March 6, 2003

Mr. Lewis H. Warrix
County Judge Executive
Breathitt County
1137 Main Street
Jackson, KY 41339

Re: Nim Henson Geriatric Center

Dear Mr. Warrix:

On March 20, 2002, we informed Breathitt County that we were investigating conditions at Nim Henson Geriatric Center ("Nim Henson"), in Jackson, Kentucky, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. In June 2002, we visited Nim Henson. At an exit interview conducted on the last day of the visit, we verbally conveyed our preliminary findings to the facility's administrative personnel. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings.

As a threshold matter, we wish to acknowledge, and express our appreciation for, the cooperation and assistance provided to us, particularly by the facility's administrator, Mr. Phillip Litteral, and Director of Nursing, Ms. Patricia Lutes. We hope to work with Breathitt County and Nim Henson administrators and staff in the same cooperative manner in addressing the problems that we found. Further, we note that it was apparent that many Nim Henson staff are dedicated individuals who are genuinely concerned for the well-being of the persons in their care.

We conducted our investigation by reviewing medical and other records relating to the care and treatment of individuals; interviewing administrators, staff and patients; and conducting an on-site review of the facility. Our findings are supported by the assessments contained in our expert consultants' reports.

At the time of our visit, Nim Henson had a bed capacity of 122; its actual census was 104. The facility is divided between a "skilled" care unit and an "intermediate" care unit. The skilled care unit has 44 beds, 42 of which were occupied when we visited. The remaining 78 beds are on the intermediate care unit, 62 of which were occupied during our tour. In addition t residents' rooms, the facility has one large dining room, a "Florida" room designated for resident activity, such as group programs and rehabilitation services, and a large activity annex in the rear of the building.

Residents of state and county-operated facilities have a right to receive adequate health care, along with habilitation, and other supports and services, to ensure their safety and freedom from unreasonable restraint, prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). Similar protections are accorded by federal statute. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483 (Medicaid Program Provisions); 42 U.S.C. § 135li-3; 42 U.S.C. § 483 Subpart B (Medicare). The County also is obligated to provide services in the most integrated setting appropriate to individual residents' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. L.C., 527 U.S. 581 (1999).

I. Facility Conditions

Areas in which the facility appears to be performing reasonably well include cleanliness in the kitchen and throughout the facility, the adequacy of staffing, and dietary supports. However, in the areas of general medical care, chemical restraints, wound and nutritional care, restorative care, psychiatric care, and incident management and quality assurance, Nim Henson does not provide levels of care that are consistent with the Constitution or statutory or regulatory requirements. Our findings, the facts supporting them, and the remedial steps that we believe are necessary are set forth below.

A. General Medical Care

As a nursing home, Nim Henson is required to provide medical, nursing and related services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 U.S.C. § 1396r(b)(4)(A). Nim Henson is not meeting these standards. More particularly, its medication management practices; its medical notes and documentation; and its oversight and management of medical care do not meet generally accepted standards of care. These deficiencies place residents at risk of harm.

1. Medication Management

Generally accepted standards of care dictate that use of medications, especially those having potentially harmful side effects, be clinically justified. This is particularly true when drugs are used in combinations that increase the risk of harm and when drugs are used that pose particular risks for the elderly. Generally accepted standards of care also dictate that, for drugs having therapeutic ranges, below which the drug is ineffective and above which it is potentially toxic, monitoring be conducted pursuant to generally accepted protocols to ensure that the drug is helping, not harming, the patient. Generally accepted standards of care further dictate that consideration routinely be given to whether continued use of drugs, and the amounts in which they are consumed, remains appropriate, or whether the drugs can be tapered down or replaced by others having fewer adverse side effects. As a general matter, none of these standards of care is adhered to at Nim Henson. The facility has virtually no medication management, and many of its residents are harmed or placed at risk of harm every day as a result.

a. Lack of Clinical Justification for Prescribed Medications

At the time of our review, 40 percent of the Nim Henson residents were receiving more than nine medications, and several residents were actually receiving 15 to 25 separate medications. In many, if not most, instances, the residents' medical records contained no clinical justification for these medications, and frequently certain medications appeared to be prescribed inappropriately.

Often, powerful psychotropic medications were administered to patients based solely on nurses' observations that they were "agitated." Agitation, although a potential symptom of multiple medical problems, including both psychosis and physical pain, is not itself a disease or disorder, and does not alone provide a clinical justification for psychotropic medications. Physicians routinely issued standing daily orders for certain medications that ordinarily would be given on an as-needed basis.

b. Unjustified Use of Polypharmacy

The use of more than one medication from the same class (polypharmacy) can be appropriate in some cases but must always be clinically justified. At Nim Henson, many patients were subjected to multiple psychotropic, anticholinergic, and/or benzodiazepine medications without clinical justification. Psychotropic medications can irreversibly cause uncontrollable muscle spasms, muscular rigidity, restricted speech and movement, and agitation, among other side effects. They also can cause swallowing difficulties, a particular concern at Nim Henson, because, as discussed below, an unusually high percentage of its residents are fed through gastrointestinal feeding tubes. Anticholinergic medications can cause mental confusion, especially in the elderly, as can benzodiazepines, which can be addictive. Each of these classes of medication can have great therapeutic value, but if used inappropriately can cause great harm. When, as at Nim Henson, multiple drugs within and among each of these classes of medication are prescribed to a resident without clinical justification, there is a significant likelihood that that resident is being seriously harmed. Certainly, a high number of Nim Henson residents displayed symptoms consistent with many of the harmful side effects of polypharmacy, particularly muscular rigidity, swallowing difficulties, restricted speech and movement, and mental confusion.

c. Inadequate Monitoring to Ensure Medications are Therapeutic

Many medications commonly used at Nim Henson, such as valproic acid, Phenobarbital, Dilantin, Tegretol, and Digitalis, must be monitored to ensure that their dosages are neither subtherapeutic, and ineffective, nor toxically high. According to the facility's consulting pharmacist, Nim Henson has no policies regarding the monitoring of such medications; monitoring is a matter left to each physician. This, in itself, is problematic. In any event, our chart review found little evidence that monitoring of these drugs was occurring at appropriate intervals, and we found several patients who were receiving subtherapeutic levels of mood

stabilizers and antidepressants, such as resident K.D.,[1] whose lithium and valproic acid levels had been documented as low on January 20, 2002, without a physician's order to increase them, and resident P.D., whose Zoloft level was also subtherapeutic. Further, although many Nim Henson residents are on Lipitor, their charts do not indicate that their cholesterol or serum lipids are measured. Dosing of Aricept (used to treat Alzheimer's disease) at a much less than recommended amount was common, rendering the medication useless.

d. Lack of Appropriate Consideration for Patients' Medication Regimen

We saw little evidence that Nim Henson physicians periodically reevaluated the continued necessity of certain drugs or drug dosage levels when symptoms of the condition for which the medication ostensibly had been prescribed had not arisen for extended periods of time and when alternative, less harmful medications were available. More fundamentally, based on our chart review, and with more than 40 percent of its residents prescribed nine or more medications and many receiving 15 to 25 drugs, it appears that the physicians frequently add medications with scant consideration of the impact on the existing pharmacological mix. In particular, they did not appear routinely to consider whether changes in the existing drug regimen were warranted.

For example, T.I.'s medications include phenobarbital, propranolol, valproic acid, iron, Claritin, Miacalcin, Oscal, Colace, Macrobid, Toprol, Isordil, Lipitor, Plavix, Ranitidine, Dulcolax, Darvon, and Lactulose. Many of these medications appear to be duplicative; in the absence of clinical justification for them in T.I.'s chart, such duplicative medications are unwarranted.

I.N.'s medications include thiothixine, Estrace, Claritin, Dulcolax, nitroglycerine, Tylenol, Glucophage, insulin coverage, digoxin, Lasix, nitropaste, Inderal Zoloft, Lipitor, propylthiouracil (PTU), Aricept, Ditropan, Metformin, Oscal, Coumadin, and Actos. Few of these medications were justified in the medical record. The use of thiothixine (Navane), an anti-psychotic medication, without justification, is of special concern.

S.T.'s medications include Micalin, Prozac, methocarbamol, milk of magnesia, Tylenol, meclizine, Mylanta, Darvocet, Protonix, Claritin, Cozaar, Flovent, Lasix, potassium, Serevent inhaler, Glyburide, iron, and vitamin C. This is a complex medication regimen that is not clinically justified in the resident's medical notes.

Some medications used at Nim Henson are especially problematic, such as Phenobarbital. This is a sedating, potentially addictive, barbiturate, the use of which is not recommended in the elderly. An unusually high number of Nim Henson residents were

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[1]To protect their privacy, we do not refer to residents by their actual initials. We will transmit separately a schedule that will enable the facility to identify these individuals.

prescribed this medication, although most individuals with seizure disorders today are treated with other, less potentially harmful medications. The facility's consulting pharmacist offered no justification for the high Phenobarbital use, other than that these patients were all on Phenobarbital when she began consulting to the facility. Certainly, we saw no evidence that attempts had been made to switch residents to less harmful alternatives.

e. Poor Physician-Pharmacist Consultation

A contributing factor to the facility's medical management difficulties is the lack of effective consultation between the facility's consulting pharmacist and the physicians who treat its residents. Although the pharmacist reportedly reviews each patient chart once a month and makes medication recommendations in the chart, she stated that she rarely meets or communicates directly with the medical director or physicians. Further, she told us that her recommendations were often ignored. Our own chart review indicated that, at least in the case of N.C., the treating physician either did not see or chose to ignore each of the pharmacist's monthly medication recommendations that we reviewed.

f. Lack of Adequate Medication Policies and Guidelines

In addition to policies and procedures regarding the monitoring of medication blood levels, referred to above, Nim Henson lacks adequate policies and guidelines regarding use of polypharmacy, reduction or replacement of older, more harmful medications, and reduction or elimination of unnecessary medications.

g. Inadequate Consideration of Etiologies

In the absence of clinical direction from the medical director or facility policies and procedures, the physicians have focused on treating symptoms identified by facility staff, rather than diagnosing and treating the underlying sickness or disorder. This is especially apparent in the excessive number of residents receiving valium, and other sedatives not recommended for the elderly, because of problems with "agitation."

2. Medical Notes and Documentation

Nim Henson's medical documentation is unreliable. The facility lacks records through which it can accurately track wounds for residents on its intermediate care unit, and there typically is little documentation supporting the use of psychotropic and other medications. Physician's notes often are seriously deficient.

A comparison of resident "condition change" reports, documented by nurses in their notes, with physician entries for the same time period indicates that physician assessments are often incomplete or inaccurate. For instance, during the period in which nurses filed three "condition change" notifications regarding developments in I.N.'s medical status, the treating physician entered four sets of notes (on December 12, 2001, February 10, 2002, April 10, 2002,

and June 10, 2002). Apart from a date change, the physician's assessments of I.N.'s condition were word-for-word identical, and nowhere in them did the physician address the medical changes that prompted the nurses to prepare the three condition change reports. In our chart review, we found numerous examples in which physician notes were identical, or nearly identical, over extended periods. For instance, the May 31, 2002 and June 12, 2002 physician notes in K.I.'s chart were identical, the monthly physician notes in H.M.'s chart for a six-month period were basically the same, and the notes in P.I.'s chart for December 1, 2001, February 2, 2002, April 2, 2002, and June 2, 2002 were exactly the same.

Further, a physician acknowledged to us at the facility that he assesses patients without recording notes on their condition. Although the physicians' notes should provide a reliable guide as to residents' condition and symptoms, and should provide a reliable basis for diagnoses and corresponding treatments, physician notes at Nim Henson do not. Without reliable documentation, it is impossible, over time, to track changes in medical status, assess the accuracy of diagnoses, and evaluate the efficacy of treatments. Nim Henson's medical documentation deficiencies constitute a substantial departure from generally accepted standards of care that expose Nim Henson residents to actual harm or significant risk of harm. These deficiencies are particularly troubling in light of the fact that the facility exercises no oversight, either by peers or the medical director, of physician care.

3. Oversight and Management of Medical Care

Generally accepted standards of care dictate that nursing home residents receive accurate and timely assessments, proper diagnoses of the etiology of the assessed conditions, treatment based on the diagnoses, monitoring of the individual's condition and the treatments' efficacy, and, as appropriate, revised diagnoses and treatment. Without such elements of care, nursing home residents are at risk of inadequate medical care. As discussed above, each of these elements of care at Nim Henson has significant shortcomings, a fact that indicates that a functioning, competent medical director is not in place at Nim Henson.

The current Nim Henson medical director has retired from the active practice of medicine and is available to the facility for one half-day a week. In interviews, he indicated that he had taken the position of medical director reluctantly and that he had no particular expertise in geriatric medicine, or in the supervision and management of physicians. He acknowledged that his current contractual arrangement with the facility keeps his involvement there extremely limited and that he has essentially no leadership or quality assurance role. Instead, his duties, as he described them, were "reactive" and were limited to assisting in locating physicians for Nim Henson residents who lacked them. He acknowledged that there is little, if any, interdisciplinary involvement in the treatment of Nim Henson's residents and that the physicians work independently of one another. In fact, he stated that unless someone brings a problem to his attention, he does not know whether the facility's medical care is sufficient.

Nim Henson effectively has no functioning medical director. Its medical services are devoid of supervision and quality assurance checks. The primary care physicians, none of whom

have had formal training or prior experience in geriatric medicine, do not receive adequate guidance. These deficiencies heavily contribute to the significant problems in medical care at this facility that expose its residents to actual and potential harm.

B. Chemical Restraints

Facility staff expressly stated to us that it was often necessary to keep residents sedated to avoid potential staff injuries. One nurse we questioned about the appropriateness of a medicine that is identified by a nationally recognized standard, the so-called "Beer's List," as inadvisable for use in the elderly, replied that the drug was nevertheless warranted for one elderly resident, because without it, "he would come alive." During our visit, we saw numerous residents who appeared to be heavily sedated. Medicating residents for reasons not associated with a medical condition is a violation of federal regulations and does not comport with generally accepted standards of care. This practice constitutes impermissible chemical restraint, and it is harming many Nim Henson residents. Staff concerns for safety are certainly appropriate, but there are viable alternatives to overly sedating residents with medications that are dangerous to the elderly.

C. Wound Care

Wounds in nursing homes are common and include skin tears, pressure ulcers, surgical wounds, and wounds related to vascular disease. Pressure sores are an important and universally accepted indicator of the quality of skin care. The facility's wound care policy appeared to be adequate. Further, from our review, it appeared that wound care on the facility's skilled nursing unit was generally adequate, although this was not true for the facility's intermediate care wing.

On the skilled nursing unit, treatments that we observed were performed using accepted infection control techniques, respecting resident dignity, and utilizing currently accepted wound care practices. Pressure relief surfaces appeared to be appropriate, and wound tracking sheets were utilized to document weekly size and appearance of wounds. Although the care of pressure ulcers on this unit seemed to be good, it appeared that inadequate care was provided to one resident, whose recent surgical wound bore obvious signs of infection.

On the intermediate care unit, we randomly selected for review two residents who were identified by the facility as having Stage I pressure ulcers, which are characterized by a persistent area of nonblanchable skin redness. We found that each resident actually had Stage II ulcers, which involve a partial loss of skin layer that presents clinically as an abrasion, blister, or shallow crater. Even after we notified staff of the further deterioration of these residents' skin, the medical chart for one them was not updated to indicate that he had experienced any skin breakdown.

These residents' continued skin breakdown appeared to be caused, at least in part, by the facility's failure to provide them with any preventative devices, such as anti-pressure mattress overlays, or to position them properly. In fact, eight hours after we first notified the facility of

these residents' Stage II ulcers, neither of the residents had received anti-pressure relieving supports. One resident appeared to have been left lying in the same position in which we found him, with his weight still bearing on his wound. Further, although the responsible nursing staff then on duty should have been monitoring both of these residents carefully, that staff clearly did not even know that either resident had developed any skin breakdown.

When we asked why one resident had not been repositioned after we had alerted staff to his condition, we were told that he does not stay in position and "rolls back over." It later became apparent that at least four residents on this unit who were considered to be high-risk for skin breakdowns were not repositioned in accordance with the facility's own policy or generally accepted standards of care, and a family member of a resident told us that he had developed a bed sore, which the family first discovered, because he was not properly repositioned.

The intermediate care unit lacked wound tracking sheets or any other system through which it could identify, assess and monitor wounds. Further, it appeared from interviews of nurses on this unit that, generally speaking, they could not identify residents who had wounds, residents who were at risk of wound development, and residents who required frequent monitoring for repositioning.

D. Nutritional Care

1. Weight Loss/Gain

Particularly in the elderly, significant changes in weight are often an indication of, and contributor to, significant changes in general health. Adequate weight monitoring is an essential component of nursing home health care. Generally speaking, Nim Henson is properly monitoring and developing appropriate nutritional interventions for its residents.

Commendably and importantly, it appeared from our review that residents were weighed and reweighed appropriately. Also, the dietician was notified promptly of weight loss/gain and recommended appropriate nutritional interventions. Further, it appeared that residents were being served the proper diet, with thickened liquids and "self-help" feeding devices, as appropriate. The facility's "Red Napkin" program was useful in assisting staff in identifying residents targeted due to recent weight loss.

However, issues involving tube-fed residents, discussed below, suggest that there are some problems in the area of nutrition. The facility also is not systemically tracking, through food intake records, residents who have sustained weight loss. It also did not consistently notify physicians or responsible parties of significant changes in weight. Further, the facility did not reliably update care plans to describe the interventions for the weight loss or gain.

Most fundamentally, in the 15 charts that we reviewed of residents who had experienced significant weight loss during the month of our tour, there was no evidence to suggest any physician involvement in determining the cause of the weight loss, such as presence of infection,

psychotropic or other medications, or psychosocial factors. This absence of physician input unacceptably places residents at significant risk of harm, as it leaves potentially unaddressed the root causes for the change in weight.

2. Use of Gastrostomy Feeding Tubes

The decision to insert a feeding tube into a resident should involve the resident, family, physician, nutritionist, nurse, and speech therapist. Investigation of a resident's condition should include the extent and cause of the swallowing disorder, the potential for improvement through strengthening exercises of the torso, and the need for special diets. Medications warrant particular consideration, because medications such as psychotropics can cause or exacerbate swallowing problems. General psychosocial factors must also be reviewed, as the person's mood and sense of wellbeing will inevitably contribute to a willingness and ability to eat.

An overuse of feeding tubes is an indication that a facility is failing adequately to handle residents' weight loss, decline in physical function, and slowness in eating. Tube feeding tends to be the easiest and most convenient manner by which to deal with these issues. Thus, when a nursing home has a comparatively high rate of feeding tube use and lacks clinical justification for that high rate, the implication arises that decisions are being made for the convenience of staff rather than in the interests of the residents.

Nim Henson fails to provide adequate assessments of and interventions for residents experiencing swallowing difficulties. A significant number of residents are placed on feeding tubes without clinical justification, under questionable circumstances. Sixteen percent of Nim Henson's residents have gastronomy tubes. As the facility's speech therapist acknowledged to us, this is an unusually high figure. Although the characteristics of a particular nursing home's residents may justify a high percentage of feeding tube use, such justification was not apparent at Nim Henson.

Our interviews with staff revealed minimal direct communication between the physicians, on one hand, and the speech therapist, dietician and nurse, on the other, regarding decisions around tube feeding. To the contrary, these interviews made clear that the physicians decide to insert gastrostomy feeding tubes into Nim Henson residents without receiving the input of other relevant disciplines. Our chart review of selected tube-fed residents also did not reveal an adequate interdisciplinary investigation of poor oral intake. Finally, it was clear from our consultants' face-to-face examinations of selected tube-fed residents that the use of the gastrostomy tube was, at best, sometimes highly questionable.

K.I. provides a telling example. Her medical chart contains a June 7, 2002 note by the speech therapist that the resident "swallows okay," and numerous physicians' notes over the seven months immediately preceding our visit contain similar assessments. Remarkably, when we met with K.I., she offered us candy bars and proceeded to eat one, herself –- with no difficulty. Obviously, K.I.'s physician was not actively engaged in determining this resident's nutritional needs, and her use of a feeding tube was unjustified.

E. Restorative Care

1. Physical Environment

During our tour, staff appeared to be kind, respectful and friendly, and they answered call buttons promptly. The facility was generally neat and clean. Residents were out of bed and involved in activities. Most residents were dressed and wearing shoes. These observations reflect positive staff-patient interactions and good restorative care, although they are tempered somewhat by comments that we received from family members of various residents to the effect that the facility had "really cleaned up its act" in anticipation of our visit.

2. Active Treatment

Federal regulations recognize the critical importance that activities and mental stimulation play in maintaining good health among nursing home residents. See, e.g., 42 C.F.R. 483.15(f)("facility must provide for an ongoing program of activities designed to meet . . . the interests and the physical, mental, and psychosocial well-being of each resident"). The activities that we observed did not meet resident needs. In the same vein, we understand that the facility intentionally congregates residents of varying cognitive abilities to stimulate lower-functioning residents. This essentially passive practice, which is not used in conjunction with active interventions, does little to help the more cognitively impaired and, rather than motivate higher-functioning residents, is likely to foster despair and depression. Group activities can meet important rehabilitative goals, but only if those activities are reasonably targeted to the participants' abilities and needs. Nim Henson's group activities are not.

Also, more than half of Nim Henson's residents eat their meals in their rooms. Providing in-room dining occupies a significant portion of the nursing staff's workload and keeps staff from care-related activities. This practice also limits social opportunities for residents and ignores a major opportunity to provide rehabilitation in the practical, meaningful context of coming to the dining room and eating with others.

The facility lacks adequate functional furniture, such as dining room chairs and recliners, thus relegating many residents to their wheelchairs. This shortcoming predisposes residents to functional decline, falls, poor posture, contractures, and skin breakdown.

3. Care Planning

Our review of 15 patient charts indicated that the plan of care for each resident accurately reflected the results of the facility's assessment of that resident. Further, each care plan that we reviewed addressed the residents' needs, strengths and preferences, as identified in the resident's assessment. However, one out of every three care plans that we reviewed failed to provide restorative interventions addressing preventable declines in the resident's functioning, predisposing residents to loss of function, contractures, worsening incontinence and/or behavioral difficulties. That is, in a high number of reviewed care plans, Nim Henson did not

provide appropriate supports and services to address preventable declines in its residents' condition, predisposing them to harm. Further, the facility's use of chemical restraints appeared to increase with residents' loss of function, and the reviewed charts indicated that, in such instances, social work and related disciplines did not develop individualized alternatives to the chemical restraints.

4. Interventions Regarding Change of Status

The certified nursing aids ("CNAs")with whom we spoke demonstrated an understanding of the residents' direct care needs and restorative care. They also demonstrated that they knew the residents' preferences and routines. The nurses we spoke with demonstrated an understanding of general resident information and needs.

However, particularly on the intermediate care unit, it was evident that staff often did not identify and respond to significant changes in residents' health status. As indicated above, nurses we spoke with there were not able to properly assess skin breakdowns. They often were unable to identify where pertinent data were located or which residents were presenting clinically significant problems.

One of the nurses we spoke with was unaware that a resident for whom she had responsibility appeared to be excessively sedated, and she did not appear to recognize that his sedated condition constituted a change of status that she should bring to the attention of the resident's physician.

Nurses were slow to detect, and then act on, a resident who had recently returned from the hospital and appeared to be excessively lethargic and impaired. The resident's oral intake of food and liquids also appeared low. After our team identified this resident to nursing staff, we were notified that she had been transferred to a hospital emergency room with a diagnosis of probable CVA (stroke) and dehydration.

Particularly on the intermediate care unit, nursing staff does not have a systematized approach to resident assessment and the provision of early intervention regarding significant changes in resident status. The process by which nurses communicate changes in resident clinical status is weak. Nurses do not clearly understand their role in assessing for and reporting clinical changes to the physicians, especially regarding medication side effects, functional decline, new onset incontinence, and behavioral exacerbations.

F. Psychiatric Care

Nim Henson's residents have a right to adequate health care, including appropriate psychiatric supports and services. See Youngberg, 457 U.S. at 324; 42 C.F.R. § 1396. Many of Nim Henson's residents suffer from dementia, depression, or other psychiatric disorders, yet the facility provides essentially no effective psychiatric treatment for them. These residents either are untreated or treated incorrectly, leaving their distress unchecked and sometimes worsened.

During our tour, we reviewed 14 residents chosen randomly from a list of residents having multiple psychiatric diagnoses and/or receiving multiple psychotropic medications. From our chart review and interviews of these residents, at least three displayed an immediate, unmet need for aggressive psychiatric interventions, including possible hospitalization; the primary intervention for acute psychiatric or behavioral episodes for another two was sedation; another appeared to be excessively sedated when we spoke with her; another displayed a significant, but unaddressed, tremor and other side effects of psychotropic medications; and another was receiving sub-therapeutic doses of an antidepressant. Thus, at least half of the residents sampled were receiving psychiatric care that substantially departed from generally accepted standards.

As with the facility's medication management practices generally, its management of psychotropic medications is poor. Further, no psychiatric and no behavioral professional is available to the facility; physicians and nurses at the facility have no training in geriatric psychiatry generally, or in treating individuals experiencing dementia or depression; and residents who badly need acute psychiatric care are rarely transferred to psychiatric hospitals. Also, as noted above, physicians at the facility tend to prescribe medications for presenting symptoms rather than to address the underlying cause. Thus, residents in acute distress are sedated, in violation of federal regulations and generally accepted standards of care, instead of receiving appropriate psychiatric or behavioral supports to address the cause of the distress.

G. Incident Management and Quality Assurance

1. Incident Management

Nim Henson's management meets monthly to review all incidents. Further, falls are tracked according to time and location through an analysis of incident reports and post-fall assessments. The reports often identify interventions, which appear to be immediately implemented. The interventions, however, are inadequate.

The most frequent intervention, even with residents who are cognitively impaired, is to "remind to use the call bell." The inadequacies of this approach are self-evident and underscore that the primary deficiency of the facility's falls management practices is its failure to anticipate and limit foreseeable incidents.

In this regard, the facility does not perform individualized assessments to develop treatment plans to prevent the reoccurrence of falls and similar incidents. Further, as indicated above, it does not provide a comprehensive restorative program to maximize resident function and thereby decrease risk of falls and injury. It also does not conduct quality control environmental rounds to identify and correct potential threats to resident safety. Most fundamentally, Nim Henson does not pull relevant disciplines together to identify and provide needed supports and services to prevent falls and injuries. Consequently, post-fall assessments do not address root causes of falls, such as incontinence, medications, medical problems, functional decline, seating and/or presence of illness. Accordingly, interventions are not

adequate.

For instance, a major intervention for bed falls at Nim Henson is the use of fully elevated side rails ("full side rails"). One night when we toured the facility, 62 out of 104 residents were in beds with full side rails in place. Nursing home residents are prone to becoming entangled in the full side rails and injured, and residents often attempt to climb over the rails to exit the bed, falling in the process to the floor. Many of the residents whom we observed with full side rails were cognitively impaired, which increases their susceptibility to injury.

Full side rail use, as a fall intervention, is a substantial departure from generally accepted standards of care and exposes residents to risk of harm. Further, full side rails are restraints and should be planned for as such. See 42 C.F.R. § 483.13(a). Failure to do so violates federal regulations, which require that all restraints be addressed in the individual's plan of care, along with identified alternatives to the restraint, and that restorative care be provided to eliminate the need for the restraint.

Nim Henson's primary intervention (used greater than 80 percent of the time) for falls from chairs is chair alarms. Because of their extensive use, alarms sound so frequently at the facility that staff tend to ignore them, rendering them ineffective.

2. Quality Assurance

It is standard practice in facilities like Nim Henson to have a quality assurance program that: (1) actively collects data relating to the quality of services, (2) assesses these data for trends, (3) initiates inquiries regarding problematic trends and possible deficiencies, (4) identifies corrective action, and (5) monitors to ensure that appropriate remedies are achieved. It is apparent from its difficulties in most of the foregoing areas, especially medication management, that Nim Henson lacks an effective quality assurance system that can track significant trends and events and ensure that proper corrective action occurs. This systemic weakness leaves its residents vulnerable to risk of harm.

H. Most Integrated Setting

Nim Henson's treatment professionals do not assess residents to determine whether their continued stay at the facility, rather than in more integrated settings, is appropriate. This is contrary to Title II of the Americans with Disabilities Act of 1990. See 42 C.F.R. § 35.139(j)(public entities must provide services in the most integrated setting appropriate to the needs of the individual); Olmstead v. L.C., 527 U.S. 581, 602 (1999) (public entity is required to provide community-based treatment when the entity's treatment professionals have determined that community placement is appropriate, the affected person does not oppose such treatment, and the placement can be reasonably accomodated). In failing to have its treatment professionals periodically assess whether community-based treatment is appropriate, Nim Henson improperly constrains the possibility of any its residents being served in a more integrated setting.

II. Minimum Remedial Measures

In order to remedy these deficiencies and to protect the constitutional and federal statutory rights of Nim Henson residents, Nim Henson should implement promptly, at a minium, the following measures.

A. General Medical Care

Nim Henson residents should be promptly assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed and treated, consistent with current standards of care, including with documentation adequate to withstand clinical scrutiny.

1. Medication Management

Every Nim Henson resident should receive prescription medications only after first having been thoroughly evaluated/worked up and diagnosed according to generally accepted standards of care, including with sufficient documentation to withstand clinical scrutiny, and each medication similarly should be clinically justified as an appropriate treatment for the diagnosed medical condition for which it is prescribed. More particularly, Nim Henson should:

a. develop and implement adequate policies and protocols regarding:

(i) blood level monitoring for medications such as anticonvulsants, lithium and digitalis;
(ii) medication side effect monitoring;
(iii) use and monitoring of medications that are problematic for the elderly, such as benzodiazepines and anticholinergic medications;
(iv) long-term use of medications for conditions when the relevant symptoms are unchanged over long periods of time; and
(v) use of as-needed (i.e., "PRN") sedatives and analgesics.

b. undertake a thorough evaluation/workup of all current residents and determine whether there is a clinically justifiable, current diagnosis for each medication that each individual receives.

c. ensure that all remaining medications are prescribed at optimum therapeutic levels and that all polypharmacy is clinically justified.

d. monitor all medications for efficacy, side effects and continued appropriateness; and modify medication usage as monitoring warrants.

e. conduct chart reviews to ensure that, on an ongoing basis, all medications are clinically justified and are prescribed consistent with applicable facility policies and protocols.

f. ensure that its Pharmacy and Therapeutics Committee ("P&T Committee"), with input from its medical director, pharmacist, pharmacy consultant, and administration, promptly provides guidance to its physicians regarding the use of polypharmacy and the use of medications contraindicated in the elderly.

g. ensure that, either through the P&T Committee or otherwise, the pharmacist, pharmacy consultant, and physicians communicate directly and regularly regarding the appropriateness of medications used, alone or in combination, on facility residents, and regarding developments in medications.

2. Medical Notes and Documentation

Medical notes and documentation should be accurate, current, complete and organized in a manner allowing relevant information to be quickly identified.

3. Oversight and Management of Medical Care

Nim Henson should retain a well-qualified medical director who would be responsible for maintaining a consistent level of adequate medical care throughout the facility. More particularly, Nim Henson should ensure that the medical director will:

a. dedicate sufficient time to the facility to provide adequate oversight and management of medical care at the facility.

b. establish a medical quality assurance program that:

(i) actively collects data relating to the quality of medical services;
(ii) assesses these data for trends;
(iii) initiates inquiries regarding problematic trends and possible deficiencies;
(iv) identifies corrective action; and
(v) monitors to ensure that appropriate remedies are achieved.

c. establish a system to track errors in the administration of medicine.

d. establish uniform medical care policies and protocols, particularly

regarding medication usage, nutrition and wound care, to ensure the consistent provision of medical care.

e. take an active role in chart review and quality assurance in medical documentation.

f. ensure the provision of appropriate specialized medical services, such as psychiatric, neurologic, dental, opthalmologic, podiatric and dental care.

g. take an active role in staff education regarding critical issues such as psychiatric symptoms, medication side effects, nutrition, infection control, and wound care.

B. Chemical Restraints

Any device, procedure or medication that restricts, limits or directs a person's freedom of movement (including, but not limited to, powerful sedatives) ("Restrictive Controls") should be used only when less restrictive measures have been unsuccessfully attempted and not as a substitute for treatment of the underlying causes of the condition provoking the Restrictive Controls. More specifically, Nim Henson should:

1. comply with 42 C.F.R. § 483.13 and other federal regulations that prohibit the use of physical or chemical restraints not required to treat a resident's medical condition.

2. provide meaningful activities, restorative care and psychosocial supports to minimize the occurrence of disruptive or dangerous behavior.

3. eliminate use of all Restrictive Controls except:

a. when treatment strategies have been considered and attempted and would not protect the person or others from harm;

b. other less intrusive or restricted methods have been ineffective; and

c. as a temporary, planned intervention in a plan of care, in which the underlying cause of the condition leading to Restrictive Controls has been clinically determined, or on an emergency basis, when an unexpected crisis situation occurs in which a person poses an immediate risk of harm to self or others.

4. develop and implement a policy on Restrictive Controls that comports

with federal regulations and generally accepted standards of care.

C. Wound Care

Nim Henson should ensure that wounds are promptly detected, closely monitored and properly treated, consistent with current standards of care, including with documentation adequate to withstand clinical scrutiny. More particularly, Nim Henson should:

1. establish a facility-wide system for wound tracking that would include:

   a. timely and accurate wound statistics;

   b. a master list, updated at least daily, of residents with wounds (including pressure ulcers, surgical wounds and skin tears), identifying preventative measures, sites, stages, and treatments; and

   c. quality assurance evaluations of wound treatments and outcomes, including incidences of facility-acquired wounds and stages, wound statistics, and staff compliance with facility wound care policies and protocols.

2. ensure that all staff responsible for resident care are competent in pressure ulcer prevention and staging.

3. ensure that nursing staff know the current wound status of each resident in their care, promptly communicate changes in wound status to the resident's physician and promptly document such changes.

4. establish a wound care formulary.

D. Nutrition

Nim Henson should ensure that, in addition to properly monitoring its residents' weight, it provide residents, especially those with swallowing difficulties, appropriate dietary and nutritional interventions. More particularly, Nim Henson should:

1. systemically track, through food intake records, residents who have sustained weight change.

2. consistently notify physicians and responsible parties of significant changes in weight.

3. ensure that, for residents experiencing significant weight change:

a. a comprehensive investigation of the extent and cause of the resident's condition is performed that includes consideration of potentially reversible or treatable factors, such as medications, environmental conditions, disease state, sensory loss, cognitive status and mood;

b. the potential for improvement be fully considered before a feeding tube is used;

c. ensure that staff responsible for resident care know the indications that justify the use of tube feeding;

d. ensure appropriate interdisciplinary participation in identifying interventions for the weight change, and particularly in the decision to insert a feeding tube into a resident, including participation from persons such as the resident, the resident's family, the physician, the nutritionist, the nurse, and the speech therapist;

e. ensure that the considerations leading to use of feeding tubes are fully documented in the resident's chart;

f. ensure that residents with a feeding tube are reviewed on an ongoing basis to determine whether the tube can be discontinued;

g. reliably update care plans to describe interventions for the weight change;

h. ensure that direct care staff are competent in implementing the weight change interventions identified in the care plan; and

i. monitor, and revise, as necessary, the weight change interventions.

E. Restorative Care

Nim Henson should assist its residents to "attain or maintain the highest practicable physical, mental and psychosocial well-being." 42 U.S.C. § 1395i-3(b)(4)(A). More particularly, it should:

1. develop and implement restorative care plan policies and procedures that are consistent with federal regulations, see, e.g., 42 C.F.R.§ 483.25, addressing change in resident condition.

2. develop and implement a plan for each resident to provide restorative care

based on the resident's assessed needs. At appropriate intervals, reassess each resident's need for: mobility, continence, and Activities of Daily Living ("ADL") support, activities that promote self care, seating supports, and meaningful activities. Update the plan based on this assessment.

3. provide furniture and seating supports adequate to permit residents to transfer out of wheelchairs and so-called Geri-chairs (chairs on rollers, with side-arm and other supports, intended for use by a geriatric population) to facilitate resident physical functionality.

4. ensure that nurses and Nim Henson staff responsible for resident care are competent in:

   a. identifying significant age-related changes;

   b. functional assessment and restorative care;

   c. basic elements of common pathology and physical assessment;

   d. medication effects and side effects; and

   e. facility policies and procedures regarding change of condition.

F. Psychiatric Care

As part of its obligation to provide its residents with adequate health care, Nim Henson should provide its residents with adequate psychiatric supports and services. See 42 U.S.C. § 1396r(b)(4)(A). Nim Henson residents should receive psychotropic medications only after having been thoroughly evaluated and diagnosed according to current standards of care, including with sufficient documentation to withstand clinical scrutiny. More particularly, Nim Henson should:

1. obtain sufficient psychiatric services, consultative or otherwise, to meet the ongoing psychiatric needs of Nim Henson's residents.

2. develop or procure standard psychological and psychiatric assessment and interview protocols for reliably reaching a psychiatric diagnosis for individuals who are elderly. Use these protocols to assess each person upon admission for possible psychiatric disorder(s).

3. ensure that all staff directly interacting with residents display at least a basic competence in providing appropriate supports for persons experiencing depression and/or dementia.

4. as to all residents receiving psychotropic medications, undertake a psychiatric consult to ensure that all such medications are appropriate and are specifically matched to current, clinically justifiable diagnoses.

5. obtain informed consent or proper legal authorization prior to administering psychotropic medications and other invasive treatments.

G. Incident Management and Quality Assurance

Incidents involving injury and unusual incidents should be reliably and accurately reported and investigated, with appropriate follow-up. More particularly, Nim Henson should:

1. address the root causes of falls and other injuries to minimize their occurrence, and provide appropriate, individualized interventions.

2. replace unwarranted use of full side rails with less harmful interventions for falls.

3. ensure that incidents involving injury and unusual incidents are tracked and analyzed to identify root causes.

4. ensure that analyses are transmitted to the relevant disciplines and direct-care areas for responsive action, and responses are monitored to ensure that appropriate steps are taken.

5. ensure that assessments are conducted to determine whether root causes have been addressed and, if not, ensure that appropriate feedback is provided to the responsible disciplines and direct-care areas.

H. Most Integrated Setting

Nim Henson should ensure that its treatment professionals periodically and reliably assess its residents to determine whether community placement is appropriate for any of them. If treatment in a more integrated setting is determined to be appropriate, then such treatment should be provided, if the affected person does not oppose such treatment, and the placement can be reasonably accommodated.

* * * *

We hope to work with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding Nim Henson.

We will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the

Department of Justice - their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of Nim Henson residents, 49 days after the receipt of this letter. 42 U.S.C. §§ 1997b (a)(1). Accordingly, we will contact County officials soon to discuss in more detail the measures that the County must take to address the deficiencies identified herein.

Sincerely,

/s/ Ralph F. Boyd

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Assistant Attorney General

cc: Brendon Miller, Esq.
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