U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

December 18, 2008

The Honorable Bob Riley
Governor of Alabama
Office of the Governor
State Capitol
600 Dexter Avenue
Montgomery, AL 26130

Re: CRIPA Investigation of the W.F. Green State Veterans' Home in Bay Minette, Alabama

Dear Governor Riley:

I am writing to report the findings[1] of the Civil Rights Division's investigation of conditions and practices of resident care and treatment at the W.F. Green State Veterans' Home ("W.F. Green") in Bay Minette, Alabama. On November 8, 2007, we notified you of our intent to investigate conditions of resident care and treatment at W.F. Green pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional and federal statutory rights of persons who reside in public institutions.

As part of our investigation, on February 10-15, 2008, we conducted an on-site inspection of W.F. Green with expert consultants in various disciplines. Our tour focused on the general care and treatment of residents as well as the facility's discharge planning and community integration practices. Before, during, and after our site visit, we reviewed a wide variety of

[1] Minor administrative corrections were made to this letter after it was issued. These corrections do not affect any of the findings contained in the letter. The State has been notified of the changes to the document.

relevant facility documents, including policies and procedures, medical records, and other records relating to the care and treatment of W.F. Green residents. During our visit, we also spoke with administrators, professionals, staff, and residents.

Before discussing our findings, we would like to express our appreciation to the staff of W.F. Green for the extensive cooperation and assistance provided to us throughout our investigation. We hope to continue to work with State officials and the staff at W.F. Green in the same cooperative manner going forward.

In keeping with our pledge to share information and to provide technical assistance, at the close of our tour we conveyed our preliminary findings to counsel for the Alabama Attorney General's Office and Board of Veterans' Affairs, the Veterans' Affairs Homes Coordinator, certain W.F. Green staff, and consultants retained by W.F. Green. Additionally, Alabama's Veterans' Affairs Commissioner, Admiral Clyde Marsh, participated by telephone. We especially appreciate that Admiral Marsh took the time to participate in the exit conference.

Consistent with our statutory obligations under CRIPA, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at W.F. Green violate the constitutional and federal statutory rights of its residents. In particular, we find that residents of W.F. Green suffer significant harm and risk of harm from the facility's inadequate medical and nursing services assessment, planning, and care; inadequate nutritional and hydration services; improper and dangerous psychotropic medication practices; inadequate pressure sore treatment and skin care; inadequate restorative care and specialized rehabilitation services; failure to protect residents from harm due to falls; failure to adequately investigate allegations of resident abuse; and the inappropriate use of restraints. See Youngberg v. Romeo, 457 U.S. 307 (1982). These deficiencies have contributed to the untimely deaths of W.F. Green residents as well as led to other preventable illnesses, injuries, and harm from a variety of sources. In addition, we find that the State fails to provide services to certain W.F. Green residents in the most integrated setting, as required by the 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).

I. BACKGROUND

W.F. Green is a state-owned nursing home serving Alabama veterans or their family members and overseen by the Alabama Board of Veterans' Affairs.[2] The facility opened in 1995 and is one of three such nursing homes operated by the Board of Veterans' Affairs. At the time of our tour, the census at W.F. Green was approximately 150. The majority of residents of W.F. Green are elderly men, and most of the residents are veterans. The nursing home is made up of five units, one of which is a locked unit designated for care of residents with dementia. Residents' stays at W.F. Green are funded primarily by a mix of state and federal Veteran Affairs' money with a smaller contribution coming from the resident.

II. FINDINGS

A. INADEQUATE HEALTH CARE SERVICES

At issue is whether the State is providing W.F. Green residents with adequate health care in accordance with its constitutional obligations. Residents of a public nursing home, such as W.F. Green, have a Fourteenth Amendment due process right to adequate health care. Youngberg, 457 U.S. at 315; see Johnson v. Florida, 348 F.3d 1334, 1339 (11th Cir. 2003) (finding that Youngberg recognized a due process right to "reasonable care"); S.H. v. Edwards, 806 F.2d 1045, 1046 (11th Cir. 1988) (interpreting Youngberg to require states to provide living accommodations in accordance with relevant standards of care). Federal regulations specify the generally accepted professional standards for health care in nursing homes. 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide nursing and medical services to "attain or maintain the

[2] The State of Alabama contracts with a private management company, Human Management Resources ("HMR"), to operate the nursing home on a day-to-day basis. The majority of W.F. Green staff are HMR employees. As such, HMR is a vendor to the State of Alabama and an agent of the State. Ultimately, therefore, it is the State of Alabama that is responsible for the care and treatment of W.F. Green residents and accountable for the actions of HMR. The actions of HMR are attributable to the State of Alabama for the purposes of this investigation.

highest practicable physical, mental, and psycho-social well-being of each resident").[3]

W.F. Green fails to adequately address the health care needs of its residents, including failing to adequately assess and plan for residents' health care needs, failing to provide adequate nutritional and hydration care to residents, using dangerous psychotropic medication practices, failing to provide psycho-social alternatives to medication for residents, failing to provide adequate pressure sore treatment and skin care to residents, and failing to provide adequate rehabilitative and restorative care to residents.

1. Inadequate Assessment and Planning for Health Care Needs

At W.F. Green, medical and nursing staff fail to adequately assess and implement plans addressing the health care needs of residents. As a consequence, residents are at risk of harm or experience harm, and, in some cases, inadequate assessment and planning has contributed to the untimely deaths of residents.

Generally accepted professional standards require W.F. Green to develop and implement comprehensive care plans for each resident that specifically address the resident's individualized needs. 42 C.F.R. § 483.20. Assessment and care planning should be a multidisciplinary effort, involving physicians and nurses to develop, implement, and update care plans.

Nursing assessment is the foundation of this process. Assessments must be conducted upon admission and as often as needed thereafter, including in response to changes in a resident's condition. Because assessments are fundamental to

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[3] W.F. Green and the State of Alabama do not participate in the federal Medicaid/Medicare programs. Thus, W.F. Green is not required to comply with the federal programs. See Title XIX of the Social Security Act, 42 U.S.C. §§ 1395, 1396r and implementing regulations, 42 C.F.R. § 483 Subpart B (Medicaid and Medicare Program Provisions). However, these regulations do establish the generally accepted professional standards for quality of care and service in nursing homes. We note that the State of Alabama has adopted regulations that closely mirror the federal regulations. We will refer and cite to the federal regulations throughout this letter as the generally accepted standards of care and practice in the relevant area.

develop a comprehensive care plan, nurses have a duty to timely recognize and identify problems or risks for each resident. Accurate assessments are necessary to promote quality and continuity of care. 42 C.F.R. §§ 483.20(k)(2)(iii),(d),(k).

The failure of W.F. Green staff to adequately assess and implement care plans cuts across numerous aspects of care, affecting residents' health and well-being with respect to nutrition and hydration, including sufficient food intake; psychotropic medication management; fall prevention and response; and physical and rehabilitative care. Through our record review and on-site observations, we found examples in which these multiple failings lead to harm to W.F. Green residents.

A sentinel example of the intersection of these failures to adequately assess and plan care is that of W.F. Green resident A.R.[4] Mr. R. was admitted to W.F. Green in May 2007. He has several medical issues, a history of falls, and he takes anti-depressants due to his diagnosis of depression. In November 2007, Mr. R.'s health started to decline rapidly. He began to lose weight and was noted to have increased confusion during the month. On December 11, 2007, Mr. R. fell, suffering a laceration to his forehead for which he had to be taken to a local emergency room. Despite the serious fall, W.F. Green staff failed to evaluate the cause of the fall, disregarding the presence of multiple risk factors, including his medications, and the likelihood of more falls. Further, there was no evaluation regarding his increased risk of serious bleeding as an adverse side effect of his medications. No revised care plan to prevent future falls was developed. His psychotropic medication use was never assessed or monitored during this time and likely was a contributing factor to his declining health.

The day after Mr. R.’s serious fall, staff noted that Mr. R. was “shaking” and later fell, again hitting his head. Again, there was inadequate medical follow-up and evaluation of Mr. R. after the fall. Six days later, he fell a third time. During this time, Mr. R. was experiencing low blood pressure, which could have contributed to his falls, but this issue was not followed-up on adequately. Following these episodes, staff noted ecchymotic (dark discoloration of skin, similar to bruising) areas on his upper body. Mr. R. was started on a rehabilitation

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[4] To protect residents’ privacy, we identify residents by initials other than their own. We will separately transmit to the State a schedule that cross references the initials used in this letter with the residents’ actual names.

program at this time.

On December 22, 2007, Mr. R. fell again, suffering a laceration to his face, and was taken to the emergency room. A CT scan revealed bleeding in his brain. It was not until this fourth fall that W.F. Green staff reduced his medications in an effort to lessen the risk of falling. Inexplicably, however, he was also taken off his rehabilitation program, despite a clear need for the program due to his loss of functioning.

On January 1, 2008, he suffered cuts and lacerations to his head from another fall and was again sent to the emergency room. Despite this, W.F. Green failed to adequately assess the cause of the fall or plan further interventions. Mr. R. became increasingly agitated in January, possibly as a result of neurological damage, but again, there was no assessment of his change in behavior. Although professional standards would require neurological, psychiatric, or psychological interventions to assess and address his condition, no action was taken. Throughout January, Mr. R.'s functional abilities declined, including his balance, but W.F. Green staff did not perform adequate evaluations or develop interventions to address his decline.

Another failure to evaluate occurred with respect to Mr. R.'s psychotropic medications and other risk factors. He was prescribed psychotropic medications without adequate justification and without adequate monitoring of the potential adverse effects of the medications. In January 2008, due to his disruptive behavior, his medications were changed, disturbingly, to include a medication that carries with it a Food and Drug Administration warning for risks associated with heart attacks and strokes. Mr. R. had already had at least one stroke and had significant heart disease.

There are no nurses' notes for February 1-7, 2008 in Mr. R.'s records. The notes resumed on February 8, documenting that Mr. R. had a bruise to his face. Staff concluded that Mr. R. had fallen yet again, suffering another injury to his head. Later the same day, he fell again.

While visiting W.F. Green's dementia unit on February 12, 2008, our consultant physician observed Mr. R. in a gerichair. He was totally unresponsive, unarousable, with generalized rigidity and spasticity, and had a fresh bruise above his left eye, covered with a bandage. Our consultant was told Mr. R. had fallen that day, but there were no nursing notes about a fall. Despite his continued falls, Mr. R.'s records had an order in place from earlier the same morning to “discontinue neurochecks.”

Neurochecks are the generally accepted practice of care to assess and evaluate individuals for head and neurological trauma. In our consultant's opinion, discontinuing the neurochecks in light of Mr. R.'s falls and head injury placed Mr. R. in immediate jeopardy to this health and safety. Our consultant informed W.F. Green's acting administrator of his concern.

Mr. R. also suffered from inadequate nutritional care. He experienced significant unplanned weight loss that was not assessed or addressed. Between November 2007 and January 2008, he lost 13 pounds but the cause of the weight loss was not investigated. There was also inadequate evaluation to examine his potential eating or swallowing difficulties, a likely possibility due to his stroke history. Blood tests during this time revealed low levels of albumin, an essential protein in the blood. The low albumin level could indicate the presence of a number of serious issues, yet there was no adequate examination of these findings or follow-up care.

The failure of W.F. Green to adequately assess and respond to Mr. R.'s condition is emblematic of the systemic failure of W.F. Green to adequately assess and respond to residents' conditions. Residents such as Mr. R. are placed at great risk to their health and safety and are harmed by W.F. Green's disregard of the necessity of assessment and planning.

The following are some of the further examples we encountered of W.F. Green's failure to assess residents adequately and implement needed interventions to address the medical and nursing care needs of residents:

- Resident B.E. was 93 when he died at W.F. Green in May 2007, only one month after he was admitted to the nursing home. He had a history of blood disorders for which he required frequent transfusions. At the time of admission, he could ambulate with a walker. While at W.F. Green, he was prescribed aspirin, which thinned his blood, putting him at further risk of bleeding problems. On April 26, Mr. E. twice told staff he had fallen, but no investigation was done as to whether he had fallen or not. On April 29, a family member called W.F. Green to report that Mr. E. had bruises on his trunk. The next day, a nurse noted further purple discoloration above his left and right hip. Mr. E. told staff that the bruises were the result of falls. On April 30, he was seen by a nurse practitioner for the multiple bruising on the lower and upper parts of his body. On May 1, five days after Mr. E. reported he had fallen, he was finally seen by a physician who wrote that he believed

Mr. E.'s bruising was not related to any trauma. At 12:45 a.m. on the morning of May 5, Mr. E. was found on the floor near his bed. He was noted to be "unresponsive, pale and clammy." No neurochecks were done, and it was not until a hospice nurse came at 2:00 a.m. that he was sent to a hospital upon her direction. Mr. E. was dead by the time he arrived at the hospital.

- In our consultant physician's opinion, Mr. E. "died prematurely due to neglect" by the W.F. Green staff. Mr. E. was at risk of increased bleeding and staff were aware of a possible fall on April 26, but discounted the resident's report, even though he twice told staff he had fallen. It is quite likely that the bruising that appeared on his body was the result of slow, internal bleeding that was not assessed or responded to adequately and that likely contributed to his untimely death.

- C.T. was 81 when he was admitted to W.F. Green in November 2006. He had a history of Parkinson's disease, vascular dementia, gastroesophageal reflux disease, and iron deficiency anemia. Beginning at the end of October 2007, Mr. T. began developing peripheral edema in his legs (swelling related to fluid retention). In early November, tests began to show that Mr. T. was becoming dehydrated, quite possibly as the result of medication being given for the edema, and that his blood potassium was dropping.[5] There was no adequate assessment or response to any of these events. Mr. T. died suddenly on November 8, 2007. In our consultant's opinion, Mr. T. likely developed peripheral edema due to deep vein thrombosis (the formation of a blood clot in the leg) which could have led to the blood clot traveling to Mr. T.'s heart and resulting in his quick decline and death. The fact that the death note by the W.F. Green physician stated that the cause of death may have been pulmonary embolism indicates that W.F. Green staff were aware of this possibility but neglected to assure that necessary tests were done or that Mr. T. was sent to the hospital in a timely manner. This is in addition to the failure to recognize and treat dehydration and the previous failure to evaluate significant laboratory findings, such as the showing of critical irregularities in his blood. In our consultant's opinion, the circumstances leading to Mr. T.'s death represent a substantial departure from generally

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[5] Potassium is essential for many body functions, including muscle and nerve function.

accepted standards of nursing home medical care.

- In February 2008, resident L.J., who has a history of aspiration pneumonia (a life-threatening condition in which food and/or liquids gets into the lungs), developed a serious cough and abnormal lung sounds. Two days later, he had a fever and increased pulse rate. Despite these obvious warning signs of a possible infection or aspiration pneumonia, no medical evaluation was ordered.

- Resident S.C. has a diagnoses of Alzheimer's disease, diabetes, depression, seizures, hypertension, and congestive heart failure, and is dependent on the nursing staff for all of his daily needs. On February 9, 2008, Mr. C. started vomiting dark brown emesis and had a fever of 103 degrees axillary, indicating an extreme fever.[6] Nursing staff failed to assess his condition and risks, and it was not until Mr. C.'s family intervened that he was sent to the hospital. The hospital records show that he was mildly dehydrated by the time he got to the hospital and that he also had a possible urinary tract infection that had not been detected at W.F. Green.

Another significant departure from generally accepted professional standards regarding health care assessment and care planning at W.F. Green is the facility's use of "standing orders." W.F. Green has established protocols to be followed by the nursing staff upon the occurrence of certain clinical events such as vomiting, diarrhea, or fever. Standing orders are intended to assure expedient care for residents in minor emergencies. However, the use of standing orders presumes that the W.F. Green nursing staff possess adequate skills and training and that the orders have built-in safeguards. This is not the case with several of the standing orders at the nursing home. First, the nursing staff at W.F. Green do not have sufficient clinical skills to ensure the appropriate implementation of the orders. Second, several of the standing orders are inappropriate, incomplete, or lack sufficient safeguards to assure that supervisory nursing personnel, a physician, or a nurse practitioner is notified to assess the resident on a timely basis after nursing staff implement the standing order. Finally, the use of standing orders, without appropriate training or oversight, leaves open the possibility that appropriate follow-up may not occur if the acute episode subsides. Thus, the reliance on these protocols may lead to clinical events that are not

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[6] Temperature readings taken axillary, i.e., under the arm, may be one degree less than an oral temperature reading.

evaluated on a timely basis, or not evaluated at all, by medical staff and risks negative outcomes.

For example, in November 2007, resident M.I. had an episode of vomiting and diarrhea. In February 2008, resident K.O. had a fever with periods of confusion. In both instances, nursing staff gave the residents symptom-controlling medications according to the standing orders. However, in neither case was supervisory medical staff notified nor was there adequate follow-up to determine what the causes of the illness might have been, leaving both these residents at risk of the presence of a serious, long-term concern.

W.F. Green also fails to adequately assess, manage, and treat communicable diseases. We were told that, at the time of our tour, W.F. Green did not have a dedicated Infection Control Nurse. During our tour, we observed the nursing staff's failure to follow generally accepted professional standards of practice to control infectious diseases within the facility, and their general lack of knowledge of appropriate infection control practices.

For example, some residents at W.F. Green were being treated for contagious conditions, including tuberculosis ("TB"),[7] Methicillin Resistant Staphylococcus Aureus ("MRSA"),[8] and Clostridium Difficile ("C.-Diff.").[9] Examples of the inadequate assessment and care planning for communicable diseases include:

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[7] Tuberculosis ("TB") is a potentially life-threatening infectious disease that commonly attacks the lungs. The transmittal of TB to staff and residents can be prevented or controlled with an appropriate TB control plan that defines how the disease is to be identified, treated, and controlled to prevent transmission.

[8] MRSA are drug-resistant bacteria that can cause different kinds of illness, including skin infections, bone infections, pneumonia, and severe life-threatening bloodstream infections. MRSA is particularly prevalent and virulent in institutions where many people are housed in close proximity and basic hygiene may be lacking.

[9] The presence of C.-Diff. bacteria indicates a potentially life-threatening infection of the colon that is highly contagious.

- Resident U.Y. had a conversion to positive PPD[10] in January 2008, indicating the presence of TB. He was given a chest x-ray and was determined not to have active TB. However, the nursing home did not take any measures to identify the person with TB with whom Mr. Y. may have been in contact. The Center for Disease Control recommends that if the source of infection of a skin-test converter is unknown, periodic testing of residents and a careful search for the source case should be continued. W.F. Green had done no further assessment, leaving open the possibility that other residents may be exposed to the source of the TB.

- At the time of our tour, W.F. Green resident T.V. had orders in place for contact isolation due to MRSA of penile drainage. Our nurse expert observed a nursing assistant providing care to Mr. V. The nursing assistant did not have an accurate understanding of why Mr. V. was in contact isolation or where the infection was on or in his body. In addition, she was not wearing a necessary, protective gown. In response to a question about this, she stated: "I don't wear a gown." The staff member was risking further spread of the infection by not following generally accepted contact isolation procedures, which require wearing a gown and gloves while providing care to the resident in isolation and disposing of the gown and gloves in a sealed, designated bin in the room after providing care.

- Another resident, X.A., had positive C.-Diff cultures in January and February 2008. Despite these results, his records lacked any indication that the nursing staff was following contact isolation procedures. Given that C.-Diff is highly contagious and potentially life-threatening, this was an egregious departure from generally accepted professional standards.

In general, the failure of W.F. Green to develop and implement adequate infection control policies, procedures, and practices exposes both residents and staff at the nursing home to unreasonable risk from infectious diseases.

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[10] A common test for TB is the use of a Purified Protein Derivative ("PPD") injected under the skin.

2. Inadequate Nutritional and Hydration Care

Generally accepted professionals standards mandate that nursing home residents receive adequate nutrition, including sufficient fluids, to maintain their health and well-being. 42 C.F.R. § 483.25(i-j). At W.F. Green, many residents do not receive adequate nourishment or fluids.

As with other areas of health care services at W.F. Green, the facility fails to adequately assess residents' nutrition status and changes and appropriately plan for their needs. Compounding this problem is the lack of adequate inter-disciplinary communication among the clinical staff responsible for ensuring that residents receive adequate nutrition.

For example, when we reviewed records of residents with significant, unplanned weight loss, we found that the nursing home consistently failed to adequately evaluate why a resident was losing weight. First, the dietitian is not adequately informed when a resident is identified as losing weight. Then, W.F. Green's ability to respond to residents' weight loss is further limited by the fact that the dietitian does not keep a schedule of her time at the nursing home and staff do not know when the dietitian will be available. Thus, evaluations are often delayed or not performed. When we reviewed the evaluations that had been done, they were inadequate (e.g., not determining exactly how much food and fluid a resident who is losing weight is actually consuming). Also, the evaluations failed to address other basic issues such as dysphagia (a swallowing disorder or difficulty) for a resident who was losing weight. Interventions that were provided for weight loss offered only general measures, such as offering the resident supplements, that were inadequate to meet a resident's individual nutritional needs. We also observed a lack of occupational therapy interventions. Few residents who could have benefitted from assistive devices with meals, such as adaptive utensils, had them.

Weight loss may result from a chronic disease, and occasionally is a manifestation of an acute illness. Depression, a frequent condition in nursing home residents, is a common factor in residents who suffer weight loss. While many W.F. Green residents receive anti-depressant medication, there was often no evaluation of the role of depression as a possible factor in the weight loss. Medications such as antipsychotics and diuretics can cause a loss of appetite and reduced food intake. There was inadequate effort on the part of the W.F. Green medical staff to evaluate medications, or to discontinue or

change potentially problematic medications given to residents who were losing weight. Nursing staff also failed to adequately assess residents for possible side effects of these medications.

It was apparent during meals that staff in the dining rooms were not providing adequate assistance to residents who needed assistance. During our tours of the facility, we observed residents sitting alone with their meal trays in front of them, not eating, and the staff off to one side of the room visiting with each other rather than providing needed assistance to residents. Residents were also not positioned properly for eating, and no attempt was made to reposition them. For example, some residents were placed too far away from their plates to eat or had slumped down in their chairs.

The following are examples of residents harmed at W.F. Green by failures to address significant, unplanned weight losses:

- Z.L. was admitted to W.F. Green in May 2007 at age 74. He had had a stroke in December 2006 that left him disabled and unable to speak. He had a history of heart attacks, Parkinson's disease, gastroesophageal reflux disease (GERD) and depression. He also had a history of recurrent pneumonias, very likely due to aspiration. In the opinion of our expert consultant, such a history clearly mandates a dysphagia evaluation. However, there was no such evaluation done and Mr. L. was placed on a regular diet and thinned liquids. Almost immediately, this resulted in his losing weight, likely due, in part, to his inability to eat sufficient quantities of food. His weight on admission was 150 pounds, but by September 2007, four months later, it was down to 140 pounds. Blood tests also showed likely malnutrition. Nursing home staff never evaluated the possible cause of the weight loss. No calorie count was performed to evaluate Mr. L.'s food and fluid intake, nor was a dysphagia evaluation performed. Without any attempt to assess the cause of the weight loss, the dietitian's response was to add supplements and a specific appetite stimulant that has not been shown to be effective in elderly persons and, in fact, is barred from coverage by Medicare.

- By January 2008, Mr. L.'s weight was down 26 pounds to 124 pounds. Despite his weight loss, the dietitian did not see Mr. L. at any time after September 2007. Mr. L. died on February 5, 2008. His weight loss was likely the result of his inability to consume adequate amounts of calories and protein due to multiple factors, none of which were assessed or treated adequately by W.F. Green staff. The failure to

assess and respond to Mr. L.'s declining nutritional status and weight loss represents a substantial departure from accepted professional judgment and likely contributed to his untimely death.

- X.A., a 79-year-old resident, was admitted to W.F. Green in late November 2007 with several serious health issues and a diagnosis of depression. By the time we reviewed his record in February 2008, he had already lost 10 pounds, yet there was no attempt to evaluate the cause of the weight loss. No caloric count was performed. There had been no dysphagia screen or evaluation since admission. The physician made the diagnosis of "senile cachexia."[11] There is no such generally accepted diagnosis, and cachexia is not associated with aging. Furthermore, Mr. A. did not show other signs of cachexia, such as muscle loss. There could be multiple potential causes for Mr. A's weight loss, including his eating and swallowing problems and the medication he was taking, but W.F. Green failed to assess or intervene adequately to address his nutritional needs.

- M.I. was admitted to W.F. Green in October 2007 at age 80. He had a history of health issues including dementia, diabetes, high blood pressure, heart disease, depression, dysphagia, and weight loss just prior to entering the facility. However, Mr. I.'s initial nutrition assessment did not note the amount of the recent weight loss and did not document the resident's usual body weight, making it impossible to prepare an adequate nutritional care plan for him. His nutritional assessment was never completed. There was an absence of any adequate follow-up even though Mr. I. was reportedly not eating and refusing meals. There was a dietician's note about Mr. I. dated December 30, 2007. However, Mr. I. was in the hospital at that time (because he had fallen and broken his hip). Thus, the note was apparently written without any actual assessment of Mr. I. There was no nutritional assessment following his readmission despite his significant functional decline. There was also no three-month evaluation in January 2008 as scheduled. Mr. I. experienced a significant weight loss during the last two weeks of January 2008, yet this had not been addressed by either the dietitian or physician when we visited the nursing home in mid-February.

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[11] Cachexia is a loss of weight and appetite in someone who is not trying to lose weight. It is often associated with cancer or infections diseases such as AIDS or TB.

- D.F., a 79-year-old resident, was admitted to W.F. Green in December 2005. He has a history of medical conditions, including hypertension, diabetes, atrial fibrillation, and dysphagia, putting him at an increased risk of aspiration. Mr. F. lost 14 pounds between May 2007 and February 2008 and had blood test results indicating that he was becoming malnourished. Medical staff failed to address the weight loss or attempt to evaluate the cause. Further, despite the strong likelihood that the weight loss was related to dysphagia, there is no evidence that there was ever a speech therapy evaluation performed for dysphagia. Mr. F.'s weight loss was most likely due to his slow eating and inability to consume adequate amounts of food, which we observed. Instead of assistance with feeding, staff removed Mr. F.'s trays before he completed the meals, resulting in inadequate food consumption. During one of our tours of a W.F. Green dining room, we observed Mr. F. repeatedly requesting assistance from staff to help him eat, saying "I need help," but staff merely uncovered his food and otherwise ignored his requests.

- Resident N.D., an 82-year-old resident admitted to W.F. Green in May 2006, has a history of hypertension, heart problems, Parkinson's disease, lung disease, and dementia. We observed Mr. D. eating breakfast during our tour. He had a significant tremor and consequently was unable to eat without assistance. Beginning in October 2007, a blood test showed that he was not getting sufficient food. He lost 18 pounds during January 2008. However, as of the last day of our tour, February 15, he had not yet been assessed by the dietitian after that weight loss was recognized. It is likely that the cause of the weight loss is related to dysphagia (common in people with Parkinson's disease), his lack of ability to chew adequately, and his apparent need for a mechanically modified diet. These factors were not evaluated, and there is no evidence that Mr. D. ever had a dysphagia evaluation or evaluation for assistive devices during meals. A rehabilitation screen done in January 2008 documented that no rehabilitation services were necessary, even though, in the opinion of our expert physician, he clearly needed such services.

W.F. Green also fails to ensure that residents receive adequate fluids. Generally accepted professional standards require W.F. Green to ensure that residents receive appropriate treatment and services to prevent dehydration. All too frequently, however, residents who are at risk of dehydration are inadequately monitored by the nursing staff. Nursing staff often

ignore fluid orders by the physician and nurse practioner. This substandard practice was evident in our review of residents' medical records. In addition, we noticed during our tour of the facility that there was no water at residents' bedsides. The following are examples of residents who were inadequately monitored for dehydration:

- In early February 2008, resident T.V.'s laboratory test results indicated dehydration. The dietician had recommended that Mr. V. receive 2400 cc's of fluid every 24 hours. In response to these test results, an order was written to "push fluids" for Mr. V. However, the nurse's notes and intake and output records do not reflect that this was done, and his condition continued to worsen. The nurse practitioner again ordered staff to encourage fluids. The nurses did not follow the directive to increase Mr. V.'s fluids. Mr. V. went for at least five days without receiving the amount of fluids recommended by W.F. Green clinical staff.

- At the end of January 2008, resident R.H. began being fed through a tube. In addition to his nutritional solution, Mr. H. was to receive specific amounts of fluid per day. Mr. H. is totally dependent on others to provide fluids and is at-risk for dehydration. Records show that the nurses routinely failed to provide the ordered amount of fluids, in some cases by as much as 1400 milliliters (the equivalent of almost six cups of water). Although this failure in care happened repeatedly, it was apparently not recognized, indicating that the nurses are not being supervised adequately. The nursing staff's failure to administer the proper fluids put Mr. H. at significant risk of dehydration.

In summary, due to the failure of W.F. Green to assess and evaluate adequately and respond to residents' nutritional needs, particularly when residents begin to lose weight, residents suffer from the effects of not receiving adequate food and fluids. These failures have harmed residents, and in some cases, have contributed to the untimely deaths of W.F. Green residents.

3. Dangerous Psychotropic Medication Practices and Failure to Provide Psycho-Social Alternatives to Medication

Generally accepted professional standards require that, due to the risks that psychotropic medications pose to nursing home residents, the use of such medication be justified and monitored. Federal law strictly regulates the prescription of psychotropic medications for nursing home residents, and generally accepted

professional standards require nursing home residents to be free from unnecessary antipsychotic medication. See 42 C.F.R. § 483.25(l)(1). "Unnecessary medication" is defined by federal law as any medication that is excessive in dose, excessive in duration, without adequate monitoring or indication for use, or without specific target symptoms. Id. In addition, professional standards require that nursing home residents receive gradual dose reductions and, unless contraindicated, behavioral interventions aimed at reducing medication use. 42 C.F.R. § 483.25(l)(2)(ii).

Based on the documents provided to us and our observations during the tour of W.F. Green, it appears that the majority of residents suffer from one or more psychiatric disorders and that dementia and depression are widespread. The use of antidepressants, antipsychotics, and other psychoactive medications is common at the nursing home. Unfortunately, these medications are not used in conformity with generally accepted professional standards, and W.F. Green residents have suffered as a result.

The almost complete lack of qualified professional oversight to monitor the use of psychotropic medications at W.F. Green is a major reason that the use fails to meet professional standards. When we asked who provides oversight of psychiatric medication, we were informed that this oversight had been provided by a part-time psychologist for a short period of time, but that the psychologist no longer provided services at the nursing home. The facility's Medical Director admitted that he did not have an adequate background in psychiatric care to provide appropriate medication assessment and monitoring. Thus, no one at W.F. Green is providing needed oversight of psychotropic medication use at the nursing home.

We found numerous examples of inappropriate and dangerous medication use at W.F. Green:

- Resident E.L. has taken an antipsychotic medication at W.F. Green daily since at least June 2007. Mr. L. has a history of a stroke, dementia with delusions, and behavior disturbances. However, at the time of our tour, his record showed no evidence of symptoms requiring the use of an antipsychotic medication. The facility failed to do any psychiatric or psychological evaluations or interventions, including non-pharmacologic psychosocial interventions. He was also taking two other psychiatric medications that had been prescribed since 2006, without any evidence of ongoing assessment for therapeutic efficacy or adequate side effect

monitoring. We observed Mr. L. several times on our tour. He was sedated, had severe rigidity with contractures, and required the use of a wheelchair, although he had apparently been able to walk and stand in the prior months. Mr. L. had experienced a steady functional decline, falling in October and December 2007, with injuries resulting from the December fall. Despite the strong likelihood that Mr. L.'s medication contributed to his falls, there is no evidence that there was any attempt to reduce the antipsychotic medications or to evaluate adequately the medications' side effects. Further, medical staff notes failed to evaluate his rigidity and contractures. In our expert physician's opinion, Mr. L.'s sedation, rigidity, contractures, falls, and functional decline likely resulted from the inappropriate use of antipsychotic medication and the lack of evaluation for adverse effects of this medication.

- Resident I.S. was admitted to W.F. Green in April 2007 with a long history of Alzheimer's disease and some agitation. He was able to walk on his own when he entered the nursing home. In the months following his admission, Mr. S. developed inappropriate behaviors, and W.F. Green staff were unable to handle his psychological needs. He was admitted twice to a local hospital in May and June 2007 for behavior issues, and returned to the nursing home, taking high doses of antipsychotic medications. There was no assessment nor review of the need to continue these medications despite the fact that Mr. S. suffered repeated falls after they were prescribed. In December 2007, Mr. S. suffered a significant decline, and W.F. Green gradually discontinued the medications. The reduction resulted in no changes in behavior, indicating the lack of effectiveness of the medications and the paucity of appropriate assessment and monitoring. By December 2007, after only eight months in the nursing home, Mr. S. suffered several falls, became severely rigid, and developed contractures. The inappropriate use of antipsychotic medications was a contributing factor to all of these events.

- Another resident, S.P., had been taking a psychotropic medication since December 2005. He has a history of strokes, vascular dementia, and dysphagia. At the time of our tour, there was no documentation in the record of any recent symptoms that require the medication, nor any evidence of any attempts to gradually reduce the medication. There also was no evidence of whether the medication was effective or not, or that Mr. P. was being monitored for medication side effects. Mr. P. had had recent episodes of

aspiration pneumonia, which very likely may have resulted from his antipsychotic medication.

- Seventy-five-year-old resident C.W. was taking multiple antipsychotic medications that were not being adequately monitored or evaluated. When we saw him during our tour, he had tremors, rigidity, and contractures, likely adverse reactions to his antipsychotic medications. Despite the obvious visibility of these conditions, they were not documented by the physician. Mr. W. had experienced a steady functional decline in his ambulation and had suffered two recent falls.

Recreational and therapeutic activities are the cornerstone of preventing behavior problems and improving the quality of residents' lives, and many of the resident behavioral problems at W.F. Green could be alleviated with improved psychosocial services and programs. The failure to provide these essential services leaves many residents without needed care, and facility staff must contend with an escalation of residents' behavior problems. Unfortunately, W.F. Green's primary approach to residents' problematic behavior is to use antipsychotic medications and to send residents out for psychiatric hospitalizations. Frequently, residents' maladaptive behaviors manifest as aggressive acts toward other residents or staff, and W.F. Green fails to appropriately address the behaviors.

For example, W.Q. is an 86-year-old veteran with a history of dementia with violent behavior and depression, in addition to several medical conditions. In the fall of 2007, he had repeated episodes of violent behavior, including wandering and hitting staff and other residents. Despite his aggressive behavior, Mr. Q. had not been evaluated by a psychiatrist. W.F. Green's response to Mr. Q.'s behavior was to send him to an emergency room or directly admit him to a hospital. His behavior remained inadequately managed.

A specialized activities program for dementia residents focusing on individual abilities is fundamental to a dementia program. W.F. Green's dementia unit, however, deviates significantly from generally accepted professional standards regarding dementia care. Instead, the dementia unit at the facility merely prevents elopements and wandering by residents. Although the unit does have greater numbers of direct care staff, there is nothing to suggest that staff on the unit receive any specialized training in dementia care. The pervasive lack of psychosocial services at W.F. Green also impacts the dementia unit. The activities we observed on the unit were generic

activities and did not appear to be individualized. Additionally, during our tours in the unit, several residents were not engaged in activities at all.

In sum, the failure to provide adequate psychosocial services at W.F. Green, particularly to those residents with dementia or depression, results in the inappropriate use of psychoactive medications, contributing to an increased number of falls and injuries, residents being sedated, loss of mobility leading to contractures, functional decline, and other negative outcomes for the residents of W.F. Green.

4. Inadequate Pressure Sore Treatment and Skin Care

Pressure sore prevention and care at W.F. Green substantially departs from generally accepted professional standards. Most nursing home residents' pressure sores can be successfully treated. Progression to advanced stages is preventable.[12] Generally accepted professional standards require nursing homes to conduct comprehensive assessments and ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. Residents with pressure sores must receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. See 42 C.F.R. § 483.25.

While W.F. Green has made efforts to improve pressure sore care, the program has serious deficiencies that harm residents. One significant deficiency is that nursing staff — including the facility's skin care nurse — are not adequately trained in pressure ulcer prevention and treatment to meet the needs of residents. The nursing staff, including nursing assistants, must be well trained and supervised in pressure ulcer prevention. In reviewing the in-service training for the six months before we

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[12] Pressure sores, also called pressure ulcers or bedsores, are lesions that may develop from prolonged pressure on an area of the body, and can become life-threatening if not appropriately treated. Pressure sores are staged I-IV according to severity as follows: stage I - intact skin but reddened, non-blanching; stage II - partial thickness injury like an abrasion or blister; stage III - full-thickness pressure damage extending into subcutaneous tissue; stage IV - full-thickness tissue destruction to muscle, tendon or bone. It is critical that pressure sores be "staged" accurately, as the type and frequency of treatment depends on the wound being accurately assessed.

toured, there was only a very limited amount of training regarding pressure ulcers and skin care. W.F. Green's Wound Care Manual was revised in October 2007, but there is nothing to show that staff were educated on these revisions. Based on our observations, interviews, and review of medical records, it is clear that the nursing staff is not adequately following the Wound Care Manual or adhering to acceptable standards of care, reflecting a lack of training and supervision of nursing staff. The lack of adequate training has a direct impact on the quality of care delivered and resident outcomes.

Another significant problem with W.F. Green's pressure sore treatment and prevention program is its lack of multidisciplinary involvement. Adequate nutritional care is critical in the prevention and treatment of pressure sores. Unfortunately, there is no evidence that the dietician participates in any team effort on prevention or treatment of pressure sores. Further, medical staff and therapy staff are not involved in a team effort to address pressure ulcer prevention and treatment in the nursing home.

The combined deficits in adequate training and multidisciplinary involvement in pressure ulcer treatment and prevention adversely impacts residents at W.F. Green. Basic pressure sore prevention measures are not in place, such as ensuring that residents are turned and positioned adequately and that pressure relieving devices are in place as needed.

In the tragic case of resident Z.L., who is discussed earlier for issues surrounding his poor nutritional care, W.F. Green's failure to provide adequate pressure sore care likely contributed to his untimely death. After being admitted in May 2007, Mr. L. developed four different pressure sores, mostly on his hips and buttocks, clear indications that he was not positioned and repositioned adequately. There was no evidence in his record that any preventive measures, such as pressure relieving cushions or a positioning schedule in his chair, were ever implemented. Further, there was no evidence that any such measures were taken once the ulcers developed. The nursing home treated Mr. L.'s wounds with a chemical compound that can destroy healthy skin, hinder wound healing, and is not in keeping with generally accepted professional standards of wound care. In late January 2008, a pressure sore on his hip became red and enlarged and had a large amount of discharge. W.F. Green staff failed to recognize that the redness and increased discharge represented a likely infection and no steps were taken to treat it. In our expert physician's opinion, Mr. L.'s wound infection very likely contributed to his death a few days later.

The following are other examples of the harm to W.F. Green's residents because of insufficient pressure sore care:

- During wound rounds, we observed X.A., a 79-year-old resident, in his bed. Mr. A. was admitted to W.F. Green in November 2007. He is unable to adequately turn and reposition himself in bed, and had developed a pressure ulcer on his right heel and on his sacrum[13] since admission to W.F. Green. At the time of our February tour, the pressure ulcer on his sacrum was documented as resolved, but the ulcer on his right heel had progressed to Stage IV. Mr. A.'s heels were not placed in a non-weight bearing position. Instead, Mr. A.'s heels were lying on the bed with unrelieved pressure. His left heel was wrapped in a gauze bandage "for protection" according to staff. Although the gauze might be helpful in reducing friction from rubbing his feet on the bed, it prevents the nursing staff from visually checking his skin in that area to detect signs of unrelieved pressure and early skin changes. Staff were failing to adequately turn and reposition Mr. A. Our nursing expert observed that he remained in the same position for at least three hours on two different occasions during our site visit.

- V.Z. is another W.F. Green resident who is at risk of skin breakdown and is totally dependent on the nursing staff to turn and reposition him. While walking through the nursing home on our tour, one of our experts found him soiled with dried feces and old, dried blood on his T-shirt. He was left on his back for four hours without repositioning or turning. Mr. Z. was using an air mattress that likely provided some pressure reduction, but there were no pillows or wedges on his bed or in his closet that the nursing staff could use to turn him.

- At the time of our tour, resident L.J. had two Stage II pressure ulcers: one on his right outer foot and a second on his right heel. We noted that Mr. J. was not being turned and repositioned at least every two hours as required by generally accepted standards. Further, although his record identified these pressure ulcers as "inherited" from a recent hospital stay, his medical records showed that the

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[13] The sacrum is a triangular bone at the base of the spine, above the coccyx (tailbone), that forms the rear section of the pelvis.

right outer foot ulcer was present at W.F. Green before he went to the hospital.

It was also clear to us that W.F. Green does not have an adequate system to appropriately identify which residents were at risk of skin breakdown. Without such a system, the nursing home cannot develop adequate care plans for residents' skin needs. Additionally, data regarding the origin of pressure sores was inaccurate. Records would show that a resident came to the facility with a pressure sore, when in fact, the sores were developed at W.F. Green. This failure prevents the nursing home from implementing adequate pressure ulcer prevention measures.

W.F. Green's failure to develop and implement professional standards of care for pressure ulcer prevention and treatment and its lack of adequately trained staff places residents at unreasonable risk of skin breakdown. This failure places residents at risk to their health and safety and has, in fact, led to resident harm.

5. Inadequate Rehabilitative and Restorative Care

For nursing home residents, rehabilitative and restorative nursing care is essential to promote resident independence in areas such as feeding, bathing, toileting, continence, and moving and positioning. Therefore, generally accepted professional standards require that residents receive adequate restorative nursing care to meet their needs and maintain their highest practicable physical, mental, and psychological well-being. See 42 C.F.R. § 483.25.

Our physician consultant found that the number of residents at W.F. Green who receive rehabilitative or restorative care is unusually low, given the needs of the population. The major problems contributing to the facility's failure to provide these vital services are the lack of an adequate screening and referral system; a pervasive lack of multidisciplinary communications to address resident care; and insufficient space and equipment for an adequate rehabilitation program.

W.F. Green lacks an adequate screening and referral system for rehabilitative and restorative care. Staff reported that all residents are screened to determine whether a referral to rehabilitation is appropriate, but we were unable to verify this through resident records or outcomes. Residents were not consistently screened at admission or readmission, and screening was not always done in a timely manner. Many residents who are screened are inexplicably denied rehabilitative services. W.F.

Green should assure that every resident who may potentially benefit from rehabilitation therapy is actually screened, and that such screening occurs in a timely fashion.

Another problem is that notification to rehabilitation staff of residents who have a functional decline, such as a decline in activities of daily living ("ADLs")[14] or worsening of contractures, is too often inadequate or nonexistent. The pervasive lack of multidisciplinary interaction to address resident care affects residents' access to rehabilitative and restorative services.

W.F. Green also lacks adequate space and equipment to serve the needs of residents. There is not an adequate amount of equipment for strength building or the equipment or space to assist residents in ambulation or walking exercises. Services that we did observe were very limited and treatments were all performed with the residents seated in their wheelchairs.

The failure to provide adequate rehabilitative services is resulting in serious negative outcomes for W.F. Green residents. For example:

- When resident M.I. was admitted to W.F. Green, he was determined not to need a rehabilitation screen even though he was clearly at risk of falling. His admission assessment stated that he was using a walker and a wheelchair to ambulate. However, within three weeks, Mr. I. began to lose much of his ambulation ability, to the point that he could no longer use his walker. There was no evidence in his record that this was communicated to any clinical staff or that Mr. I. received any further rehabilitation evaluations or services. In late December, Mr. I. fell and broke his hip. Again, after his return from the hospital, no timely rehabilitation screening, evaluations, or services were provided. At the end of January 2008, a rehabilitation screen documented: "no change in functional ability. Tx [treatment] not recommended." This indicates that the screener either did not read Mr. I.'s record, or does not possess the needed skills to perform the screen. In these circumstances, generally accepted professional standards require that Mr. I. receive extensive rehabilitation therapy. His condition did not prevent him from participating in therapy and making functional gains. However, this was not done, and Mr. I. remained at risk of injury from unnecessary falls.

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[14] ADLs include eating, bathing, dressing, and toileting.

- In August 2007, resident I.S. was noted to have an unsteady gait when he walked, putting him at risk of falling. A rehabilitation screen was requested by the staff, but no treatment was recommended. In December 2007, Mr. S. was found in a dayroom lying on his back by a recliner. Later that month, his wife told the W.F. Green physician that Mr. S. had not been walking. Another rehabilitation screen was conducted, but no skilled treatment was recommended. When we observed Mr. S. on February 12, 2008, he had spasticity, rigidity (both disorders of body movement), and contractures. A nurse on the dementia unit explained that he began having difficulty standing and could take a couple of steps only with "much encouragement" and personal assistance. Yet, towards the end of January 2008, a rehabilitation screen documented: "[R]esident does not demonstrate any change in functional ability at this time." However, the resident had lost, or was losing, his ability to walk. This scenario demonstrates a serious lack of interdisciplinary communication. Mr. S. clearly had been on a path of relentless functional decline for at least several months prior to late January. There was insufficient response to this decline.

The failure of adequate rehabilitation services was also evident by the number of residents we observed in inappropriate or ill-fitted wheelchairs or gerichairs. We observed residents who were sitting too low or too high in their chairs or who did not have proper supports for their feet. The lack of appropriately fitted footrests may compromise the stability of a wheelchair, resulting in tips and falls, and it may cause residents' lower extremities to be positioned in a way that compromises the circulation. The lack of footrests may also cause a resident's leg or legs to be caught under the chair and may cause an injury.[15]

A further contributing factor to these health care deficiencies is the failure of the nursing home to have adequate quality assurance mechanisms in place. An adequate quality

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[15] There may be situations when it is desirable to remove the foot rests, particularly in residents whose arms are too weak to self-propel a wheelchair. However, the resident must have an assessment to assure that he or she has the physical and cognitive ability to self-propel safely. There were inadequate structures in place to assure that this was done for residents whose wheelchairs did not have footrests.

assurance program would help to identify, and to respond to, many of the health-care related, as well as other, deficiencies at W.F. Green identified in this letter.

B. INADEQUATE PROTECTION FROM HARM

Residents of nursing homes such as W.F. Green have the constitutional right to live in reasonably safe conditions. See Youngberg, 457 U.S. at 315. W.F. Green is failing to ensure that residents are reasonably free from harm or unnecessary risk of harm. Specifically, the facility is failing to ensure that residents are protected adequately from the risk of falling and that incidents of potential resident abuse are adequately investigated to protect residents from harm at others' hands.

1. Inadequate Fall Prevention Programs

Generally accepted professional standards require nursing homes to assess residents for their risk of falls, make appropriate diagnoses related to fall risk, develop appropriate care plans to mitigate risk of falls, and supervise residents adequately to protect them from falling. See 42 C.F.R. § 483.25(h)(1-2); 483.20(a-k). Elderly persons are at particular risk from the injuries that can result from falling.

W.F. Green lacks systems to assure that residents at risk of falls are appropriately assessed and offered individualized interventions to prevent falls. This is particularly true in the nursing home's failure to consider the effects of psychotropic medication on increasing residents' risk of falls and injuries.

The facility uses a generic risk assessment form for falls. The purpose of the risk assessment form is to obtain a numerical value that correlates with risk so the staff can determine if the resident is at risk. Although the form contains some individualized risk factors, it is incomplete as an assessment tool from which to develop a care plan. Nonetheless, it appears that it is used in that fashion. The form is completed on a quarterly basis and after each fall, but there is little evidence that even the incomplete information contained on the form is used for care planning. For every W.F. Green resident we reviewed where falls, or the risk of falling, were issues, staff failed to perform a comprehensive risk factor assessment. Such an assessment should include a medication review with particular attention to psychoactive medications, high blood pressure medications, and diuretics; a review of health issues, such as diabetes and neurological conditions; and assessment of other factors such as gait, balance, and feet condition.

For example, orthostatic hypotension[16] is a common issue in an elderly population. However, in dozens of forms we reviewed, it appeared that this part of the fall assessment form is completed without actually doing the required test or that the assessor does not know how to perform this test. The facility also failed to adequately assess gait and balance, as only a minuscule number of residents were assessed for these factors when judged to be at risk or following actual falls. Falls from chairs, common at W.F. Green, have been shown to be caused, among other factors, by balance problems. Physical therapy or occupational therapy evaluations or interventions after such falls were inadequate.

Further, although there was frequently an attempt to document the immediate cause of the fall, it seems that this task was often left to inadequately educated nursing assistants and to Licensed Practical Nurses ("LPNs"), who too often do not possess adequate assessment skills to determine causation of a fall.

Examples of harm to residents due to W.F. Green's inadequate fall prevention measures include the following:

- Resident N.X., who was admitted to W.F. Green in March of 2006, is a resident who has a history of falls and injuries, along with multiple medical issues that, as we saw in other records, were not evaluated adequately to determine any possible connection to his falls. On January 1, 2008, Mr. X. began complaining of severe pain in his shoulder. That same day, his record showed that he was found on the floor beside his bed on his right side with abrasions to his right leg. He was not evaluated until two days later, when he was sent to a local emergency room. Then, Mr. X. was diagnosed with acute rhabdomyolysis.[17] Our review revealed it very likely that Mr. X. had fallen twice on January 1. Again, there was no adequate investigation of the circumstances of the fall (or falls) and no new care plan or

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[16] Orthostatic hypotension is a change in blood pressure from sitting or lying to standing, which can cause dizziness and increase a person's risk of falling. The condition worsens with age and is therefore a critical issue in falls among the elderly.

[17] Rhabdomyolysis is the breakdown of skeletal muscle tissue due to an injury to the tissue. The destruction of the muscle releases material into the blood stream that can lead to acute kidney failure. Rhabdomylosis is often found in victims who have been crushed, such as after an earthquake or a bombing.

interventions to prevent further falls or to increase his supervision were developed or implemented. Our consultant physician was preparing to tell W.F. Green staff that he believed Mr. X. was in jeopardy when our nurse consultant entered Mr. X.'s room and found him on the floor, again.

- In October 2007, resident K.O. fell six days after being diagnosed with hypoglycemia (low blood sugar), his second fall in 10 days. The possibility of hypoglycemia causing the falls was not assessed. He continued to fall, falling at least three times in January 2008, suffering a head injury, skin lacerations, and bruises. The failure to evaluate the possible medically-related causes of Mr. O.'s falls, as well as other possible causes, places Mr. O. at heightened risk of untoward outcomes from falls as he is taking medications that increase his chances of excessive bleeding. Again, the nursing home failed to ensure that other disciplines, such as rehabilitative therapies, were involved in assessing and implementing interventions to prevent Mr. O. from falling.

- The nursing admission assessment for resident M.I., discussed above, stated that he had generalized weakness and used a walker and a wheelchair to ambulate. His fall risk assessment indicated that he was a high fall risk, in part, because he had a history of falling. However, there was no evidence that the specific risk factors for M.I. were evaluated and addressed in his care plan. There was no medication review to see if any of the medications he was taking could be contributing to his falls. An immediate care plan was not implemented at the time of admission despite the known history of falls. One day after admission, Mr. I. was found on the floor. An adequate post-fall evaluation was not performed and there was no rehabilitation evaluation.

- Later, Mr. I. was started on antidepressant medications, which increase the risk of falls, but no additional fall prevention measures were instituted. His blood pressure was consistently low, but there was no evaluation to possibly reduce the medication for blood pressure. In December 2007, he fell and suffered a hip fracture. After his return from the hospital, there was again no assessment of specific fall risk factors, and there was no change in the care plan. Mr. I. continued to fall, including a fall at the end of January where he was found on the floor in front his wheelchair, in pain and with bruising on his left inner thigh. W.F. Green never implemented adequate measures to

prevent Mr. I. from falling. This failure led to harm and keeps him at unnecessary risk of further harm.

- Resident, I.S., discussed above, was admitted to W.F. Green in April 2007 and suffered at least eleven falls between May and December 2007. His admission fall risk was not done correctly and, of the subsequent fall risk assessments done following his falls, it appeared that nurses failed to do a complete assessment. I.S.'s care plan was not properly evaluated for appropriateness of interventions and he was not monitored closely enough by the nurses. Even after he had fallen numerous times, the nurses still allowed him to walk unassisted with an unsteady gait.

- Further, I.S. was prescribed antipsychotic and anti-epileptic medications which can cause orthostatic hypotension, syncope,[18] drowsiness, dizziness, and weakness, all of which put Mr. S. at higher risk of falling. W.F. Green nursing staff should have known these risks and should have supervised Mr. S. closer to prevent his falling. For example, both the W.F. Green physician and Mr. S.'s wife became concerned that he was over-sedated as a result of his medication, because at one point he "fell asleep and fell out of his wheelchair into [his] food." Nursing staff should have been aware of Mr. S.'s condition, but they were not monitoring his reaction to the various medications, and he was allowed to continue to fall. Mr. S. has continued to fall throughout his stay at W.F. Green.

W.F. Green's failure to assess residents' fall risk appropriately and develop and implement measures to help ameliorate future falls, continues to place residents at undue risk of harm and in danger to their health and safety.

2. Failure to Investigate Residents' Injuries

Unfortunately, episodes of resident-on-resident assaults are not uncommon at W.F. Green. Generally accepted professional standards require the nursing home to investigate incidents to determine if interventions are necessary. In addition, when injuries of unknown origin occur, these must be investigated to determine if staff abuse occurred. W.F. Green does not adequately investigate resident injuries. For example:

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[18] Syncope refers to a brief loss of consciousness caused by a temporary deficiency of oxygen in the brain.

- Resident W.Q. has a history of rib and clavicle fractures, potentially related to past violent behavior. In September 2007, he hit another resident and was sent to an emergency room for evaluation. That same day, a deep hematoma was found on his left forearm. Given Mr. Q.'s aggressive behavior, this episode was potentially related to a retribution or an altercation with another resident but this was not reported or investigated.

- Another resident, E.L., was found in December 2007 with his ear bruised and swollen. His left wrist and hand were also bruised. There was no investigation or explanation of these findings. Three days later, Mr. L. was suffering from additional injuries to his forehead and face and what was described as a "knot" on his inner thigh. A medical evaluation called this "knot" a "hematoma of unknown origin." These unexplained injuries and the possibility that they were related to staff abuse were not investigated.

- On February 1, 2008, I.S. was noted to have swelling and tenderness on his left hand. The cause of the swelling was identified simply as "etiology unknown" and "edema" (swelling). When our consultant physician saw Mr. S. during our tour, almost two weeks later, his hand was still swollen. No attempt was made to investigate the possibility of an unwitnessed fall, trauma, or abuse despite the lack of medical explanation for this swelling and the fact that Mr. S. had a history of multiple falls.

Further, W.F. Green does not report injuries of unknown origin to proper State authorities. This reporting is required by Alabama law, which is similar to federal law requiring that such matters be reported to proper authorities. See 483.13(c)(2). In reviewing records, we came across incidents in which residents were found with injuries of unknown origin, but the incidents were not reported to the proper State authorities. When we showed the incidents to the Acting Administrator, he acknowledged that he would expect such incidents to have been reported to State authorities.

In summary, the failure of W.F. Green to investigate the cause of residents' injuries and take necessary steps to prevent further injuries continues to place residents at undue risk of harm.

C. INAPPROPRIATE USE OF RESTRAINTS

Generally accepted professional standards require that nursing home residents be free from physical restraints imposed

for the convenience of staff, without medical justification, or when lesser-restrictive interventions are possible. Youngberg v. Romeo, 457 U.S. 307 (1982); See 42 U.S.C. § 1396r(c)(1)(A)(ii). W.F. Green staff fail to assure that residents are not unduly restrained.

For example, when touring the facility at night, we observed resident T.V. in bed with both full-length side rails of the bed raised. While Mr. V.'s record stated that side rails could be used for "mobility" or "position," there was no need for full-length side rails to accomplish this. Moreover, his Minium Data Set[19] documented that he was to be helped by staff for his mobility in bed, which conflicts with the assessment on the side rails screen. There was no physician order for bilateral full-length side rails. The risks associated with the use of side rails are well known, such as an increased danger of falling. Even if Mr. V. were in need of elevated side rails to enable him to improve his bed mobility and positioning, there should have been an evaluation, a statement of the medical reason for the use of restraint, an informed consent, a physician's order, and a care plan to address the risks, all of which are required by W.F. Green's own policy on restraints. There was no assessment, care plan or physician's order for the bed rails, which serve to restrain Mr. V. in his bed.

Further, we also observed many residents in seating devices, including reclining chairs and gerichairs, which constituted a functional restraint due to the residents' lack of physical strength or control to reposition or to sit upright. For example, while a reclining chair is not a per se restraint, placing a person without the ability to adjust the chair or reposition his or her body without assistance in a recliner and then reclining the chair as W.F. Green does, functionally restrains the resident. Similarly, a gerichair is a functional restraint when a resident is unable to reposition or move while seated in the gerichair without assistance. However, staff did not realize or evaluate the arrangement as a restraint, did not consider less restrictive measures, did not provide an adequate care plan, and did not obtain a physician's orders for the restraint.

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[19] The Minimum Data Set is part of the federally mandated process for clinical assessment of all residents in Medicare/Medicaid certified nursing homes. The MDS process is intended to provide a comprehensive assessment of a resident's functional capabilities and helps nursing home staff identify resident's health care problems.

For example, we observed resident E.L. in the rehabilitation department in a narrow gerichair. Mr. L. had severe generalized rigidity and multiple contractures. The narrowness of the gerichair prevented Mr. L. from getting in and out of it, and therefore it is a functional restraint. There was no restraint evaluation or physician's order calling for restraint.

We saw another resident, A.G., in a similarly ill-fitted gerichair. From observing his body movements, it appeared he likely had Parkinson's disease. He was unable to get out of the gerichair. Indeed, Mr. G. told our consultant physician that he cannot get out of the chair, thus the gerichair serves as a functional restraint. Again, there was no clinical justification for the restraint, in violation of generally accepted professional standards.

D. FAILURE TO SERVE RESIDENTS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

Residents at W.F. Green are covered by the civil rights protections of the Americans with Disabilities Act. 42 U.S.C. § 12101 et seq.[20] As a state-run facility, W.F. Green has legal obligations toward residents pursuant to Title II of the ADA.[21]

Among other obligations toward residents under the ADA, the State must actively pursue timely discharge of institutionalized residents to the most integrated setting appropriate for their needs. The ADA regulations provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). In the preamble to the regulations, "the most integrated setting" is defined as that setting which "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. A at 450.

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[20] Disability is defined under the ADA as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual, . . . a record of such impairment; or. . . being regarded as having such an impairment." 42 U.S.C. § 12102(2). See also 28 C.F.R. § 35.104.

[21] Title II applies to "all services, programs, and activities provided or made available by public entities," including any State or local government and their departments, agencies, or other instrumentalities. 42 U.S.C. § 12131; 28 C.F.R. § 35.104.

The Supreme Court had addressed the rights of persons with disabilities to be served in the most integrated setting appropriate to their needs. In construing the anti-discrimination provision contained within the public services portion of the ADA, the Supreme Court held that "[u]njustified [institutional] isolation ... is properly regarded as discrimination based on disability." Olmstead v. L.C., 527 U.S. 581, 597 (1999). Specifically, the Court established that states are required to provide community-based treatment for persons with disabilities when the state's treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected individual, and that the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. Id. at 607. Further, where community transition does occur, the State is responsible for providing adequate follow-along services. See Armstead v. Coler, 914 F.2d 1464, 1467 (11th Cir. 1990).

With his New Freedom Initiative, President George W. Bush further emphasized the need to tear down barriers to equality and to expand opportunities available to Americans living with disabilities.[22] On June 18, 2001, the President signed Executive Order No. 13217, entitled "Community-Based Alternatives for Individuals with Disabilities," as one step in implementing the New Freedom Initiative. Specifically, the President emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities. Exec. Order No. 13217, §§ 1, 66 Fed. Reg. 33155 (June 18, 2001). The President directed the Attorney General to "fully enforce" Title II of the ADA, especially for the victims of unjustified institutionalization. Id. at § 2.

At W.F. Green, the State is failing to adequately assess and determine whether residents are in the most integrated setting appropriate to their individualized needs. When W.F. Green residents are discharged to a more integrated setting, they are left adrift without appropriate follow-up by the State.

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[22] Available at http://www.whitehouse.gov/news/freedominitiative/freedominitiative.html.

1. Assessment of the Most Integrated Setting Appropriate for W.F. Green Residents' Needs

W.F. Green's treatment professionals have taken some actions to identify residents for whom community placement is appropriate. At the beginning of our tour, W.F. Green provided to us a list of 22 residents who, in the opinion of its professional staff, might function well in a more integrated setting than the setting at W.F. Green. These are residents who have very minimal needs for assistance and have few ongoing nursing needs requiring the level of care at a nursing home.

O.U., for example, is a 70-year-old resident who was admitted to W.F. Green in November 1999. He is diagnosed as having had a stroke, hemiplegia (paralysis on one side of the body), and vascular dementia. He is also incontinent of urine. Mr. U. needs limited assistance[23] with dressing, bathing, and bladder continence, and supervision[24] with toilet use, and is able to walk on his own with the use of a cane. In addition, he is alert and oriented. Mr. U. was a career Army man who could recall the exact number of years, months and days he was in the service. He told us he participates in activities and outings. Given his minimal needs for assistance, Mr. U. does not seem to require nursing home care.

Another resident identified by W.F. Green staff as a possible candidate for a more integrated setting is L.B. Mr. B. is 79 years old and has lived at W.F. Green since December 2006. The only help Mr. B. needs is supervision with bathing. He is alert and oriented, and uses a motorized scooter to get around the nursing home. He has family close by who visit him.

P.J. is a 63-year-old resident who was admitted to the facility in July 2007 and may function well in a more integrated setting. He has dementia, chronic obstructive pulmonary disease, and diabetes. The only help he needs is supervision with bathing. He told us that he has family in the area and that he would prefer to live somewhere other than the nursing home.

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[23] "Limited assistance" means that the resident is highly involved in performing a given activity, and yet still receives physical help in performing the activity.

[24] "Supervision" means that staff have to provide oversight, encouragement, or cueing three or more times during the last seven days, or supervision plus physical assistance only one or two times during the last seven days.

As the examples above illustrate, and as recognized by W.F. Green, there are clearly residents living at W.F. Green who could, with adequate supports and services, live in more integrated, community-based settings. However, during our tour, our expert consultant identified additional residents who could live in more integrated settings but whose potential for discharge seems to have been inadequately assessed.

One example is E.M. Ms. M.'s discharge potential does not seem to have been adequately assessed. She is 84 years old and has been at W.F. Green since November 2007. She is diagnosed with dementia and diabetes and requires supervision with locomotion, dressing, personal hygiene, and bathing, but she is able to ambulate with a manual wheelchair. Ms. M. was not on the list of residents with good discharge potential and her record merely documented that there were no discharge plans indicated by her sponsor.[25] However, our expert consultant recommends that her discharge potential be further explored.

2. Discussion of Discharge Options and Residents' Interest in a More-Integrated Setting

The second prong of the Olmstead analysis considers whether a resident does not oppose transfer to a community-based setting. The written discharge planning policies and procedures at the facility are proactive, but this proactive approach is not reflected in practice. The policies and procedures recognize that discharge planning begins at the time a person enters the facility and must be continually reviewed as long as a resident is at W.F. Green. However, the records we reviewed and our conversations with residents demonstrated that discharge planning is inadequate in practice.

W.F. Green staff should not only assess whether a resident may function well in a less restricted setting than the nursing home, but also discuss with the residents whether they would like to move to a more integrated setting if they could. It is the responsibility of the State to identify other more-integrated living options, to discuss possible discharge options with residents, and to include steps in a post discharge plan of care to ensure that a resident's needs will be met when discharged. At a minimum, W.F. Green should coordinate with the resident, family, and State agencies to identify and contact appropriate resources.

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[25] W.F. Green uses the term "sponsor" to refer to a family member or guardian of a resident.

The documentation in residents' records indicated that staff erroneously believe that the onus is on the resident or his or her sponsor to bring up the issue of discharge. Staff statements in resident records, such as "Wife has voiced no wishes to explore discharge planning," "No future discharge plans indicated by sponsor," the resident "has not expressed a desire for discharge," or a common cursory note that "D/C (discharge) poor due to heath care needs," was too common and indicated a lack of professional effort in discharge planning. In our conversations with residents, even the residents listed by W.F. Green as having good discharge potential (described above) could not recall ever having discussed the issue of discharge with W.F. Green staff. While some expressed a desire to remain at W.F. Green, none were opposed to discussing the issue of discharge.

Further compounding the failures surrounding discharge planning was the general sense among W.F. Green staff and residents that, from the perspective of the veterans' system, residents had no other housing alternatives.[26] Based strictly on that perspective, there was a sense that were no community based alternatives in the Alabama veterans' system, and few residents could be discharged. The discharge data bears this out, as only six residents were discharged back to the community during the more than one year period from January 1, 2007 through February 11, 2008.

There is also inadequate post-discharge follow-up of residents to determine if the residents' needs were being met in the community. W.F. Green should include in its discharge planning process follow-up interventions for those residents who are, or will be, discharged.

For example, T.N. was admitted to W.F. Green in June 2007 and discharged four months later. The records indicate that he had been admitted to, and discharged from, W.F. Green on a prior occasion. His admitting diagnoses included coronary artery disease and chronic obstructive pulmonary disease. The Interdisciplinary Discharge Summary noted that the resident was very focused on going home and his grandson was planning to provide Mr. N. with in-home care. However, Mr. N.'s record described his discharge potential as "[p]oor due to his health care needs."

Another resident who was discharged to home was O.K. Mr. K. was admitted to W.F. Green in November 2007 and discharged within days. His diagnosis was cardiovascular accident and he had

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[26] As discussed below, there <u>are</u> housing alternatives in Alabama with which staff and residents should become familiar.

speech and visual deficits, but was noted to be alert and oriented. W.F. Green initially considered his discharge potential to be "poor due to health care needs." However, shortly after his admission, his sponsor, who was also his wife, quickly changed her mind about Mr. K. staying long term at W.F. Green. He was able to be discharged despite the nursing home's determination that his discharge from the facility was unlikely. In fact, Mr. K. was at the facility such a short time that a physician never saw him to render an opinion about his health care status. Therefore, it appears that W.F. Green is not sufficiently thorough in assessing residents' discharge potential.

For residents who have been discharged, as in the cases of both Mr. N. and Mr. K., the post discharge planning was incomplete. W.F. Green staff should make referrals to community based agencies that could make necessary home visits to see how the placement was progressing, especially in light of the fact that their discharge potential was considered to be poor. The fact that Mr. N. had been discharged to home before and returned to the facility should have indicated that follow-up contact was appropriate. In the example of Mr. K., the sponsor was clearly ambivalent about his discharge. A referral for follow-up should have been made.

3. Alternative Placement Can Be Reasonably Accommodated, Taking Into Account The Resources Available To The Jurisdiction And The Needs Of Others Who Are Similarly Situated

The third prong of Olmstead requires consideration of whether an alternative placement can be reasonably accommodated, taking into account the resources available to the jurisdiction and the needs of others who are similarly situated.

Historically, long term care services were only available in nursing homes. However, more of these services are now being provided in the home and in community-based, residential programs that can address both the physical activities of daily living as well as the nursing needs of individuals. Despite this development, it was apparent in our tour of W.F. Green and review of resident documentation that staff responsible for discharge planning were not aware of these, or other, potential resources in the community.

There are both public and private sources of home and community based services in the State of Alabama that may provide services in a more integrated setting to residents of W.F. Green. The first source of services are provided through Medicaid

administered by the State. Even though the nursing home does not receive Medicaid monies, the Alabama Medicaid Agency administers several Home and Community Based Care waiver programs, two of which might provide alternative services to residents of W.F. Green.

The Elderly and Disabled waiver and the Independent Living waiver are two resources that may be utilized by residents at W.F. Green to move to a more integrated, community-based setting. The Elderly and Disabled Waiver is designed to provide services to allow elderly and/or disabled individuals who would otherwise require a nursing facility level of care to live in the community. The primary focus of this waiver is to provide services in a person's home. The second waiver, the Alabama Independent Living waiver, provides services to adults with disabilities who have specific medical diagnoses, such as residents with severe neurological impairments, quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis (Lou Gehrig's Disease), multiple sclerosis, muscular dystrophy or spinal muscular atrophy or similar disability.

Many W.F. Green residents could benefit from one of these Medicaid waiver programs that allow them to receive services in their homes. It also could be a potential resource for residents who have greater needs but strong family support. One drawback with these programs is that the Medicaid waiver programs often have waiting lists, and services may not be readily available for a resident who is ready for discharge. Nevertheless, examples of residents who might benefit from this resource are O.U., L.B. and P.J., mentioned above.

There are also some private resources available that could meet the needs of some residents at W.F. Green. There are facilities and programs in W.F. Green's geographic area that have nurses on staff and are specifically licensed to address the needs of persons with cognitive impairments. These resources would have to be paid for by the resident's finances. There are no public funds available to purchase this service.

Taking all of this into consideration under the third prong of Olmstead, it is the opinion of our expert consultant that there are public and private resources in the community that can meet the needs of some residents of W.F. Green and that these needs can be reasonably accommodated. The resources include private assisted living facilities that provide personal care services and nursing services, and some assisted living facilities that provide services for residents who are cognitively impaired. There are also services provided by

Medicaid waivers for persons who meet the eligibility criteria and can live in their homes.

However, the discharge planning process and practices at W.F. Green do not meet generally accepted professional standards. The facility does not accurately assess residents' discharge potential. More in-depth assessment of the resident's discharge potential needs to be done. The nursing home needs to develop an attitude that all admissions to W.F. Green are initially temporary until there is overwhelming evidence that the person cannot be served in the community. At the time of admission, social service staff need to ascertain as accurately as possible what the resident's and the resident's family's thoughts are on the resident returning to the community. Currently, staff assume that there is no interest in discharge and that there are no resources available.

Unfortunately, at present, the State only has a one dimensional long term care model that only provides for nursing facility care for veterans or their family members. The generally accepted professional standards in the design of long term care systems emphasize the need for a broad array of long term care services, particularly services that can be provided in the community. These types of services are less institutional, less expensive, and are more humane for the resident.

In summary, there are residents of W.F. Green who have needs that could be met in the community and professional staff have identified many of these residents. W.F. Green's policies recognize the importance of appropriate placements and the importance of discharge planning. However, these policies are not being adequately implemented. There are residents who would prefer to be in the community. However, W.F. Green puts the onus on the resident and family to bring the subject up. The facility needs to strengthen the admission process to effectively determine the attitude of the individual, family, or other interested parties toward overall placement goals.

Finally, there are resources in the community that could meet the needs of some residents of the facility. The financial realities of each individual is an important factor in making the decision whether to pursue alternative services in the community, but it is the role of the facility to provide accurate, current information on what those alternative resources might be.

IV. MINIMAL REMEDIAL MEASURES

To remedy the identified deficiencies and protect the constitutional and statutory rights of W.F. Green residents, the State should implement promptly, at a minimum, the measures set forth below:

A. HEALTH CARE SERVICES

1. Ensure there is adequate supervision of all clinical disciplines, including medical and nursing staff, rehabilitation, and activities staff to ensure that clinical services provided to W.F. Green residents comport with generally accepted professional standards.

2. Provide each resident with adequate medical and nursing care, including appropriate and on-going assessments, individualized care plans, and health care interventions to protect the resident's health and safety. To accomplish this, W.F. Green should:

   a. Ensure that each resident's health status is adequately monitored and reviewed, and that changes in a resident's health status are addressed in a timely manner;

   b. Ensure that all W.F. Green medical and nursing staff members are adequately trained in generally accepted professional standards for their respective areas of responsibility, that policies are updated and reflect generally accepted professional standards, and that the staff members are trained on those policies;

   c. Ensure that medical and nursing staff address, with particular attention, residents' medical conditions, such as diabetes;

   d. Develop policies and protocols that ensure that nursing staff identify and respond adequately to abnormal laboratory findings that indicate a change in a resident's condition;

   e. Ensure that residents receive restorative care services in order to allow residents to attain and maintain their highest practicable level of functioning;

   f. Cease the use of "standing orders" as the practice was employed at the time of our February 2008,

tour. Ensure that all medical or nursing care issues are responding in an individualized manner to residents' conditions in keeping with generally accepted professional standards;

g. Ensure that policies and practices are developed and implemented to adequately identify and manage communicable diseases such as TB and MRSA, and that infection control practices comport with generally accepted professional standards; and

h. Employ and deploy a sufficient number of adequately educated nursing staff, including Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants, to provide adequate supervision, routine care, preventative care, and restorative care and treatment to each W.F. Green resident.

3. Provide each resident with adequate nutrition and hydration services, including:

a. Conducting adequate nutritional and hydration assessments, especially calculation of calories, protein, carbohydrates, and fluids, of individual resident's specific nutritional and hydration needs;

b. Ensuring that adequate, individualized care plans, including plans for nutritional needs, are developed that address the individual needs of residents;

c. Ensuring that residents receive appropriate diets, as medically necessary;

d. Monitoring residents' nutritional status, weight, and food intake;

e. Ensuring that any change in residents' nutrition and hydration status is identified and responded to adequately and that residents have adequate access to water and fluids as needed;

f. Ensuring that residents who need assistance in eating are assisted by adequately trained staff;

g. Ensuring that residents are not fed in manners that expose them to risks to their health and safety, such as aspiration pneumonia;

h. Conducting peer reviews of any death where weight or hydration is an issue as well as reviewing any residents who suffer unexpected weight loss as defined by CMS regulations, with particular emphasis on the cause of weight or hydration concerns;

i. Ensuring that there is adequate professional oversight of nutrition and hydration services by a dietician adequately educated and experienced in the needs of the elderly and that the dietician participates in educating W.F. Green staff regarding nutritional needs of residents; and

j. Developing appropriate policies, procedures, protocols, and clinical guidelines to ensure that nutrition and hydration services comport with generally accepted professional standards.

4. Ensure that psychopharmacological practices comport with generally accepted professional standards. All use of psychoactive drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Medications should be prescribed based on clinical need. Medications should not be used in manners that expose residents to undue risks to their health and safety. Specific attention should be paid to the use of those medications that pose increased risks to the elderly and that may contribute to falls.

5. Provide sufficient and meaningful activities for all residents and make efforts to get residents involved in activities.

6. Provide adequate and appropriate psychiatric, mental health, behavioral, and psychosocial services, including dementia care services, in accordance with generally accepted professional standards.

7. Provide effective preventive systems for pressure sores and provide adequate care for residents with pressure sores, including ensuring that residents are appropriately positioned and that treatments comport with generally accepted professional standards, and that the nursing staff are adequately educated in the proper assessment for risk and treatment of pressure sores.

8. Ensure that residents receive adequate rehabilitative and restorative nursing care in areas such as feeding, bathing, toileting and continence care, and moving and positioning.

9. Implement adequate quality assurance mechanisms that are capable of identifying and remedying resident quality of care deficiencies.

B. PROTECTION FROM HARM

1. Design and implement appropriate interventions to assess and develop care plans for residents at risk of falling. Ensure that when a resident does fall, staff investigate adequately the reason for the fall and implement measures designed to ameliorate future falls to the extent possible. Particular attention should be paid to the effect psychotropic and other medications may have on residents falling. Train staff to ensure that changes in blood pressure relevant to falls is taken into account as appropriate.

2. Institute policies, procedures, and practices to investigate adequately, and implement corrective measures regarding instances of potential resident abuse, including instances of resident-on-resident assaults, and neglect, and/or mistreatment. Follow all relevant law regarding reporting incidents of unknown injury, or possible abuse, to appropriate State authorities. W.F. Green's Medical Director should also review all incident reports and ensure that appropriate administrative or clinical action is being taken.

C. USE OF RESTRAINTS

1. Ensure that any device that intentionally or functionally serves as a restraint is used only after an adequate assessment of the risks, and medical need for, such restraints in accordance with generally accepted professional standards.

2. Timely review the continued need for a restraint and remove the restraint as soon as clinically appropriate.

D. MOST INTEGRATED SETTING

1. Ensure that residents admitted to W.F. Green for long term care have needs that make them appropriate for such care.

2. Ensure that discharge planning meets professional standards of care, discharge plans accurately reflect residents' true discharge potential, and discharge options are discussed with residents and their families.

3. Ensure that W.F. Green residents who do not oppose placement in the community are being served in the most integrated settings appropriate for their needs.

* * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. 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 the Civil Rights Division's website until 10 calendar days from the date of this letter.

We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with regard to W.F. Green. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. The reports are not public documents. Although their reports are the work of each expert consultant and do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses, and recommendations provide further elaboration of the relevant concerns 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 prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, we will soon contact State officials to discuss this matter 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 Troy King
Attorney General
State of Alabama

The Honorable Bob Riley
Governor of Alabama
Office of the Governor

Larry Weapa
Administrator
W.F. Green State Veterans' Home

W. Clyde Marsh
Commissioner
Alabama Department of Veterans' Affairs

Deborah Rhodes
United States Attorney
Southern District of Alabama

Jack Wallace, Jr., Esq.
Assistant Attorney General
State of Alabama

Sandra "Sandy" Ingram Speakman
General Counsel
Alabama State Department of Veterans Affairs