U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

November 7, 2002

The Honorable Paul E. Patton
Governor of the Commonwealth of Kentucky
Office of the Governor
700 Capitol Avenue
Suite 100
Frankfort, KY 40601

Re: Investigation of the Oakwood Developmental Center

Dear Governor Patton:

On June 22, 2001, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, that we were investigating conditions of confinement at the Oakwood Developmental Center ("Oakwood"), a facility for individuals with developmental disabilities located in Somerset, Kentucky. On November 5-9, 2001, we conducted an on-site review of the care and treatment of individuals at Oakwood with experts in behavior management, and medical and nursing care. We reviewed numerous records and interviewed administrators, staff and residents. At an exit interview conducted on the last day of the tour, we verbally conveyed our preliminary findings to selected facility staff, counsel, and senior officials of the Kentucky Cabinet for Health Services. Consistent with the requirements of CRIPA, we are now writing to inform you of our findings.

At the outset, we wish to acknowledge and express our appreciation to the hardworking and committed staff of Oakwood and the Cabinet for Health Services officials for their assistance during our tour. At all times, Oakwood staff, Cabinet officials, and counsel were very cooperative and professional. We particularly recognize the commitment demonstrated by the Secretary of the Cabinet for Health Services, Marcia R. Morgan, who attended our exit conference, and the Commissioner of the Department of Mental Health and Mental Retardation Services, Margaret Pennington, who was present throughout our on-site review.

Oakwood opened in 1972 as a residential facility for persons with developmental disabilities. It consists of 27 buildings on 200 acres. The facility is licensed to serve 420 individuals and has an average daily census of 394. Oakwood consists of 18 separate residential buildings, therapeutic and habilitative service areas, a medical services building that includes an infirmary, and administrative and support buildings. Each of the 18 residential buildings consists of two wings with approximately 12 beds each that are separated by a shared kitchen and laundry area. As of the time of our visit, the population of Oakwood consisted of approximately 249 men and 143 women ranging in ages from 19 to 67 years with the majority of residents between the ages of 22 and 46. The majority of residents (332) are persons with severe or profound mental retardation; approximately 52 residents use a wheelchair for mobility, seating, and/or positioning; approximately 190 of the residents receive anti-epileptic medications; and 154 residents receive psychotropic medications.

Recently, Oakwood has initiated a plan to divide the institution into four separate facilities called communities. As this process was still being implemented during our tour, our letter evaluates Oakwood as a single facility.

Our findings, the facts supporting them, and the minimum remedial steps that we believe are necessary to correct constitutional deficiencies are set forth below. Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation, 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). The State also is obliged to provide services in the most integrated setting appropriate to individual residents' needs. Title II of the American with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. Zimring, 527 U.S. 581 (1999).

As a brief summary, we find that Oakwood fails to provide adequate: (1) protection of its residents from harm due to abuse, mistreatment, neglect, improper use of restraints, pica behavior, and an overall lack of environmental safety; (2) behavioral and psychology services, including adequate treatment team meetings, individual and behavioral support plans, and training programs; (3) psychiatric services; (4) medical care, including neurological

care; (5) nursing care; (6) staffing and staff training; (7) nutritional management; (8) physical therapy, and (9) quality assurance mechanisms designed to self-correct institutional problems.

I. PROTECTION FROM HARM

A. Abuse and Mistreatment

Oakwood fails to protect its residents from harm. There have been numerous and recurring incidents of abuse and mistreatment by staff members over the past several years. A serious example of abuse occurred on August 22, 2000, when an Oakwood staff member stomped on a resident's head and rendered the resident unconscious. An internal facility investigation uncovered three further instances of this staff member physically abusing residents at Oakwood. Kentucky's Office of the Inspector General, Division of Long Term Care found that ". . . the facility's failure to develop and implement policies/procedures that prohibited continued employment of individuals who had allegations of substantiated abuse/neglect against them and the facility's failure to develop/implement a system to evaluate client incident/accidents also presented imminent danger to the facility clients."[1] We concur in that assessment.[2]

In another example, a staff member was observed pushing, slapping, and cursing at a resident on a daily basis for approximately four months, from April to August, 2000. Oakwood's internal investigation revealed that there was a "code of silence" among facility direct care staff regarding reporting allegations of abuse/neglect on other facility employees. Staff were afraid to report client abuse because of retaliation by other employees. Further, Kentucky's Office of the Inspector General, Division of Long Term Care found that the facility failed to conduct a thorough investigation of the incidents after allegations of abuse relating to the same resident's hip fracture were identified.[3]

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[1] Complaint Intake Report, December 8, 2000.

[2] The Office of Attorney General for the Commonwealth of Kentucky has indicted three Oakwood staff members on felony charges of knowingly abusing or neglecting an adult for incidents of abuse occurring in the years 2000 and 2001.

[3] Complaint Intake Report, September 25, 2000.

In addition to several substantiated reports of abuse and neglect, a high number of reported incidents of harm have occurred that present serious threats to resident safety but were unsubstantiated because the perpetrators could not be adequately identified. For example, a resident was beaten with a coat hanger but investigators could not confirm allegations identifying certain staff members.

Finally, the sheer volume of incident reports of harm is unacceptably high, especially recurring incidents with specific individuals over long periods of time. For example, from July to September, 2001, one resident in unit 117B, had 30 reported incidents of harm, another resident in unit 112A had 20 reported incidents of harm, a third resident in unit 104B had 16 reported incidents of harm. During the above three month period, we noted 24 residents with an unacceptably high number of recurring incidents of harm. Ms. Myers (Director of Performance Improvement and Quality Assurance) and Mr. Greene (Director of Administrative Services) agreed that the number of incidents of harm at Oakwood is a major problem and that immediate remedial steps should be taken to reduce such incidents to a minimum.

B. Neglect and Lack of Environmental Safety

Oakwood also fails to protect its residents from harm due to neglect and an overall lack of environmental safety. A particularly egregious example occurred from July, 2000 through our tour in November, 2001. On July 29, 2000, a resident collapsed in a bathroom. Facility staff pried open the resident's clenched teeth and removed a large amount of fecal material from the resident's mouth, whereupon he began breathing again. The resident was admitted to the hospital with a diagnosis of fecal aspiration pneumonia.

Previously, on July 11, 2000, the resident's interdisciplinary team had met and agreed that due to the resident's history of pica behavior (ingesting inedible foreign objects) he was inappropriately placed in his current residence. The team, however, made no further recommendation for his placement. In his Individual Support Plan ("ISP"), the team recommended that the resident receive direct supervision while inside and outside the cottage, and one-on-one supervision while eating and/or bathing. Despite the team's recommendation for direct supervision, before the resident collapsed on July 29, 2000, staff were providing only indirect supervision for the resident while in the living unit. Staff in the living unit were apparently unaware of the treatment team's reassessment of the resident in its July 11, 2000 meeting.

Review of the records of pica incidents for the resident following the July 29, 2000 episode for the months of August and September, 2000, reveal at least 70 more attempted and/or actual incidents of pica behavior involving paper, trash, toilet paper, shoestrings, a washcloth, an ink pen, a sock, and fecal material. The logs noted that on September 25, 2000, the resident was again found with fecal material in his mouth. On October 6, 2000, the Centers for Medicare and Medicaid Services ("CMS") issued a citation of immediate jeopardy with regard to the resident, citing Oakwood for inadequate supervision and failure of the interdisciplinary team to adequately reassess the resident's active treatment program. On November 17, 2000, Oakwood submitted a Plan of Correction ("POC") to address the concerns of CMS. In its POC, Oakwood stated that it would develop a special living unit for residents with pica behavior and transfer the resident into the new unit. In the interim, all current living unit staff were individually trained in the resident's active treatment plan and the resident was placed on one-on-one supervision in his current living unit.

In April, 2001, the resident was placed in a special needs living unit designed for pica behavior. The resident's Individual Support Plan (ISP), dated July 18, 2001, stated that placing the resident in a special needs cottage would decrease the resident's incidents of pica due to environmental factors and supervision. However, while in the special needs unit from June through September 2001, the resident engaged in six episodes of significant pica behavior. On August 16, 2001, as the resident continued to engage in pica behavior, staff supervision was actually decreased to indirect supervision inside and outside the cottage.

On November 5, 2001, the week of our visit, the resident was admitted to the hospital with a possible bowel obstruction. Two days later, on November 7, 2001, five plastic gloves were removed from the resident's stomach.[4] Prior to surgery, staff were completely unaware of these pica incidents. Staff, however, admitted to observing on several occasions used gloves were left throughout the special needs living unit, including the resident's

[4] On November 13-16, 2001, CMS conducted an abbreviated standard survey and as a result issued an another immediate jeopardy concerning the same resident for the same issues as outlined in the immediate jeopardy letter of October 6, 2000. CMS found that Oakwood did not adequately supervise clients to protect them from physical harm or report incidents of harm, neglect, or abuse.

room. Staff failed to report several of the incidents of improper glove disposal to supervisors and those reported to supervisors remained unreported to the administration. Thus, effective environmental controls critical to operation of the special needs unit remained unenforced. Furthermore, as discussed later in this letter, no quality assurance mechanism exists to monitor the special needs unit to ensure that proper environmental controls are consistently implemented.

Staff neglect and unsafe conditions in the living units appear to be widespread across the facility. Incident reports are replete with instances of harm such as resident aggression, property destruction, self-injury and other behavioral problems. We reviewed numerous incidents of residents being chemically restrained due to aggression toward staff instead of being provided appropriate behavioral programming, along with cases of residents being victimized by other residents.

Pica continues to be a serious problem at the facility. We noted several incidents of residents eating fecal material. For example, on September 2, 2001, one resident picked up and placed in her mouth the bowel movement that another resident had dropped on the floor. There are also numerous documented instances of residents eating cigarette butts outside their homes. This problem has been identified to Oakwood by CMS and its own consultants. Still, during our visit we found numerous cigarette butts lying just outside the doors of many of the homes.

II. BEHAVIORAL SERVICES

An adequately functioning system of care and treatment for persons with developmental disabilities should have timely interdisciplinary treatment team meetings designed to create an overall plan of care for each resident in a facility, often referred to as an Individual Support Plan or ISP. The ISP should be based on adequate professional assessments of the individual and have objective, measurable outcomes that are reviewed and reassessed periodically. Residents with behavioral issues should also have a professionally generated behavior management plan, often called a Behavior Support Plan ("BSP"), that is integrated into the resident's overall ISP. A facility should have sufficient professional staff to assess residents, formulate BSPs, attend treatment team meetings, train and monitor direct care staff in implementing the BSPs, take and assess data, and periodically modify the BSPs based on the collected data. We found Oakwood deficient in all major systemic categories related to behavioral services, including treatment team meetings, Individual Support Plans, Behavior Support Plans, and professional psychology services.

A. Treatment Team Meetings

The treatment team meetings, designed to formulate, discuss and update resident ISPs and BSPs, are inadequate. Treatment teams are disorganized, often lack key professional personnel, and fail to identify and/or discuss progress toward concrete, identifiable goals. The training and clinical objectives discussed at the meetings are vague and demonstrate a mindset that residents are at Oakwood, not for short term skills development and ultimate discharge, but for long term care and maintenance.

B. Individual Support Plans

The ISPs of Oakwood residents are insufficient. The ISPs fail to outline the overall vision for the residents while at Oakwood, discuss and integrate resident strengths and weaknesses, or formulate specific goals with defined training objectives to achieve such goals. In general, the ISPs at Oakwood are generic, repetitive across residents, and infrequently updated.

C. Behavior Support Plans

Oakwood fails to provide adequate behavior management for its residents, even though many of them have a history of high-risk behavioral problems. Almost half of the Oakwood residents that need a behavioral plan have none. Of the plans that exist, most are ineffective. The majority of the resident records examined showed individuals admitted for short-term skills training but not receiving any short term training or skills development and, instead, remaining at Oakwood for an extensive period of time while developing severe behavioral problems. For example, according to one resident's chart, he was admitted for "refinement of self-help skills, personal hygiene skills, and to develop appropriate leisure-time activities, communication skills, and socialization skills." While at Oakwood, this resident deteriorated into multiple behavioral problems including aggression and pica behavior. His BSP and ISP, however, still indicate the same training goals as they did more than twenty years ago. This resident's case is not an isolated example.

1. Restraint Use

As resident behavior has become increasingly difficult to manage due to lack of adequate behavior management, Oakwood staff have resorted to increased use of physical and chemical restraints even though all of the Oakwood psychologists interviewed stated that restraints and other aversive or restrictive procedures such as helmets and mittens are unnecessary and unwarranted. The continued use of restraints and aversive procedures to control

behavioral problems for the convenience of staff and in place of effective active treatment constitutes active harm to the residents of Oakwood.

2. Training Programs

Oakwood fails to provide adequate training programs for its residents. A large number of residents do not have day programs and remain idle most of the day engaging in self-stimulation and other problematic behaviors. For example, one resident we observed engages in self-injury and aggression and has a program for these behaviors. However, the behavior program contains no out-of-home component in his daily routine. He remains in the unit without any meaningful activities all day. The residents who do have day programs often engage in meaningless activities designed only to keep them busy. Contributing to the problem of inadequate day programs and recreational activities for the residents is the lack of adequate transportation and an efficient system for accessing the limited transportation options that do exist.

3. Pica Behavior

As discussed earlier, Oakwood fails to provide adequate behavior plans and training programs for its residents with pica behavior. Oakwood has yet to provide any systematic intervention or training to address this problem.

D. Psychology Services

The current psychology staff are unable to provide adequate behavior and psychology services to Oakwood residents given their case loads and other administrative responsibilities. Oakwood has two clinically trained psychologists, one with a caseload of 84 residents and the other with a caseload of 68 residents, which is simply too high to provide adequate services given the behavioral needs of the residents. While the full time psychology staff is overextended, Oakwood underutilizes its part-time clinical psychologist who works four hours per week, has experience in neuropsychology, but has no patient-care duties. Oakwood's four behavioral analysts also have caseloads that do not permit adequate evaluation and treatment of Oakwood residents.

Given the extensive caseloads, psychology staff is unable to adequately train or monitor the direct care staff in implementing the behavior programs they develop. Many of the direct care staff we interviewed were unfamiliar with the residents or their programs. Other staff who knew the residents did not know the resident's behavior plan and were unable to communicate what to do

if a resident exhibited a behavior covered by his or her plan. In addition to direct care staff being unfamiliar with behavior plans, supervisors were also unfamiliar with the plans. For example, we observed one resident hitting his head, which was very red and swollen. A direct care staff merely stated "R. don't hit your head" as she walked past him; six other direct care staff failed to intervene. He continued hitting himself. Finally, a staff member from the psychology department took the resident outside and then brought him back inside. The resident continued to hit himself the whole time. He hit himself a total of 27 times without adequate intervention while we were observing the unit.

Compounding the lack of oversight and training by the psychology staff is the inadequate orientation and follow up training on behavioral interactions given to direct care staff. New staff are given only two hours of training on behavioral interactions with no evaluation made as to their competency to apply such skills on the living units. Consequently, many direct care staff demonstrate little behavioral skills when working with individuals with challenging behaviors. During the tour, we often observed staff providing negative reinforcement to individual residents with behavior problems instead of active treatment.

III. PSYCHIATRIC SERVICES

Psychiatric services at Oakwood fall substantially below accepted professional standards of care. A significant problem currently exists with the diagnoses of psychiatric disorders. More than 50 percent of the diagnoses are no longer correct. Many of the diagnoses upon admission were in error and have yet to be corrected or updated. Furthermore, a number of Oakwood residents are receiving psychotropic medications without any psychiatric diagnosis. This is unacceptable practice.

Currently, about 42 per cent of Oakwood residents are treated with psychotropic medications, an unusually high number for a facility such as Oakwood. Oakwood is using psychotropic medications to treat the behavioral problems of residents in place of adequate behavioral treatment plans. We noted a number of Oakwood residents on psychotropic medications without any behavior support plan. Many residents are on medication solely by default because other treatment methods for their severe challenging behaviors have not proven effective. It violates professional standards to use drugs in lieu of appropriate and effective behavioral treatment. In addition, many residents are on multiple psychotropic drugs without adequate clinical justification in their charts for such polypharmacy. Currently about 60 per cent of those on psychotropic medication are on such polypharmacy. The

Oakwood psychiatrists agreed that polypharmacy, especially the use of three or more drugs, is problematic both in terms of drug interactions and adverse effects on residents.

Oakwood lacks a peer-review system for psychiatric care (and for physician services in general), which is an essential component of an effectively functioning clinical services. Further, Oakwood lacks an adequately functioning Pharmacy and Therapeutics Committee, a critical function in monitoring and correcting important quality of care issues, especially in the important and currently deficient area of psychotropic medication use. The existing Pharmacy and Therapeutics Committee fails to adequately: (1) address psychopharmacology issues such as the prevalence and patterns of psychotropic drug prescriptions; (2) conduct peer review of drug prescription practices of individual physicians; (3) monitor use of specific medications for given indications; and (4) improve rational psychopharmacotherapy at the facility. Given the current inadequate state of psychopharmacology practice at Oakwood, the lack of the above Committee functions is a serious gap in psychiatric services.

A collateral problem is the lack of a functional system for assessing Tardive Dyskinesia ("TD") and other movement disorders,[5] or for system-wide monitoring of the side effects of psychotropic medications. An effective system for assessing TD is important because TD and other involuntary movement disorders often result from prescribed psychotropic medication, especially typical antipsychotics. However, Oakwood has no records on the prevalence of serious side effects from the use of psychotropic medications and no policy or procedure for assessing such involuntary movement disorders such as TD. An example of the problem of a lack of an adequate system for assessing serious side effects of psychotropic medications occurred in a treatment team meeting we attended. Partway through the meeting, various staff members commented on the resident's tendency to self-stimulate herself by rubbing her thumb and fingers together called pill-rolling. Staff suggested they ought to find something more functional for her to do with her fingers. However, the behavior of pill-rolling is a clear sign of Tardive Dyskinesia. TD, as the root of the problem, was not discussed until the end of the meeting when a new physician brought up TD as a possible explanation of the problem. No one,

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[5] Tardive dyskinesia is a syndrome which involves involuntary movements such as tongue thrusting or facial grimacing caused by side effects of certain drugs, including antipsychotic medications (Haldol) and other dopamine antagonists. The condition may be reversible if recognized in the earliest stages by stopping the offending drug.

including the nurses, direct care staff, and behavior analysts had considered TD before, though the resident had been at the facility for years and had apparently been evidencing the behavior for some time.

Finally, the psychiatric and psychology staff admitted that they have not been adequately trained in integrating behavioral and psychopharmacological treatments necessary to appropriately treat many of the Oakwood residents with psychiatric diagnoses.

IV. MEDICAL CARE

A. General Medical Care

Oakwood provides inadequate medical care, especially preventative care designed to keep serious medical problems and disease from developing. The lack of close monitoring and adequate preventive measures can cause harm to Oakwood residents. For example, a resident with a history of constipation was sent to the emergency room of a local hospital for evaluation of severe constipation and possible bowel obstruction. Even though she had been receiving multiple bowel medications, the date of her last bowel movement was not known. She was admitted to the hospital for chronic colonic inertia and a urinary tract infection. Within a few days of admission, she died due to sepsis; her autopsy revealed a markedly dilated bowel. In another example, one resident suffered nine fractures over the course of two years from 1998-2000 before Oakwood finally evaluated her for osteoporosis and began treatment for severe osteoporosis.

Bowel and bladder disorders have been identified as a recurrent medical issues in residents at Oakwood. In a review of the charts of residents who died while at Oakwood, all of the autopsy reports indicated dilated colons. Despite this pattern, Oakwood does not perform screening colonoscopies unless the resident presents symptoms of rectal bleeding or gastrointestinal symptoms. Regular use of screening colonoscopy comports with professional standards of care in evaluating colon complaints, including detecting and preventing cancer. Still, Oakwood fails to document bowel elimination in a resident's chart and has not developed protocols regarding the use of laxatives or enemas in the event that a patient does not have a bowel movement within a designated period of time. In one instance, a resident's primary care physician observed that the resident's seizure activity was closely connected to the resident's fecal impaction; nevertheless, no data existed in the resident's chart regarding bowel movements. A staff member told the doctor that any information that does exist on bowel movements was kept locked in the medication cart. Keeping data locked in the medication cart not only prevents easy

recording of this important information but is useless to a medical care provider reading the medical chart for information on bowel habits.

The medical care of Oakwood residents is further compromised by inadequate communication between medical professionals. When Oakwood residents are referred to the hospital emergency room and to private medical specialists, information concerning the resident is frequently incomplete and unreliable. It is not uncommon to find in a patient's chart consultant notes such as, "There is no lab work here for comparison," or "The caretaker with the patient has no information regarding his past medical history." Oakwood physicians do not always send a note to the consulting specialist as to their medical concerns, nor do they routinely discuss their concerns with the consultant. Often, a non-medical staff fills out the referral note to the consultant. The lack of direct physician to physician communication regarding Oakwood residents greatly compromises the adequacy of medical care provided at Oakwood.

Documentation in Oakwood's medical charts is incomplete and often illegible. The Medical Director is listed in each chart as the patient's physician even though he is not the primary care physician for any patient. Physician progress notes often do not provide periodic documentation of acute problems, diagnostic evaluations, or therapeutic interventions. Such documentation is critical for determining whether medical treatment is effective. Furthermore, the medical charts fail to contain an easily accessible active problem list or chronic problem list necessary to provide adequate diagnosis and treatment. For example, the physician of one resident could not determine from the chart whether the client had a previous surgery. Oakwood referred the resident to a gastroenterologist because of weight loss with a concern that she might be experiencing gall bladder disease. It was later learned that she had her gall bladder removed in the past, most likely while she was a resident of Oakwood.

A critical component of an adequate medical service delivery system is a properly functioning mortality review process. Although Oakwood has a mortality review committee, the committee's review process is inadequate. The goal of a mortality review committee is to understand the cause of death and make necessary changes in policies and practices to prevent future suffering and possible deaths. Oakwood's own mortality review policies and procedures reflect the above goal in stating that the purpose of a mortality review is to "identify preventive measures and opportunities for improvement at the provider and systems level." However, the mortality review committee does not implement its own mortality review policies and procedures. All of the mortality

reviews from January 2000 to November 2001 were incomplete and missing important information, even though these are required under Oakwood's internal policy. Conclusions or recommendations for improvement in care were generally lacking and, if they were present at all, did not result in any policy change or followup. With regard to one resident, the mortality review committee did not even know the cause of the resident's death at the time of the review.

Finally, current physician staff at Oakwood lack sufficient training in the field of developmental disabilities. Of the four new physicians hired, only one has had training or previous experience diagnosing and treating patients with developmental disabilities. Although in September, 2001, Oakwood completed its Medical Best Practices Guidelines, which outlines protocols for the treatment of common medical problems for person with developmental disabilities, at the time of our visit in November, 2001, none of the physicians were aware of the contents of these guidelines and some were not even aware that the guidelines existed.

B. Neurological Care

Oakwood fails to provide adequate evaluation, diagnosis, and treatment for residents with seizure disorders. Insufficient staffing, inadequate communication between physicians, and poor follow up treatment are significant contributing factors to the lack of adequate neurology services. Neurology consults are required to provide minimally adequate neurological care. Such consults are needed to evaluate the necessity of anticonvulsant medications as well as to decide when to taper these medications to minimize harmful side effects. Fifty percent of the nearly 400 residents at Oakwood have a diagnosis of seizure disorder. Until November 2001, however, Oakwood had only one consulting neurologist who provided neurology services for ten to fifteen residents per month. No policy exists to give guidance as to which residents take priority for evaluation. During the week of our visit, Oakwood added the part-time services of a second neurologist who held his first clinic during that week for nine residents. His ability to evaluate and treat Oakwood residents with seizure disorders was significantly compromised by the failure of Oakwood's primary care physicians to communicate adequately the reason for the referral to neurology and to answer questions about the patient. Not one primary care physician attended the Neurology Clinic when we observed the clinic. For many of the residents attending the clinic, Oakwood did not send a staff member who could describe the client's seizures or medical history. For example, one resident was referred for an evaluation of "spells." Staff, however, could not describe the spells to the

neurologist. The consultants' expertise was not fully utilized, both in evaluating the clients and in educating the professional staff at Oakwood.

The lack of adequate, timely evaluation, diagnosis, and treatment of residents' neurological needs causes many Oakwood residents to remain on powerful anticonvulsant medications with potentially severe side-effects and dangerous adverse reactions to other drugs. This is especially true in the case of older anticonvulsant medications (such as Phenobarbital and Dilantin), which many Oakwood residents continue to take. The use of older anticonvulsants is causing many adverse effects as observed in the neurology clinic we attended, including gum disease, gait problems resulting in a significant number of falls, and further cognitive dysfunction. Such harm could be avoided by closer monitoring by a qualified neurologist and adjustment of medications.

Furthermore, our record review revealed that 40 Oakwood residents continue to be treated for seizures, in many cases with more than one anti-convulsant drug, despite not having a single seizure for significant periods of time. For example, we examined one resident diagnosed with a seizure disorder whose last seizure was in 1976. Even though no one knew the resident's type of seizure disorder, and the information was not apparent from the resident's chart, the resident remained on Depakote three times daily. A neurologist did not evaluate him until September 17, 2001, when he was admitted to an acute care hospital due to unexplained unresponsiveness. The hospital conducted an EEG but the results of the test were not in his chart upon returning to Oakwood and no follow up with a neurologist had occurred. In another example, a resident was admitted to Oakwood in 1979 with a diagnosis of a seizure disorder. His last seizure was in 1992. He takes Dilantin and Phenobarbital, yet no record exists of him ever being evaluated by a neurologist. On August 5, 2001, a physician had written an order for an evaluation by a neurologist, but at the time of our visit no evaluation had occurred.

V. NURSING CARE

A. Nursing Assessments and Documentation

Nursing assessments and documentation, particularly those of acute illnesses and injuries, are incomplete, fragmented, inconsistent and simply repeat prior assessments. For example, when one resident complained of chest pains, the nurse only documented his vital signs, that his skin was "cool to the touch" and that he was able to talk with staff. A full nursing cardiac and respiratory assessment should have been conducted and documented, including evaluating the presence, strength and

regularity of pulses, breath sounds and breathing patterns. When another resident's blood pressure was measured at 158/110, the nurse made no mention in her note of this unusually high blood pressure reading, and did not conduct an appropriate physical assessment.

Nursing assessments are not adequately integrated into the ISPs. By Oakwood policy and under minimum professional standards of nursing care, a Health Care Plan ("HCP") is to be initiated upon admission. The HCP should also be integrated into a resident's ISP and periodically updated throughout the year to reflect changes in the goals and outcomes of nursing care for each resident. Not only are HCPs not properly integrated into the ISP process, many residents have no HCP at all. The lack of HCPs and HCP integration into the ISP process at Oakwood decreases continuity of care and results in inconsistencies of treatment that delay desired nursing outcomes. For the HCPs that do exist, the nursing goals and outcomes are updated only once per year. Of the 21 HCPs we reviewed, only three were reviewed or updated prior to the annual evaluation. Active treatment is an ongoing process and such infrequent evaluation of the nursing needs of the residents fails to properly reflect a resident's progress toward identified nursing goals and outcomes.

In addition, participation by the nurses in the interdisciplinary team ("IDT") meetings that give rise to the ISP is inadequate and their role is not clearly defined. The nurse, therefore, does not play an integral role in the overall care and desired treatment outcomes of the resident. Nurses are not proactive and do not advocate to benefit the resident at the team meetings. The nurse rarely provides information obtained from nursing assessments and does not share nursing diagnoses that the IDT needs to address and possibly incorporate into the ISP. Finally, the nurse does not participate in the IDT group discussions for ideas to solve residents' problems.

Inadequate documentation by Oakwood nurses also prevents timely and appropriate medical and nursing care. Flowsheets and logs are undated and show gaps in documentation. Nurses are inconsistent in their use of the DAP format (i.e., Diagnosis, Analysis and Plan) in noting resident conditions. Even where notes are placed in the DAP format, they are incomplete, fail to describe the health event, and prevent appropriate, adequate followup on identified problems. The seizure record in use at Oakwood is vague and requires too much subjective judgment. For example, the nurse is to indicate "light" or "heavy" seizure on the form, but there is no criteria on the form or in the nursing seizure protocol to define such terms. Nursing progress notes are disconnected and do not flow from shift to shift resulting in

failure to followup on identified problems. A nursing progress note should fully describe the problem, and each subsequent note should address the problem until resolution. Reviewed Oakwood charts fell below such standard of care. The inadequate nursing documentation is a function of the poor quality of the Oakwood medical charts in general. The entire chart is confusing, hard to follow, and in no logical order. Such poor medical records fail to promote prioritizing problems and developing appropriate treatment strategies to maximize desired outcomes.

B. Medication Administration

The nursing staff at Oakwood does not follow established standards and protocols regarding medication administration resulting in an unacceptably high number of medication errors and consequent harm to residents. We reviewed numerous incident reports that demonstrated that nurses often administer medication to the wrong resident. The number of pills found lying on the floors of the living units also indicates that the nurses are failing to ensure that residents are actually taking the medications. In a survey completed on October 12, 2001, CMS also noted these problems regarding medication errors. None of the nurses we interviewed were either aware of the CMS survey conclusions or of the problem of unidentified medications found on the living unit floors; the nurses stated that medication errors were rare at Oakwood. We observed nurses administering medications and several took no steps to ensure that the medications were swallowed.

Several factors contribute to the unacceptably high rate of medication errors at Oakwood. First, nurses are routinely assigned multiple housing units and made responsible for a number of residents exceeding the number that may be safely managed. Second, due to high nursing turnover rates and frequent staffing shortages, new nurses or nursing staff reassigned from other cottages are unfamiliar with resident identities. Third, nurses are insufficiently trained on safe medication administration practices and their ability to properly administer medications are inadequately evaluated. For example, with regard to administering psychotropic medications, Oakwood has no competency based assessments to evaluate nurses on the proper use of new analytical tools to measure possible symptoms of tardive dyskinesia, a harmful side-effect of psychotropic drug usage. Oakwood's use of videotapes to evaluate competency in medication administration does not effectively ensure that safe practice is occurring. Fourth, the medication error reporting system is ineffective and fails to promote safe nursing care. Oakwood has no formal system in place to track adequately medication error data and provide detailed analysis such as problem identification, plans for

improvements, implementing changes, and evaluating the effect of changes. Finally, poor communication at all levels of the nursing staff regarding medication error data and the serious problem of underreporting of medication errors at Oakwood further exacerbates the lack of an effective system to evaluate medication error data. There are no regular forums at Oakwood in which aggregate data on medication errors from within or across communities is shared with nursing staff. Such poor communication and underreporting of medication error data is a function of a reporting system that focuses on blaming and punishing nursing staff for medication errors while ignoring the deeper systemic nature of the problems surrounding medication administration.

C. Medical Emergencies

The medical emergency response system at Oakwood falls below accepted standards of care and places the health and well being of residents at risk of injury and death. The current protocol at Oakwood is overly broad and vague, and does not provide clear expectations for staff during a medical emergency. Staff responding to an emergency have no idea as to the severity and immediacy of the emergency or the type of medical emergency equipment that may be needed. For example, the protocol does not define a medical emergency (a Code 300), does not list any examples of emergencies, and does not indicate when staff should call a medical emergency. The protocol fails to identify which staff should respond to a Code 300, and does not specify the role staff should play. Although not directed by the protocol, in practice, Code 300's are called whenever a nurse is needed (whether for treatment of a laceration, a long seizure, or cardiac arrest). When a Code 300 is called, all nurses from all four communities must respond. The result is that nursing staff must abandon medical duties to respond to numerous non-emergent situations. Such use of nursing staff is inefficient and places other residents of the facility at risk as their medical staff leaves to respond to an open call for medical help that often is not an emergency requiring all staff.

Furthermore, information concerning medical emergencies is documented inadequately on a regular incident report form. Oakwood needs to establish a separate code for life threatening emergencies, clearly define the response team members and their respective duties, and designate a nurse to record and document accurately the event.

Finally, nurse training with regard to medical emergencies is inadequate. For example, protocol directs that a nurse may administer I.V. medications, but nurses are given no formal training on I.V. medication administration. If a physician is not present at the emergency (which occurs especially on evening and night shifts), an unskilled nurse may have to delay providing emergency medication until an Emergency Medical Technician or physician arrives. This delay of potentially critical treatment places residents at risk of severe injury or even death.

D. Infection Control

Oakwood staff engage in infection control practices that are outdated, unsafe, and ineffective for preventing the spread of infectious and contagious diseases, placing themselves and Oakwood residents at risk of harm. The Oakwood Infection Control Manual is at least three years old and fails to reflect the most recent accepted professional standards of care, especially in the critical areas regarding current guidelines for Bloodborne Pathogens and Tuberculosis. Throughout our visit, we witnessed instances of unsafe and unacceptable infection control practices, particularly with regard to staff failing to wash hands or change gloves before touching or assisting multiple residents during eating, toileting, and dressing. Finally, Oakwood lacks a full time person to direct the infection control process. Accountability for developing and overseeing infection control practices is distributed among other professional staff rendering the system fragmented and inefficient. Such a fragmented system fails to collect, organize and report sufficient data to assess trends and/or performance improvement opportunities within or across the Oakwood living units.

E. Training

Oakwood's nursing and direct care staff training programs are insufficient to protect its residents from harm and is a major contributing factor to the inadequate nursing care provided at Oakwood. In addition to a lack of an adequate nursing training program, the training provided is not competency based. Nurses are not evaluated on whether they are capable of actually performing the skills presented in training. Oakwood merely has employees and supervisors sign a checklist acknowledging attendance and that the employee understands the skills presented. Nurses must be evaluated on their competency to perform critical nursing tasks (especially with regard to high risk nursing skills such as inserting and maintaining I.V.'s and suctioning). A mere checklist is inadequate. Furthermore, Oakwood does not provide sufficient, ongoing, competency based training that should be conducted at regularly established intervals throughout the year.

F. Staffing Systems

Oakwood's system for staffing nurses and direct care staff is inadequate and jeopardizes resident safety and quality of care. Oakwood lacks a computerized information system, and at the time of our tour, was unable to present to us complete data as to staffing minimums, ratios of nursing and direct care staff to residents, and actual staff in attendance (as opposed to scheduled). Such a disorganized staffing system creates a high risk for inaccuracy and miscalculations, and makes it impossible to generate meaningful, essential reports that are necessary for appropriate staffing analyses of trends, gaps, and/or imbalances in staffing, and to ensure minimal staffing requirements are being met throughout Oakwood.

Compounding the inability to access critical staffing information is the lack of any centralized organization of staffing. Staffing organization is fragmented and logged manually within the separate communities even though nursing staff may be shared across communities if needed. Each community director is responsible for all staffing needs (nursing and direct care staff) of the community. However, the director of nursing for each community still determines the nursing schedules and there is little coordination between the director of nursing and the community director.

Furthermore, Oakwood's attempt to allocate nursing staff across the communities fails to take into account the particular needs of the residents within the different communities. For example, Willow Run has the most fragile residents but has the least number of nurses resulting in the unacceptable situation that the community with the greatest need has the worst staff to resident ratio. As a result of the lack of staffing organization, incomplete staffing data, and fragmentation of staffing analysis, Oakwood is unable to determine any staffing minimums for its communities for nursing across shifts and days of the week. Indeed, the deficiencies left us unable to determine whether Oakwood has sufficient numbers of nurses or direct care staff to safely conduct its operations. However, we do find that current nursing and direct care staff, even if sufficient in raw numbers, is inadequately deployed to give appropriate care and protect Oakwood residents from harm.

VI. NUTRITIONAL MANAGEMENT

Residents are not adequately managed during mealtimes. Many residents do not have an adequate individual meal management plan ("MMP"). We observed several residents without MMPs, with problems swallowing and coughing, with foods and liquids coming

out of their mouths due to poor head positioning, and drinking and eating too fast, with no staff monitoring them. Furthermore, residents with MMPs are not being adequately managed. We observed several instances of staff not following the MMPs and placing residents at significant risk of choking, and/or aspiration. A major concern across the MMPs was residents eating too fast. We observed several residents with identified choking risks and specific instructions to eat slowly, eating much too quickly with staff failing to intervene or even acknowledge the problem. One of the residents, after finishing eating, proceeded to cough for over thirty minutes. The other resident guzzled liquid so fast that it was pouring out of his mouth. The direct care staff had no response and, in fact, was not even observing the resident. In a third example, a resident with a strong history of aspiration pneumonia had instructions to be fed slowly, one bite/sip at a time. We observed the direct care staff feeding him one bite after the other without waiting for the resident to swallow each bite. Such manner of feeding is a major health risk for this individual.

Compounding the problem is the lack of adequate staffing and the unpleasant eating environment. With food being served at different times during the meal due to lack of staff, many residents wait 20 minutes or more to receive cold food and begin yelling, talking loudly, and banging on tables.

Finally, often nutritional management issues are related to a resident's behavioral problems, but Oakwood has no interdisciplinary management committee that meets at regular intervals to discuss the nutrition management needs of the residents, the current meal plan, or changes needed to the meal plan. We observed several residents whose behavioral problems impacted their nutritional management program. In one example, a direct care staff was having difficulty feeding a resident because of his self-injurious behavior of banging his head to the point that his forehead was red, bruised and knotted. The staff member, however, did not acknowledge the self-injurious behavior, or provide any intervention or prompts to cease such behavior, but merely kept trying to feed the resident.

VII. PHYSICAL THERAPY

Oakwood does not provide sufficient physical therapy services to residents in need of such services. Physical therapy is critical to the residents of Oakwood in order to maintain gross motor skills, joint range of motion, gait training, and posture. Oakwood does not, for example, have a positioning program which is critical for proper swallowing, adequate digestion, and otherwise proper nutritional management. The lack of a positioning program

contributes to the inadequate nutritional management discussed above.

Many of the residents at Oakwood remain in wheelchairs without a specific medical indication that such confinement is necessary. Confining clients unnecessarily to wheelchairs greatly increases their risk of osteoporosis, atrophy, scoliosis, skin breakdown, and muscle weakness over time. We observed that many of the residents confined to wheelchairs have the potential to walk but have not received adequate physical therapy services to enable them to do so. The physical therapy department recognizes the need to "get people out of wheelchairs," but little appears to have been done to achieve this goal.

Furthermore, the direct care staff ultimately responsible for much of the physical therapy needs of the residents are inadequately trained. Oakwood provides new direct care staff with only two hours of training on transfers, positioning, and handling pressure ulcers and such training does not involve competency-based evaluations of the direct care staff. Due to their high case loads, the physical therapists also do not have sufficient time to conduct ongoing training of direct care staff necessary to ensure that physical therapy programs are being adequately implemented. The physical therapists concentrate mainly on the most egregious cases, leaving many residents with physical therapy needs untreated.

Finally, due to inadequate staffing of the physical therapy department, the physical therapists have only been able to attend a small minority of interdisciplinary team meetings and, consequently, have been unable to effectively present to other Oakwood professionals the physical therapy needs of the great majority of residents. In one team meeting we observed, the physical therapist in attendance stated that staff should work with the resident on ambulation skills; the Director of Nursing for that community questioned the need for such training and stated, "She gets along pretty fast by crawling."

VIII. QUALITY IMPROVEMENT

Although Oakwood currently has a quality improvement ("QI") program, it is inadequate to address the crisis of care found to exist within the clinical services provided at Oakwood. The current program is too limited to provide adequate monitoring and improvement of critical areas of care and treatment of Oakwood residents. Oakwood lacks a systematic approach to recognizing and resolving many of the problems outlined in this findings letter. In the critical area of protecting residents from harm and abuse, Oakwood does not have a risk management system that integrates

risk investigations, outcomes, and remediation. There is no formal feedback system so that clinicians and administrative staff are informed of gaps in services with remedial actions taken. For example, in the critical area of pica behavior, we noted that one resident had a history of severe pica behavior having swallowed batteries, screws, razor blades, pennies, and nuts and bolts, among many other items. We reviewed this resident's incident reports for the last week of August and the month of September, 2001, and found five separate incidents of harmful pica behavior. On August 23 he swallowed 6 "A" batteries; on August 26 he swallowed 4 "A" batteries; on August 28 he swallowed 2 metal matchbox cars; on September 1 he swallowed another battery; and on September 27 he swallowed a large toenail clipper. Ever since his admission on December 9, 1999, this resident has been engaging in harmful pica behavior and has had to be treated for chronic esophageal ulcers caused by chemical and mechanical irritation from pica items. Oakwood has failed to provide appropriate clinical interventions to prevent such instances of pica behavior from reoccurring. Aside from the obvious harm and neglect caused by the serious lack of clinical intervention for this resident, Oakwood's quality improvement program has failed to monitor and prevent the above serious pattern of harmful pica instances. An effective risk management system would have prevented the recurrence of such incidents through a monitoring, feedback, training, treatment, and accountability system.

Oakwood's QI system also fails to ensure that safe, appropriate nursing care is provided to residents. Although the nursing performance areas monitored under the current QI system are appropriate and important (i.e., documentation; gastrostomy tube/jejunoscopy tube use; medication errors; infection control and seizure management), the goals are not objective and measurable, thus precluding any reliable assessment of improvement in care at Oakwood. For example, simply providing training to nurses on the use of tube feeding does not indicate improvement. Root causes of problems need to be identified, evaluated and addressed directly. Nursing administrators need to actually obtain baseline data on problem areas such as aspiration, intolerance during feeding, and rates of infection at tube sites, and then review outcome data to identify whether improvement has actually occurred. As previously discussed, in the area of medication administration, there exists a similar failure to identify root causes of problems. Oakwood needs to collect and analyze baseline data regarding medication administration, analyze the current processes, recommend changes, and design a plan to monitor outcomes after changes are made.

Finally, compounding the inadequate quality improvement program is Oakwood's total lack of a management information system. Oakwood does not have an integrated, system-wide clinical database for all residents. An effective support and services system cannot be managed without a responsive and efficient management information system.

IX. SERVING INSTITUTIONALIZED PERSONS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

Individuals who desire to live in the community and who reasonably can be accommodated are denied an adequate opportunity to do so in violation of Kentucky's obligations under Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 et seq., and the regulations promulgated thereunder, 28 C.F.R. § 35.130 (d). The Commonwealth of Kentucky is responsible for providing appropriate accommodations and services in the community for residents of Oakwood and should take active steps toward such goals.

The current administration of Oakwood informed us that Oakwood was originally designed to serve people for a maximum of three years, but residents' stays have been continuously extended. Many residents, however, are able and desire to move into the community. Individuals at Oakwood with whom we spoke, from direct care staff to professional staff, including the new director of the facility, stated that with appropriate supports and services the great majority of individuals at Oakwood can and should be served in the community. It is clear from interviews with staff and reviews of resident records, however, that Oakwood is being operated as a long-term residence. Admissions to Oakwood are frozen and the yearly census is relatively unchanged signifying that very few residents of Oakwood are being discharged into less restrictive settings. Treatment teams function to make individuals fit the long term institutional culture rather than prepare them for community living. At the time of our tour, discharge or transition planning was inadequate. The limited number of plans in place did not specify critical information such as time lines, transition activities, and monitoring requirements prior to and after discharge.

During our investigation, we noted that the ISPs of several residents stated a preference to live in the community. While on-site, a number of residents approached us and stated their desire to live outside the facility. For example, one resident told us of her strong desire to live in a group home near her mother in another city in northern Kentucky. This resident came to Oakwood when she was nine years old and remains at the age of 44. Her goal is to live in the community in a group home. Her physician

noted that she has good communication skills and can live in the community with minimal supports; she works on a regular basis. Oakwood explained that her father opposes any community placement. Oakwood, however, has provided her father with no choice counseling or explored other options to fulfill her express wish to live outside of Oakwood. The above resident's situation is not uncommon.

X. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of Oakwood residents, the Commonwealth of Kentucky should implement the minimum remedial measures set forth below.

A. Protection From Harm

Oakwood residents should be adequately protected from harm due to abuse and/or neglect and provided a safe and secure living environment. Specifically, Oakwood should:

1. Develop and implement an adequate risk management system, including an adequate management information system, to identify, track, monitor, and substantially reduce the incidents of harm due to abuse and neglect.

2. As part of the risk management system, develop and implement an adequate incident management plan to substantially reduce the number of overall incidents occurring at Oakwood, particularly the number of incidents due to resident aggression, self-harm, and unknown causes

3. Develop and implement policies and procedures that clearly define and detail the consequences of abuse, neglect, and nonreporting incidents of harm at Oakwood.

4. Develop and implement a plan to provide Oakwood residents and staff with a safe and secure living and working environment.

5. Adequately train all staff on identifying, reporting, and managing incidents of harm, abuse, and/or neglect, including training on client rights and consequences of violating client rights.

B. Behavioral Services

An adequate array of comprehensive individualized behavior programs and services should be provided to Oakwood residents. Such behavior programs and services should be developed by qualified professionals consistent with accepted professional standards and provide a safe, functional and stable living environment, prevent regression, and facilitate the growth, development, and independence of every Oakwood resident. To this end, Oakwood should:

1. Identify and plan for the training needs of Oakwood residents by conducting a comprehensive and timely interdisciplinary functional assessment for each Oakwood resident that uses a systematic and reliable method for assessing the impact of the physical environment on the resident.

2. Based upon adequate assessments, develop and implement individualized behavior programs to reduce or eliminate harmful behaviors by replacing them with more appropriate functional behaviors and useful skills.

3. Have a qualified professional timely develop, implement and monitor a professionally based, individualized skills training program for each resident containing appropriate skills development designed to enable each resident to grow and develop and learn useful adaptive skills.

4. Develop and implement adequate active treatment programs for all residents engaging in pica behavior.

5. Develop and implement a policy on use of restraints (physical, mechanical, and chemical) that is consistent with accepted professional standards of care.

6. Develop and implement a professionally based, individually appropriate data collection system to measure and review relevant information about maladaptive behaviors and the conditions under which they occur, including, where appropriate, the frequency, intensity, and duration of the behaviors.

7. Develop and implement meaningful day programs for all Oakwood residents based upon their assessed

needs and designed to pre-empt maladaptive behaviors.

8. Treatment team meetings should focus on writing treatment plans that actively develop skills needed in the community, that serve to enhance the quality of the resident's life, that accurately reflect who is making decisions, and that provide justifications for recommendations.

9. Write Individual Support Plans in terms of measurable outcomes where goals and objectives are to be achieved in a reasonable amount of time and be community focused. Treatment teams should be held accountable for monthly progress on each objective for resident's under their care and supervision.

10. Provide sufficient staffing, particularly direct care staff, to develop and implement all Individual and Behavior Support plans and services in an adequate manner.

11. Provide counseling to an individual and his/her parent or guardian on available community living options to assist them in making choices regarding living preferences.

12. Develop and implement a training program to improve and expand the skills of all psychology staff in behavioral management.

13. Provide adequate psychology staffing and services.

14. Develop and implement a plan to require psychologists and psychiatrists to integrate treatments.

15. Develop and implement guidelines for clinical services that are focused on the specific needs of persons with developmental disabilities and on measurable outcomes.

16. Develop and implement a staff development program to train staff in the appropriate care and treatment of residents at Oakwood, including but not limited to, implementing behavioral and active treatment programs (all staff should know and be able to implement a behavior support plan for residents under his or her care and/or

supervision), the proper functioning of the interdisciplinary treatment team process, the effects and side-effects of medications, life safety issues, recognizing seizures, environmental safety, and data collection.

C. Psychiatric Services

Residents should be provided adequate and appropriate psychiatric and mental health services in accordance with accepted professional standards, when needed. To this end, Oakwood should:

1. Retain adequate psychiatry consultation hours to meet the needs of its residents.

2. Develop and implement standard psychological and psychiatric assessment and interview protocols for reliably reaching a psychiatric diagnosis for individuals with mild and moderate mental retardation and standard protocols for individuals with severe and profound mental retardation.

3. Undertake a thorough psychiatric evaluation/workup of all individuals currently residing at Oakwood, provide a current, clinically justifiable diagnosis for each individual, and remove all diagnoses that are not clinically justified.

4. Ensure that psychotropic medications are only used in accordance with accepted professional standards and not used for behavior control in place of a training program or for the convenience of staff.

5. Provide a particularized justification for polypharmacy if more than one drug is prescribed for the same indication.

6. Monitor the use of each psychotropic medication against identified markers or target variables and evaluate its effect and reassess diagnoses and treatments as appropriate.

7. Develop and implement a plan to assess, treat, and monitor Tardive Dyskinesia (TD) and other movement disorders on a regular basis and adequately train medical and nursing staff to reliably assess TD and other movement disorders.

8. Develop and implement an adequate Pharmacy and Therapeutics Committee with, at a minimum, the following responsibilities

   a. Develop and implement policies and practice guidelines for the use of psychotropic medications for psychiatric disorders in the residents at Oakwood;

   b. Monitor prevalence and patterns of psychotropic drug prescriptions at Oakwood;

   c. Provide peer-review and guidance for prescribing medications; and

   d. In concert with the psychology staff, develop and implement a plan to teach psychiatrists and behavior analysts to integrate their treatments.

D. General Medical Care

Individuals with health problems should be promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates, reassessed, diagnosed and treated, consistent with current professional standards of care, including with documentation adequate to withstand clinical scrutiny. To this end Oakwood should:

1. Establish a formal medical peer-review system.

2. Establish an adequate mortality review process that identifies and implements any possible improvements in the care of the clients and recommendations for change.

3. Adequately document all medical services, including identifying the name of the patient's primary care physician, recording the results of diagnostic evaluations at the time they are reviewed, and developing a current and chronic problem list.

4. Have medical staff receive, at least annually, adequate education and training regarding the special needs of patients with developmental disabilities.

5. Establish a medical quality assurance program that collects data relating to the quality of medical services, assesses such data for trends, identifies corrective action; and monitors to ensure that appropriate remedies are achieved.

6. Establish uniform medical care policies and protocols to ensure the consistent provision of medical care. Such policies and protocols should include protocols for the treatment of common medical problems, such as severe constipation/obstipation, bowel obstruction, and/or urinary tract infection, and preventive care protocols that require adequate screening and periodic checkups for general medical conditions and conditions specific to persons with developmental disabilities.

E. Neurologic Care

Individuals with a neurologic disorder diagnosis should be treated and regularly monitored by a neurologist, according to current professional standards of care, including with documentation adequate to withstand clinical scrutiny, to ensure that treatment and medication are appropriate. To this end, Oakwood should:

1. Provide sufficient neurological care to meet the identified neurological needs of Oakwood residents and retain a sufficient number of qualified neurologists to deliver adequate neurological services.

2. Ensure adequate communication between the neurologist and the primary care physician and other involved staff members.

3. Evaluate promptly each Oakwood resident with a diagnosis of seizure disorder to determine if they have been properly diagnosed and, where necessary, provide appropriate, effective treatment of all such disorders.

4. Reassess the need for antiseizure medication for those who have not had a seizure for two or more years.

5. Require that a neurologist evaluate every patient with a seizure disorder at least annually.

6. Develop and implement standard seizure treatment objectives and rationalize anticonvulsant medication prescription practices.

7. Implement a facility-wide, monthly side-effects monitoring system specifically for anticonvulsant medications.

F. Nursing Care

Residents should receive adequate nursing care. Nurses should perform their responsibilities in keeping with accepted professional standards of care by adequately identifying health care problems, notifying physicians of health care problems, and monitoring and intervening to prevent and reduce health care problems. To this end, Oakwood should:

1. Conduct annually an adequate, comprehensive nursing assessment based upon an appropriate diagnosis for Oakwood residents and document such comprehensive assessment in a resident's chart.

2. Conduct follow-up nursing assessments as needed and/or as identified in the comprehensive assessment to appropriately treat Oakwood residents.

3. Develop and implement adequate and appropriate comprehensive nursing care plans based upon accepted standards of care for nursing process. Such comprehensive nursing care plans should be integrated with the Individual Support Plan and reviewed and updated monthly.

4. Develop and implement an adequate chart and documentation system that includes an adequate seizure management record with objective and defined criteria that appropriately describe the nature of the seizure, and adequate progress notes that record information chronologically from shift to shift and by issue from beginning to resolution.

5. Develop and implement a competency-based training program to train Oakwood nurses in implementing and documenting the nursing care process (including adequate diagnosis, comprehensive assessment/analysis, plan development, and integration into Individual Support Plans), and in adequate medication administration practices.

6. Clearly define the role and expectations of nurses as members of the Interdisciplinary Team and during Individual Support Plan meetings.

7. Develop and implement an adequate system of medication administration that accords with professional standards of care and includes, at a minimum, the following:

   a. Administering the correct medications to the patient properly identified to receive such medications;

   b. Ensuring that residents are actually taking their medications;

   c. Adequately recording, monitoring and tracking medication error data, including aggregating data across all living units and levels of nursing staff; and

   d. Identifying specific problems with medication administration from the medication error data and implementing corrective measures.

8. Develop and implement an adequate emergency response system that contains the following:

   a. Detailed definitions of medical emergencies that clearly differentiate between life threatening and non-life threatening emergencies;

   b. An outline of the responsibilities of all emergency response personnel;

   c. Nursing procedures for using emergency equipment and medications; and

   d. Competency based training for all staff involved in medical emergencies with periodic practice drills.

9. Develop and implement an adequate infection control system, including an infection control manual, based upon professionally accepted standards of infection control practices, particularly during mealtimes; and train all staff on such infection control practices.

10. Develop and implement an adequate uniform staffing system to ensure adequate numbers of nursing and direct care staff on the living units. Such staffing system should:

    a. Adequately assess the individual staffing needs of all Oakwood communities based upon variables other than mere census, such as acuity of residents living in a particular facility;

    b. Ensure that nursing and direct care staff are adequately allocated and deployed across all shifts and communities 24 hours per day, seven days per week, particularly third shift nurses for all communities; and

    c. Generate reports that present a complete facility wide staffing analysis on a daily basis as well as designated periodic intervals for the purpose of trend analysis.

G. Nutritional Management

Residents should be provided adequate and appropriate nutritional management, particularly for those individuals with feeding and swallowing problems. To this end, Oakwood should:

1. Have an interdisciplinary team of oral motor specialists comprehensively assess each individual who has a nutritional management problem and/or is at risk of aspiration to identify the causes for the nutritional management problem, and take all appropriate steps to ameliorate the individual's feeding and swallowing problems, including developing and implementing an individualized feeding and positioning plan, and train staff in how to implement the plans.

2. Develop and implement a system to monitor the progress of the Oakwood residents who have feeding and swallowing problems.

3. Ensure sufficient staffing to adequately develop and implement nutritional management, feeding and positioning plans for Oakwood residents.

H. Physical Therapy

Individuals having physical disabilities, including, but not limited to, those in wheelchairs or experiencing walking difficulties, should be assessed regularly for their physical therapy needs and adequacy of their supports, particularly after a significant change in their physical status. All residents with identified physical therapy needs should be treated according to accepted professional standards of care. Such physical therapy assessments and treatment should be documented in resident charts. To this end, Oakwood should:

1. Provide physical therapy and physical therapy planning for each resident in need of physical therapy interventions.

2. Ensure that therapeutic positioning is adequate to support physical needs and is reviewed regularly to ensure proper implementation.

3. Ensure that staff involved in therapeutic positioning receive sufficient competency-based training on therapeutic positioning, particularly in addressing scoliosis, mealtime needs, and functional seating.

4. Integrate physical therapy into the interdisciplinary team process, especially with regard to the nutritional management team.

I. Quality Improvement

Oakwood should develop and implement a Quality Improvement Plan that includes collecting data on staff performance in critical areas of resident care and treatment on a quarterly basis to provide for effective trend analysis and remediation.

J. Serving Institutional Persons in the Most Integrated Settings Appropriate to Their Needs

Individuals with developmental disabilities should be provided services in the most integrated setting appropriate to their needs. In particular, the Commonwealth should:

1. Develop a more comprehensive plan for community-based services for those individuals whom professionals have determined could be served in the community.

2. Develop and implement an adequate system to monitor community-based programs to ensure program adequacy and the full implementation of each individual's habilitation plan.

3. Every facility resident should be professionally assessed to determine whether continued placement in the facility constitutes the most integrated setting appropriate to meet the individual's needs. More particularly, Oakwood should:

   a. Develop and implement comprehensive, formal guidelines, policies and procedures for transition planning;

   b. Assess the most appropriate setting and support needs for each individual and periodically update the assessments for individuals who remain at the facility for extended periods of time; and

   c. If it is determined that a more integrated setting would appropriately meet the individual's needs, promptly develop and implement, with appropriate consent, a transition plan that specifies actions necessary to ensure a safe, successful transition from the facility to a more integrated setting.

*** * * * ***

The cooperative approach taken by the officials of the Commonwealth of Kentucky and Oakwood has been both appreciated and productive. We understand that officials are aware of and acknowledge many of the problems discussed in this letter. We are encouraged to note that Oakwood, its staff, and State officials are committed to changing Oakwood and look forward to continue working cooperatively with Oakwood and Commonwealth officials in addressing the concerns outlined in this letter. To this end, 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 relevant concerns, and offer practical assistance in addressing them.

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 Oakwood residents, 49 days after the receipt of this letter. 42 U.S.C. § 1997b (a)(1). Accordingly, we will soon contact Commonwealth officials to discuss in more detail the measures that the Commonwealth must take to address the deficiencies identified herein.

Sincerely,

/s/ Ralph F. Boyd

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