correction should be initiated for areas that fall below an acceptable standard of compliance. In addition, these data assist nursing management in identifying the etiology of problematic issues so that appropriate interventions can be implemented. This type of system also ensures that the Nurse Executive and facility administration are aware and responsive to the needs of department and ultimately, to the needs of the individual patients. Overall, those responsible for nursing oversight at GRHA are unaware of critical practice deficits that have become routine. In addition, there is no effective system in place that regularly reviews the practice of nursing to ensure that patients receive quality care and services.

Generally accepted professional standards require facilities like GRHA to provide sufficient nursing staff to, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization. GRHA, however, routinely compromises its patients' care and treatment by failing to satisfy these requirements. In the September 2007 melee on the Adolescent Unit, described infra, at page 8, in which local police were needed to restore order, the hospital's own staffing records called for three staff on each side of the housing unit, yet only two were present on each side. Before police could help restore order, the adolescent patients damaged property and at least one adolescent injured himself by cutting his neck with plexiglass.

The current Nurse Executive at GRHA admitted that recruitment and retention has been a major issue for the nursing department. She reported that there were a number of nursing vacancies but was unable to recall the exact number. Senior staff and administrators across disciplines agreed that there were excessive vacancies in nursing and direct care staff. A recurring issue is that GRHA has no formal mechanism with which to analyze the specific needs of each unit and determine the number and skill mix of nursing staff that each unit requires. Instead, nursing staff seem to be assigned to particular units based upon their schedules and availability, without serious regard to patients' needs. Although the facility has been working to revise the policy for minimum staffing ratios, there are no set criteria or models being used to determine adequate staffing levels. We found that many of the shortcomings in

nursing care are exacerbated by the lack of adequate staffing, support, training, and supervision. For example, recurring deficiencies in response to codes (both in drills and actual emergencies) show that staff were not retrained in essential skills, including rescue breathing and chest compressions in cardio-pulmonary resuscitation ("CPR"), maintenance of emergency equipment, and use of automatic external defibrillator ("AED") devices. Oxygen tanks were frequently empty and emergency bags were missing essential equipment, despite logs signed by nursing staff indicating that they had been checked. We saw no evidence that this falsification of documents had been addressed by supervisors or administrators.

3. Failure to Provide Basic Medical Care

Effective medical services depend on timely, thorough assessments and monitoring. GRHA staff often fail to provide even the most basic care, opting instead for a reactive approach in which patients' medical needs are addressed only after problems develop. Consequently, patients are exposed to a significant risk of harm and often suffer preventable injuries and illnesses. The harm at GRHA can be fatal:

- A.S. was 14 years old when she died in February 2006 of sepsis, likely caused by a severely impacted colon. She had been a patient at GRHA for several months. On the day before she died, she complained of stomach pain, and had nausea and vomiting, but no fever or other signs of infection. An on-call physician did not document an abdominal examination or a rectal exam to rule out impaction, a known side-effect of many antipsychotic medications used in A.S.'s treatment at GRHA.

- A.T. died at GRHA only three days after A.S.'s death. He was 33 years old and had been a patient at GRHA for several months. Several of A.T.'s medical concerns were mishandled, including failure to monitor his bowel function despite being on medications with a known side effect of constipation. He too, had a markedly-impacted colon at the time of death.

- Later that same year, a third patient, A.U., died unexpectedly, also with an impacted colon. This death likely would have been prevented, had the protocol allegedly adopted after A.T.'s death been followed. A.U. went for many days without a bowel movement, but this information was not flagged on the medical log designed to communicate daily information to physicians. While A.U.'s stated cause of

death was cardiovascular, his bowel obstruction clearly contributed to his death.

GRHA's failure to critically review the first death, which should have led to corrective actions that could have prevented the second and third fatalities, compounds the tragedy of these three deaths.

More examples of lapses in medical care, thankfully not fatal, include the following:

- Mild mental retardation, attention deficit disorder, and hyperthyroidism were noted and documented by A.V.'s psychiatrist, but not by his nurse. As a result, none of these issues are included in his nursing treatment plan.

- A.W.'s nursing treatment plan indicates that he is at risk for violence as evidenced by his self harm, aggressive behavior, and attacks on others. However, none of the nursing assessments address any of these issues.

- A.X.'s assessments indicate that he was disoriented, confused, and had a history of falls "while intoxicated." His nursing treatment plan fails to address any of these assessments. Moreover, A.X.'s nursing treatment plan indicates that he was a risk for violence against staff. However, his nursing assessments show no indication that this issue was ever evaluated.

- A.Y.'s nursing assessments are incomplete, with the section regarding emotional and behavioral status blank. In addition, there is nothing in the nursing assessments indicating that A.Y. was either aggressive or has suicidal ideation. His nursing treatment plan, however, indicated that he was at risk for violence to self or others related to aggression, as evidenced by threatening to kill animals and self-injurious behavior.

4. Inadequate Medication Administration

Generally accepted professional standards of nursing practice dictate that medications be administered as prescribed and appropriately documented. Moreover, generally accepted professional standards require that staff properly complete the Medication Administration Records ("MARs"). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and

reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently.

Our review of the MARs revealed numerous instances where several medications had not been recorded as given. Contrary to generally accepted professional standards, nurses did not perceive that these blanks were medication variances that needed to be reported. We also found blanks on the Narcotic Logs, where the on-coming and off-going nurses are to sign after the narcotics are counted together. Because narcotics have powerful and potentially addictive effects and are often classified as controlled substances, GRHA's failure to account properly for their administration is deeply troubling. Once again, the nurses did not perceive the omissions in the Narcotic Logs as medication variances that needed to be reported. This finding indicates unacceptable nursing medication practices as well as a lack of supervision by nursing supervisors during medication administration. In addition, this finding indicates that medication variances are grossly underreported.

5. Inadequate Infection Control

Generally accepted professional standards require adequate infection control. The components of an adequate infection control program fall into two general categories: surveillance and reporting; and control and prevention.

Surveillance and reporting include data collection, tabulation, and analysis on both the population of the facility and its employees. Data on infections acquired in the community before admission to GRHA, and infections acquired while residing at the facility should be collected. This data can be used to establish baseline infection rates for different units to determine problem areas or areas where in-service education could lower infection rates. This information can also be used to identify outbreaks of infections rapidly so that concentrated efforts can be initiated to prevent the spread of the infection.

In addition, facility personnel should be monitored and data analyzed for possible exposure to, or as the source of, communicable and infectious diseases. The environment itself must be monitored as a source of potential infection hazards, especially during outbreaks of infection. Also, the facility must report all communicable diseases to the appropriate health authorities in the State.

Control and prevention activities are of equal importance in an infection control program. In general, developing policies and procedures, staff training, patient educational programs regarding communicable diseases, and a regular committee review of facility infection control activities are components of a proactive infection control program.

GRHA's infection control program fails to meet these standards. Specifically, GRHA fails to provide adequate oversight to ensure that patients with infectious diseases are adequately treated, protected from additional infection or reinfection, and that other patients who live in the same buildings are appropriately protected from transmission of infections. At the time of our review, there was no system in place even to generate a list of patients or staff with infectious conditions such as hepatitis A, B or C, methicillin-resistant staph ("MRSA") infections, HIV, or other common, but serious, infectious conditions that should be monitored.

Moreover, there is no system in place ensuring that any infection control data collected throughout the facility is reliable or that any plans of correction have actually been implemented. There is currently no adequate infection control program at GRHA, a facility with a high risk population for communicable diseases, which places patients there at high risk for harm.

6. Inadequate Physical and Nutritional Management

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of patients who are at risk for aspiration/choking and the assignment of an appropriate risk level; the identification of patients' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; developing and implementing a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; providing competency-based training to all staff assisting these patients regarding individualized dysphagia[13] plans; developing a method to monitor, track, and document clinically objective data, including triggers, lung sounds, oxygen saturations, and vital signs, to determine if treatment interventions are effective or in need of modification;

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[13] Dysphagia is the medical term for difficulty in swallowing.

development of a mechanism for reporting triggers that generate an immediate response from a physical nutritional management team ("PNMT") to re-evaluate the plan and its implementation; development of an overall monitoring system conducted by members of the PNMT to ensure that plans are being consistently implemented and that this monitoring is most intense for those with the highest level of risk; and ensuring that this system is effective so that it may be transferred into the community.

GRHA patients residing at the Skilled Nursing Facility ("SNF")and the Developmental Living Center ("DLC") who are at risk for aspiration are not provided adequate assessments, interventions, proactive monitoring of symptoms, and regular treatment plan monitoring, which places them at significant risk for harm. GRHA does not provide these patients with physical and nutritional management care consistent with generally accepted professional standards.

None of GRHA's various disciplines (nursing, physical therapy, occupational therapy, speech pathology, and dietary management), have the requisite specialized training or experience demonstrating competency with physical nutritional management. This training is necessary for the care and treatment of patients at risk for aspiration and choking.

GRHA has failed to identify adequately patients who have physical or nutritional management issues. GRHA has no written criteria that adequately identify patients at risk for aspiration and/or choking. During interviews, staff were unable to identify the patients who were at risk for aspiration. Episodes of coughing or gagging were not routinely documented in the medical record. Consequently, there is no systematic collection of clinical data to indicate if a person's dysphagia is getting better or worse. Thus, GRHA rarely evaluates or modifies the interventions from treatment plans unless there has been an acute event of pneumonia, aspiration pneumonia, or respiratory distress. In some cases reviewed, there was no indication that the treatment plans were modified even when the patient experienced an acute event related to their aspiration risk. For example, A.Z., B.A., Z.Z., and N.N. were all admitted to the community hospital in 2007 for episodes of pneumonia, aspiration, and/or respiratory distress. However, none of their respective treatment plans for dysphagia included any indication that the team conducted additional assessments to evaluate the need to modify their interventions. The risks inherent in this flawed approach are not hypothetical. For example, A.Z. was admitted a second time to the hospital for aspiration pneumonia.

Moreover, there is also no system in place to accurately determine which patients fall into the severe, moderate, or mild risk categories. Consequently, there is no delineation of risk to identify those patients needing the most intensive, proactive treatments and interventions. The criteria for the risk categories should include past incidents of aspiration, episodes of aspiration pneumonia, presence of a gastrostomy ("G-Tube") or jejunostomy ("J-Tube") tube,[14] and coughing or gagging during meals and at bedtime. Developing criteria that identify patients who are at the greatest risk for physical and nutritional management problems is necessary to assist the teams in developing systems that ensure resources and interventions are appropriately focused.

Patients with dysphagia who have experienced recurrent aspiration pneumonia, pneumonia, or respiratory distress are not provided a comprehensive re-evaluation that assesses the appropriateness of the current treatment plan and modifies the interventions when necessary. There are several patients at the DCL and SNF units who have had recurrent bouts of aspiration pneumonia or pneumonia and are being fed by a J- or G-Tube. However, there was no indication that teams reassessed these patients or their treatment plans despite recurrent adverse outcomes. There was no indication that they were monitored for appropriate 24-hour positioning to ensure that the treatment plan was being implemented appropriately. Moreover, we found no proactive interventions initiated, such as monitoring lung sounds and oxygen saturations before and after meals, to detect health status changes.

Three patients illustrate the tragic consequences of deficiencies in physical and nutritional management: A.Z., B.C., and B.D., who each died of aspiration pneumonia. In each case, we found the following deficiencies:

- aspiration risk with recurrent signs and symptoms of dysphagia;

- failure to adequately identify the patients as aspiration risks and assign a risk level;

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[14] Gastrostomy and jejunostomy tubes, often referred to as a "G-Tube" or a "J-Tube," respectively, are used for the feeding of patients. A gastrostomy tube is placed in a surgical opening in the stomach, while a jejunostomy tube is placed in a surgical opening in the jejunum, a part of the small intestine.

- no indication that individual triggers or symptoms were identified, tracked, and documented;
- no adequate assessments for safe positioning and techniques for activities such as mealtime, oral care, bathing, dental appointments, or bedtime;
- no clinical justifications included in any positioning recommendations;
- no specific treatment plans containing specific instructions for any activities that increased their risks;
- no indication that staff responsible for their care received competency-based training on their treatment plans;
- no documentation of clinical objective data, including triggers, routine lung sounds, and oxygen saturations to proactively detect changes in status;
- no documentation that their plans were re-evaluated in response to changes in their health status; and
- no indication that their treatment plans were being regularly monitored to ensure consistency in implementation.

Compounding the tragedy of these three deaths, once again, is GRHA's failure to critically review the first death, which should have led to corrective actions that could have prevented the second and third fatalities.

GRHA has no protocol that addresses who is responsible for reviewing aspiration data, how often it should be reviewed, when other disciplines should alert the team to changes in the patient, and when the meal plan and treatment plan should be reassessed. These deficiencies in recording and using objective data to inform treatment decisions is the same systemic failure as the failure to record behavior data for purposes of therapeutic intervention, and the failure to record medication data and variances to monitor proactively medical conditions and medication regimes. There is no mechanism for reporting triggers to the treatment team and no time-line requiring the team to re-evaluate the treatment plan. According, the facility has no system in place to address adequately the physical and nutritional management of patients at risk of aspiration. These systemic deficiencies have resulted in tragic harm and continue to place patients at significant risk for harm.

7. Emergency Preparedness Is Inadequate

In accordance with generally accepted procedures, all staff should be well-trained in emergency preparedness, aware of emergency materials and where they are located, and conduct sufficient practice codes to be able to perform adequately when confronted with an actual emergency. Appropriate emergency medical response also includes physical plant readiness.

GRHA practices and procedures regarding emergency preparedness deviate substantially from generally accepted professional standards. For example, we found a significant lack of practice emergency codes. At the time of our September 2007 tour, no practice code had been conducted in the past year. Minutes from the Medical Emergency Committee detail a concern about the lack of drills and missing vital medical supplies discovered during an actual emergency medical code in which a patient died. Medical Emergency Committee minutes further identified other deficiencies including: emergency equipment not reaching the scene in a timely manner because the equipment was locked in medication rooms with limited accessibility; medical code sheets not appropriately completed; delayed responses due to unclear or inadequate announcements of medical codes; lack of staff familiarity with the use of emergency medical equipment; and oxygen tanks missing regulators and/or keys despite documentation indicating that the tanks were checked regularly. We found that these deficiencies noted by the GRHA Medical Emergency Committee still existed.

An example is the medical code for N.N. that we observed during our on-site tour. N.N. suffered a seizure in the GRHA cafeteria. Most of the assembled staff appeared not to be assisting, but merely observing. Contrary to generally accepted professional standards, nursing did not take the lead in conducting the code and implementing the physician's orders. Staff spent a significant amount of time trying to locate equipment and medications from nearby units because nothing was available in the cafeteria. Eventually, multiple staff members brought multiple emergency crash carts, medication, oxygen tanks, and orange emergency bags. Necessary equipment and medications were missing despite the multiple emergency bags brought to the scene. Multiple requests by the physician internist for a necessary medication and equipment went unheeded, resulting in unnecessary delay. In addition, GRHA staff responding to the medical emergency did not wear protective gloves, including the nurse who eventually injected the patient with medication. The chaos observed and evidenced during the handling of this medical code is reflective of poor training and inadequate preparedness

for emergencies. This is particularly troubling because of the vulnerable populations at GRHA. This is a gross and dangerous deviation from generally accepted professional standards.

The poor handling of this medical code was exacerbated by an equally inadequate review. The post-medical code debriefing, while acknowledging the lack of equipment, noted that "the response was quick and the staff who attended the code was [sic] efficient and followed directives well." Problematic issues that arose during the actual medical code were not addressed. Thus, the grave deficits we observed during this emergency code will likely continue to repeat.

Another example of a deficient code response - and a deficient review of the incident such that no lessons were learned to inform better practice in the future - is the suicide attempt of G.G., described earlier in this letter. Although witness statements described a confused staff response, emergency bags that did not contain scissors to cut the ligature from around G.G.'s neck, and other deficiencies, these witness statements had been removed from the official file. There was no investigation of these problems with the code, and indeed, as the example of the seizure incident during our tour illustrates, the problems persist.

E. Services to Populations with Specialized Needs Are Inadequate

1. Services to Patients with Limited English Proficiency Are Insufficient

Pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., and its implementing regulations, GRHA is required to take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency ("LEP"). See also Dept. of Justice Guidance to Recipients, 67 Fed. Reg. 41455 (June 18, 2002). Georgia's Mental Health Gap Analysis in May 2005 identified glaring deficiencies in mental health services available to persons with hearing impairments or limited English proficiency. Although the State has adopted a Limited English Proficiency and Sensory Impaired Client Services Manual, we saw little evidence that the policies outlined in the Manual were followed. Examples include R.R., who received little to no mental health treatment at GRHA; this same patient, later transferred to the Regional Hospital at Savannah, surprised his treating psychiatrist there by asking for a copy of his group schedule in Spanish so that he could read and comply with it. R.R. had not previously been identified as requiring

translation services, despite a months-long stay at GRHA. Accordingly, GRHA must take steps to ensure that meaningful access is being provided to LEP persons.

2. Education and Special Education Services for Qualified Students Are Insufficient

GRHA fails to provide sufficient education services to youth throughout the facility as required by the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401 et seq., Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504") and the Americans with Disabilities Act, 42 U.S.C. § 12101, et seq. ("ADA").

The general education program, although generally strong, has a significant deficiency. The points awarded for positive behavior during school time are based on individual instructors' point systems, and this point system is neither individualized nor integrated with any behavioral treatments or interventions that may be used in the residential units. Particularly for adolescents at the facility for more than a few days, interventions provided at the school should be consistent with their individual treatment plans.

"Related services" under the IDEA are those necessary to permit the student to benefit from instruction. 20 U.S.C. § 1414(d) (2002). We found no evidence of a plan to provide special education-related services to students at the facility. Only one student on the Adolescent Unit had a behavioral support program, despite the high rate of dangerous, disruptive behaviors on that unit and the frequent use of PRN, seclusion, and restraints to control these disruptive behaviors. Behavioral supports are frequently considered necessary related services under the IDEA. We find the failure to screen and identify any special education students needing these services to be a critical deficiency.

GRHA also fails to provide sufficient special education instructors. Staff reported that the special education teacher on the SNF unit usually serves nine patients in the morning and six in the afternoon, and does not have an instructional aide. One instructor is insufficient to provide individualized instruction to this many students with this level of impairment, especially during the morning session.

Students eligible for services under the IDEA are required to have an Individualized Education Plan ("IEP"), developed by the responsible education agency. Among other requirements, an

IEP requires assessment of a student's progress toward annual educations goals. 20 U.S.C. § 1414(d). This requires communication of this assessment data to any school that a student attends during the review period. GRHA has no policy regarding communication of assessment data to schools to which discharged adolescents return. Staff reported such follow-up to be rare, and only upon request by the outside school. GRHA's failure to provide information concerning the student's educational progress, any educationally-relevant assessments conducted during the student's hospitalization, and recommendations for necessary accommodations to the schools to which its school-eligible patients are discharged is a substantial departure from generally accepted professional standards and a critical lapse in supporting the students' successful transition and discharge.

F. Inadequate Discharge Planning and Placement in the Most Integrated Setting

Federal law requires that GRHA actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patients' needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a patient's stay, GRHA should: (1) identify, through professional assessments, the factors that likely will foster viable discharge for the patient; and (2) use these factors to drive treatment planning and intervention. Without clear and purposeful identification of such factors, patients will be denied rehabilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The GRHA discharge planning process significantly deviates from generally accepted professional standards. GRHA fails to meet the discharge planning principles stated in its own policies. The State's own audits of the "State of Georgia Behavioral Health System" prepared for the Governor in 2004 and 2005 identified egregious, systemic deficits in the coordination of care between GRHA and the community. Based on our review of recent discharges from GRHA, these same deficits persist. Specifically, we find that: (1) discharge plans are based on inadequate assessments; (2) discharges are frequently inappropriate because of inadequate coordination of care; (3) discharge planning services are not provided in accordance with GRHA policy; and (4) discharge plans fail to address repeated readmissions.

1. Discharge Plans Are Based on Inadequate Assessments

Deficits in discharge planning begin with assessments upon admission. Complete and accurate assessments are essential to develop a treatment plan that can direct rehabilitation while in the facility and to form the basis for a viable discharge plan. The deficits in assessments, discussed at page 20, supra, were particularly evident for those patients with short lengths of stay. The absence of information on critical aspects of functioning, which have often proved to be problematic in the community and contributed to the person's admission or readmission to the facility, is a serious impediment to identifying the services and supports needed for these patients to transition successfully to community living.

We were unable to locate any pre-admission information obtained from community providers in any of the records examined. Of the records reviewed, it appeared as if each admission was treated like a first admission, and GRHA failed to take advantage of available information regarding previous admissions, successful and unsuccessful treatments, and skills that needed to be developed to live successfully in the community. These failures greatly contribute to the high rate of recidivism at GRHA.

2. Inadequate Coordination of Care Routinely Leads to Inappropriate Discharges

Contrary to generally accepted professional standards, GRHA fails to provide adequate coordination and continuity of care, and this failure routinely leads to inappropriate discharges. Moreover, the failure to provide appropriate coordination of care results in numerous negative outcomes, including placements in inappropriate locations, re-admissions to the facility, and unnecessary delays in community placement. Although GRHA policy identifies the major resources necessary for a successful return to the community, in the vast majority of cases, these resources were not considered or were not made available.

More than 300 patients in a twenty-month period were discharged to inappropriate locations such as shelters and bus stops. Our investigation revealed that, during the period between January 1, 2006 and August 6, 2007, 301 patients were discharged to homeless shelters, 32 to "transportation terminal[s]," 33 to hotels and lodges, 12 to single room occupancy apartments, and 36 to what were listed as "Temporary

Locations."[15] There were 19 patients who were discharged to these locations on multiple occasions during this period. Most of these patients had multiple previous admissions to GRHA. Many patients go through the cycle of admission and discharge multiple times without any improvement in the discharge planning process.

Homeless shelters are not equipped to provide the level of care required for a patient being discharged from a psychiatric hospital, many of whom have severe and persistent mental illness. Moreover, many shelters are often at or above their capacity to serve local community needs. Thus, patients discharged to homeless shelters are likely to return to the hospital and repeat the cycle of inadequate discharge multiple times. Research indicates that the best chance for a successful recovery outcome is achieved when the person receives adequate care during the first episode of the psychiatric illness and that the opportunities for successful recovery diminish on each future episode.

Examples of discharge to inappropriate locations include:

- B.E., who had eight prior admissions to GRHA, including August 2007 and again in September 2007. She was discharged to a hotel and instructed to contact the local mental health center. There was no specific case manager, physician, or psychiatrist identified in her plan. No community provider was present at her discharge treatment meeting. Despite having returned to GRHA only ten days after her previous discharge, there was no effort by her treatment team to review the reasons for that discharge failure or to prevent its recurrence.

- A.C. was admitted to GRHA twice in 2007, and has a history of 35 prior admissions. She has co-occurring diagnoses of substance abuse and psychotic disorder with hallucinations, but received no substance abuse treatment while at GRHA. She was discharged to the Union Mission Night Shelter without adequate planning for community substance abuse care.

- A.D. has had 41 admissions to GRHA. A.D. has a dual diagnosis of schizo-affective disorder and substance abuse. On each of his discharges, including the most recent one on November 14, 2007, he was discharged to a homeless shelter

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[15] The Supreme Court, in Olmstead, stated that homeless shelters were inappropriate discharge locations. Olmstead v. L.C., 527 U.S. 581, 605 (1999).

without adequate planning for community substance abuse services and treatment.

- A.B. has a diagnosis of mood disorder and substance abuse disorder. He was admitted to GRHA twice in 2007 and has a history of 14 admissions. He was discharged to a homeless shelter in February 2007 and returned to GRHA ten days later. A.B. received no treatment for substance abuse while at GRHA and no planning for substance abuse services when he returned to the community.

3. Discharge Planning Services Are Not Provided in Accordance with GRHA Policy

We found that, although GRHA has a number of policies and procedures that articulate an adequate discharge planning and coordination of care process, in practice, these policies and procedures are not implemented. For example, GRHA's policy requires that case expediters work with both the hospital and community providers to help them understand and carry out their responsibilities. This ensures that the hospital and community providers perform their respective roles to achieve integrated transition planning for the patient. In the vast majority of cases reviewed, the roles described in this policy were not followed. In fact, there was little documented contact between the hospital and the case expediter beyond a phone call. The community transition generally consisted of the GRHA social worker making an appointment for the person at the community mental health center and providing a bus ticket for transportation.

4. Discharge Plans Fail to Address Repeated Readmissions

GRHA discharge planners and social workers identified the following primary barriers to community placement: lack of income, family, and housing; and medication non-compliance, particularly for patients with a dual diagnosis of substance abuse. Contrary to generally accepted professional standards, these professionals reported that the State lacks sufficient Assertive Community Treatment teams, which serve as a vital link between the hospital and the community for participants. Assertive Community Treatment programs offer an array of services customized to individual needs, delivered by a community-based team of mental health practitioners, and available 24 hours per day. The State's own findings in the 2005 Georgia Mental Health Gap Analysis also discussed the dearth in this essential service. Our review of discharges from GRHA suggests that this glaring gap in provision of services, and in particular for patients with a

history of repeated admissions, is as great today as it was three years ago.

In most cases, neither formal or informal supports have been developed and prepared for use by patients transitioning from GRHA. There is little indication that the facility has attempted to locate, develop, or advocate for needed supports or services that GRHA professionals know are needed to ensure successful transitions to community living.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at GRHA, the State of Georgia should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

The Georgia Psychiatric Hospitals shall provide their patients with a safe and humane environment and protect them from harm. At a minimum, the Georgia Psychiatric Hospitals shall:

1. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards. The Georgia Psychiatric Hospitals shall:

    a. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury; patient aggression; abuse and neglect; contraband; and suicide ideation or attempts;

    b. Require all staff to complete competency-based training in the revised reporting requirements;

    c. Create or revise, as appropriate, and implement thresholds for indicators of events, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide ideation or attempts, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level; whenever such thresholds are reached, this will be

documented in the patient medical record, with explanations given for changing/not changing the patient's current treatment regimen;

d. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide ideation or attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that investigation of such incidents that are comprehensive, include consideration of staff's adherence to programmatic requirements, and are performed by independent investigators;

e. Require all staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings;

f. Monitor the performance of staff charged with investigative responsibilities and provide administrative and technical support and training as needed to ensure the thorough, competent, and timely completion of investigations of serious incidents;

g. Ensure that corrective action plans are developed and implemented in a timely manner;

h. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from patient aggression and abuse and neglect allegations, to ensure that such incidents are properly investigated and appropriate corrective actions are identified and implemented in response to problematic trends; and

i. Create or revise, as appropriate, and implement policies and procedures regarding the creation, preservation, and organization of all records relating to the care and/or treatment of patients, including measures to address improper removal, destruction, and or falsification of any record.

2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards. At a minimum, such a system shall:

   a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by the Georgia Psychiatric Hospitals, as well as the outcomes being achieved by patients;

   b. Analyze the information collected in order to identify strengths and weaknesses within the current system; and

   c. Identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

B. Mental Health Care

1. Assessments and Diagnoses

The Georgia Psychiatric Hospitals shall ensure that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, the Georgia Psychiatric Hospitals shall:

   a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments; and ensure that assessments include a plan of care that outlines specific strategies, with rationales, including adjustment of medication regimens and initiation of specific treatment interventions.

   b. Ensure that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of all patients requiring restrictive interventions.

   c. Develop diagnostic practices, consistent with generally accepted professional standards, for

reliably reaching the most accurate psychiatric diagnoses.

d. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, maladaptive behaviors and substance abuse problems.

e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.

f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.

g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.

h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries, and require each clinical discipline's peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action.

2. Treatment Planning

The Georgia Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent

with generally accepted professional standards. More particularly, the Georgia Psychiatric Hospitals shall:

a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.

b. Ensure that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include:

(1) Review by psychiatrists of all proposed behavioral plans to determine that they are compatible with the psychiatric formulations of the case;

(2) Regular exchange of objective data between the psychiatrist and the psychologist and use of this data to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies;

(3) Integration of psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap; and

(4) Documentation in the patient's record of the rationale for treatment.

c. Ensure that treatment plans address repeated admissions and adjust the plans accordingly to examine and address the factors that led to re-admission.

d. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.

e. Ensure that treatment plans are consistently assessed for their efficacy and reviewed and revised when appropriate.

f. Provide adequate and appropriate mental health services, including adequate psychological services, behavioral management, and active treatment, in accordance with generally accepted professional standards.

g. Provide psychologists with sufficient education and training to ensure:

(1) competence in performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors;

(2) the development and implementation of clear thresholds for behaviors or events that trigger referral for a behavioral assessment;

(3) timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record;

(4) the development and implementation of protocols for collecting objective data on target and replacement behaviors; and

(5) assessments of each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.

h. Re-assess all patients at the facility to identify those who would benefit from speech and communication therapy and provide sufficient qualified and trained staff to provide services to all patients who would benefit from this service.

i. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs,

goals, and interventions, as well as discharge criteria.

j. Ensure that the medical director timely reviews high-risk situations, such as patients requiring repeated use of seclusion and restraints.

k. Develop and implement policies to ensure that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, and physical, cognitive and/or sensory impairments are evaluated, treated, and monitored in accordance with generally accepted professional standards.

l. Develop and implement policies for patients exhibiting suicidal ideation, including for patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.

m. Develop a system to ensure that staff receive competency-based training on individualized plans, including behavioral support plans and interventions, and document this training.

n. Ensure that restrictive interventions receive appropriate review by a Human Rights Committee, or its equivalent, to guarantee any restriction of rights are necessary, appropriate, and of limited duration.

o. Ensure that all psychotropic medications are:

(1) administered as prescribed;

(2) tailored to each patient's individual symptoms;

(3) monitored for efficacy and potential side-effects against clearly-identified target variables and time frames;

(4) modified based on clinical rationales; and

(5) properly documented.

p. Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, the Georgia Psychiatric Hospitals shall:

(1) Develop, implement, and continually update a complete set of medication guidelines in accordance with generally accepted professional standards that address the indications, contraindications, screening procedures, dose requirements, and expected individual outcomes for all psychiatric medications in the formulary; and

(2) Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, a documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely, critical review of the patient's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

C. Seclusion and Restraints

The Georgia Psychiatric Hospitals shall ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances -- i.e., when a patient poses an imminent risk of injury to himself or a third party -- any device or procedure that restricts, limits, or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, the Georgia Psychiatric Hospitals shall:

1. Eliminate the use of planned (i.e., PRN) seclusion and planned restraint.

2. Ensure that restraints and seclusion:

a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;

b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

c. Are not used as part of a behavioral intervention;

d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and

e. Are used in a reliably documented manner.

3. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:

a. The range of restrictive alternatives available to staff and a clear definition of each; and

b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.

4. Ensure that if seclusion and/or restraint are initiated, the patient is regularly monitored in accordance with generally accepted professional standards and assessed within an appropriate period of time, and that an appropriately trained staff member makes and documents a determination of the need for continued seclusion and/or restraint.

5. Ensure that a physician's order for seclusion and/or restraint includes:

a. The specific behaviors requiring the procedure;

b. The maximum duration of the order; and

c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.

6. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.

7. Ensure that at least every thirty minutes, patients in seclusion and/or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.

8. Ensure that immediately following a patient being placed in seclusion and/or restraint, the patient's treatment team reviews the incident within one business day, and the attending physician documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, or psychosocial treatment.

9. Comply with the requirements of 42 C.F.R. § 483.360(f) regarding assessments by a physician or licensed medical professional of any resident placed in seclusion and/or restraints.

10. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

D. Medical and Nursing Care

The Georgia Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards. Such services should result in patients of the Georgia Psychiatric Hospitals receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, the Georgia Psychiatric Hospitals shall:

1. Ensure adequate clinical oversight to ensure that generally accepted professional standards are maintained.

2. Ensure that patients are provided adequate medical care in accordance with generally accepted professional standards.

3. Ensure sufficient nursing staff to provide nursing care and services in accordance with generally accepted professional standards.

4. Ensure that, before nursing staff work directly with patients, they have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.

5. Ensure that nursing staff accurately and routinely monitor, document, and report patients' symptoms and target variables in a manner that enables treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.

6. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.

7. Ensure that nursing staff are appropriately supervised to ensure that they administer, monitor, and record the administration of medications and any errors according to generally accepted professional standards.

8. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.

9. Ensure that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.

10. Ensure that each patient's treatment plan identifies:

    a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;

    b. The related symptoms and target variables to be monitored by nursing and other unit staff; and

    c. The frequency by which staff need to monitor such symptoms.

11. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, the Georgia Psychiatric Hospitals shall:

    a. Actively collect data with regard to infections and communicable diseases;

    b. Analyze these data for trends;

    c. Initiate inquiries regarding problematic trends;

    d. Identify necessary corrective action;

    e. Monitor to ensure that appropriate remedies are achieved;

    f. Integrate this information into the quality assurance review of the Georgia Psychiatric Hospitals; and

    g. Ensure that nursing staff implement the infection control program.

12. Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing.

13. Ensure that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.

14. Provide adequate, appropriate, and timely rehabilitation therapy services and appropriate adaptive equipment to each individual in need of such services or equipment, consistent with generally accepted professional standards.

15. Establish an effective medical emergency preparedness program, including appropriate staff training; ensure staff familiarity with emergency supplies, their operation, maintenance and location; conduct sufficient practice drills to ensure adequate performance when confronted with an actual emergency.

E. Services to Populations with Specialized Needs

1. Provide adequate services to patients with limited English proficiency, consistent with the requirements of the State's Limited English Proficiency and Sensory Impaired Client Services Manual and federal law.

2. Provide adequate education and special education services for qualified students, including:

   a. Adequate assessments of individual educational needs and monitoring and reporting of individual progress, including reporting all relevant assessments and information to a new school upon discharge from the hospital;

   b. Development and implementation of IEPs consistent with the requirements of the IDEA; and

   c. Ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards.

F. Discharge Planning

The State shall ensure that patients receive services in the most integrated, appropriate setting that is consistent with their needs and legal status and actively pursue the appropriate discharge of patients. More particularly, the Georgia Psychiatric Hospitals shall:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:

   a. The individual patient's symptoms of mental illness, psychiatric distress, or cognitive impairment;

   b. Any other barriers preventing that specific patient from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and

   c. The patient's strengths, preferences, and personal goals.

2. Ensure that the patient is an active participant in the placement process.

3. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.

4. Provide the patient adequate assistance in transitioning to the new setting.

5. Ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

6. Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services, including:

   a. Develop a system of follow-up with community placements to determine if discharged patients are receiving the care that was prescribed for them at discharge; and

   b. Hire sufficient staff to implement these minimum remedial measures with respect to discharge planning.

7. The State shall ensure that it provides community-based treatment for persons with disabilities consistent with federal law.

. . . . . .

V. CONCLUSION

We appreciate the cooperation we received from the Georgia Department of Mental Health Developmental Disabilities and Addictive Diseases, and the State's Attorney General's Office. We also wish to thank the administration and staff at each of the hospitals we visited for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tours. Further, we

wish to especially thank those individual hospital staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at these facilities. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the State in an amicable and cooperative manner to resolve our outstanding concerns with regard to GRHA, and in due course, any additional concerns with the remaining hospitals in the Georgia system.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

cc: The Honorable Thurbert E. Baker
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Georgia Department of Human Resources

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