June 2, 2003

Governor Bob Riley
State Capitol
Room N-104
600 Dexter Avenue
Montgomery, AL 36130

Re: CRIPA Investigation of Claudette Box Nursing Home, Mount Vernon, Alabama

Dear Governor Riley:

We are writing to report the findings of our investigation of the conditions at the Claudette Box Nursing Home (herein referred to as "Claudette Box" or "the facility"). On September 12, 2002, we notified the State of our intent to investigate Claudette Box pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.

On November 19-21 and December 9-11, 2002, we conducted on-site inspections of the facility with expert consultants in psychiatry, nursing and nutrition. While at the facility, we interviewed residents and staff. Before, during, and after our visit, we reviewed documents, including policies and procedures, incident reports, and medical records.

We would like to thank the staff at Claudette Box and State officials for the level of cooperation we received during our investigation. We also appreciated the candor and openness of the facility's staff and administration. Moreover, State officials and facility staff reacted positively and constructively to the observations and recommendations for improvement made by our consultants during the site visits. We would specifically like to thank the facility director for his assistance and recognize his obvious commitment to improving the care provided at the facility.

Consistent with the statutory requirements of CRIPA, we

write to advise you of the results of the investigation. As described more fully below, we conclude that certain conditions at Claudette Box violate the constitutional and federal statutory rights of residents at the facility. We find that residents at Claudette Box suffer harm or the risk of harm from deficiencies in the following areas: medication administration, clinical services, dietary services, resident rights protection and quality assurance.

I. BACKGROUND

A. FACILITY BACKGROUND

Claudette Box is a State operated nursing facility located within the campus of Searcy Hospital, a psychiatric facility. While at the time we initiated our investigation Claudette Box housed 135 residents on three floors, during our most recent tour of the facility 91 residents were housed on two floors. Residents admitted to Claudette Box must be over 65 and have a diagnosis of a significant mental illness.

In 1986, the State and private plaintiffs entered into a consent decree regarding the conditions at Searcy, a settlement that included Claudette Box. In 1998, Claudette Box was released from the obligations of that consent decree.

On May 17, 2002, the United States Department of Health & Human Services Centers for Medicare & Medicaid Services ("CMS") notified Claudette Box that its Grants to States for Medical Assistance Programs certification was being terminated retroactively effective May 15, 2002. The decision to terminate was based on the facility's subjecting of residents to immediate jeopardy to their health and safety, by failing to adequately investigate allegations of physical and sexual abuse. On June 21, 2002, based on a finding by CMS that the jeopardy had been remedied, Claudette Box was reinstated to the federal funding program.

B. LEGAL STANDARD

Residents of state nursing 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). Claudette Box 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).

II. FINDINGS

A. MEDICATION

Generally accepted standards of care dictate that all uses of medications, especially those having potentially harmful side effects, be clinically justified. See 42 C.F.R. § 483.25(l). This is particularly true when drugs are used in combinations that increase the risk of harm or 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.

Claudette Box fails to provide its residents with appropriate medication services. Specifically, the facility administers excessive or unnecessary doses of psychotropics (including duplicate drug therapy); in other cases fails to provide effective and appropriate medication including pain medication; and administers drugs without sufficient monitoring.

These deficiencies appear to result at least in part from the failure of the facility to adequately account for the age of its residents in prescribing medication. That is, medication is dispensed to address psychiatric problems without due consideration to the effect those medications will have on a frail, elderly population. While Claudette Box has a full time psychiatrist, the psychiatrist has no expertise or specialized

training in geriatric populations.

i. Provision of Pyschotropic Medication

In reviewing the medical charts of residents, we found numerous examples of unnecessary drugs being prescribed or medications being prescribed without sufficient justification. Given the age of the resident population, there is an over-reliance on anticholinergic and antihistaminic medications. These medications may cause altered mental status, hypotension, increased fall risk, urinary retention, fecal impaction and confusion. Given the side effects, these medications must be used only when there is a clear and documented need.

Similarly, Claudette Box administers high doses of Ativan (which is also called lorazepam) to residents. While this medication can be an important treatment for the chronically mentally ill, it can have serious side effects. It increases the risk of falls or aspiration pneumonia, and can cause significant sedation. Thus, only low doses of this medication should be administered unless there is a clear and well documented need for higher doses. Out of the thirty-one medical charts of current patients we reviewed, eight were receiving high doses of this medication without there being sufficient documentation of the need for this dosage in the medical record.

There are also residents at Claudette Box who are on multiple anticonvulsants. Some anticonvulsant medications, like depakote, can not only prevent seizures, but can also control behavior. Thus, Claudette Box, to prevent the unnecessary duplication of medicines, should attempt to use depakote alone (which will address both behavioral problems and seizures) rather than prescribing one anticonvulsant to address seizures and a separate anticonvulsant to control behavior.

In some of the cases we reviewed residents were receiving multiple anticonvulsants, even though the resident did not have a well documented or characterized seizure disorder. In these cases, it was not clear that the resident needed one anticonvulsant, much less two.

There is also duplication in the use of anti-psychotics at Claudette Box. We reviewed the medical records of residents who were receiving both typical and atypical anti-psychotics without clear documentation in the medical record to support this

combined usage. Residents should generally only be receiving atypical anti-psychotics, rather than both typical and atypical anti-psychotics, or even typical anti-psychotics by themselves. Typical anti-psychotics are more likely than atypical anti-psychotics to cause involuntary movement disorders.

There are other examples of Claudette Box residents not receiving the drug therapy that will most appropriately treat their condition. Some patients on dilantin for seizure disorders are maintained on subtherapeutic levels. We reviewed the records of two patients whose dilantin levels were less than half the minimum therapeutic level. Because dilantin is not proven to be effective at this low dosage the resident's seizure disorder is essentially being left untreated.

ii. Pain Medication

Generally accepted standards of care require that residents who are experiencing pain have as part of their treatment a strategy for controlling that pain. The failure to have and implement such a strategy causes unnecessary pain and suffering.

During our first visit to Claudette Box, we observed residents whose pain was not being managed. For example, one resident who demonstrated multiple serious pressure sores received wound care without pre-medication. As a result the resident visibly demonstrated intense pain, evidenced by grimacing and withdrawal of her extremities. A second resident also did not receive pre-medication for treatment of a serious foot ulcer.

These specific cases we informed the facility about during our first visit had been remedied by the facility when we returned for our second visit. However, the larger problem remains. Residents who need pain management must be identified by the facility and treated appropriately.

iii. Inadequate Medication Monitoring

Claudette Box fails to appropriately monitor drug regimens. This failure violates the generally accepted standard of care for nursing homes. See 42 C.F.R. § 483.25(l)(iii).

For example, we reviewed the medical records of residents who continued to have blood drawn to test the levels of medications despite the fact that they were no longer being

prescribed. This subjects the residents to vein puncture without medical justification, and may impose unnecessary costs on the Medicaid Program.

Similarly, we reviewed the record of a resident whose neuroleptic medication was supposed to be discontinued, but had not been. The result was that the resident, who already exhibited evidence of a movement disorder, was unnecessarily receiving a clinically unjustified psychotropic medication that could exacerbate the movement disorder. At the time of our second visit to the facility, the resident had been receiving this unnecessary medication for over two weeks.

The failure to review and monitor sufficiently residents' medical records can have serious consequences in other areas. For example, we reviewed the record of a patient who had a history of hypothyroidism in his medical record when he arrived at Claudette Box. Despite this history, he was not tested or treated for this condition, which can cause delusions.

B. CLINICAL SERVICES

Claudette Box fails to provide residents with appropriate clinical assessment and care planning required to prevent physical and psychological harm. Nursing facilities are required to "provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being . . . ." See 42 C.F.R. § 283.24. They must also assess for and provide community-based treatment for persons with mental illnesses when such placements are appropriate. See 42 C.F.R. § 35.139(j); Olmstead, 527 U.S. at 602.

To provide adequate care, facilities like Claudette Box must assess each resident's needs and preferences, develop an individualized care plan based on this assessment, and effectively and accurately implement the care plan. Id. The assessment process must include consideration of the resident's physical condition and emotional status. Id. at § 483.20. It must also account for the resident's functional status, which measures the resident's ability to conduct the activities of daily living. Residents must be assessed on an ongoing basis for changes in health and functioning. In addition, when a resident experiences a significant event that impacts his or her health or functioning, the resident must be reassessed. Id.

This assessment must be used to develop a care plan that addresses all of the needs of the resident. Id. at § 483.25. The care plan is the fundamental tool for providing adequate care and serves as a blueprint for meeting the needs of the resident. Because the problems of the elderly are complex, the combined skills of all disciplines are necessary to meet the comprehensive needs of residents. An interdisciplinary team must collaborate and develop measurable goals and approaches consistent with generally accepted standards of care. The care plan must also describe the person(s) responsible for implementation.

The failure to conduct adequate needs assessments or to properly address identified needs through the care plan has profound negative consequences for nursing home residents. A significant and well-known threat to nursing home residents is the downward spiral in function and general well-being that is associated with living in a long-term care facility. Contractures, incontinence and a general lack of involvement in meaningful activity are common manifestations of this threat. These functional losses are also associated with medical complications such as pressure sores, falls, psychological impairment (including depression and cognitive loss), and increased mortality. This type of harm to residents is frequently preventable with proper assessment and care.

During our first visit to the facility, we examined the clinical services being provided to more than one quarter of the facility's residents. This review demonstrated serious shortcomings in Claudette Box's assessments, as well as in the areas of care plan development and implementation. We identified specific deficiencies in siderail use, the provision of restorative care, psychosocial and activity services, and discharge planning.

i. Siderails

In violation of applicable federal regulations and generally accepted standards of care, Claudette Box fails to use siderails in an appropriate manner. Nursing home residents have the "right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the medical symptoms." 42 C.F.R. § 483.13(a).

Four of the residents whose cases we examined were given full-length siderails as a restraining device. These residents demonstrated impaired cognition and decreased physical strength.

The mental health workers tending to these residents told us that the siderails were intended to prevent the resident from exiting the bed and from falling. The use of side rails to prevent falls is generally contraindicated in these circumstances, however, as siderails are not only known to be ineffective for this purpose, but pose a risk of serious injury when used to limit mobility. Weak and impaired residents who are provided siderails as a restraint are at risk for entrapment between the rail and mattress or head/footboards, asphyxiation by having their head or neck caught between the rails and mattress or head/footboards, and soft tissue injury and fractures from attempting to go over around or through the rails. They can also suffer other well documented complications from restraint use such as loss of function, depression, skin breakdown and malnutrition.

Our observations of these four residents highlight the danger to their safety posed by the use of siderails. One of the residents had both legs over the siderails and was attempting to climb over the rails. Another resident was discovered in bed with his head between the lower rung of the siderail and the mattress.

For these residents, and all residents placed in beds with siderails as a restraining device, Claudette Box should attempt to develop a care plan that provides for a safer more humane alternative to siderails. Such a plan can include a low bed, mats beside the bed, use of an alarm, a toileting plan, increased supervision, and/or analgesia.

Because of this high risk of harm described above, if Claudette Box chooses to use full length siderails as a restraining device, it must develop a care plan that is designed to prevent injury, and that requires periodic re-evaluation of siderail use. The residents should be assessed to determine the specific risk factors that predispose the resident for nighttime and bed-related falls/injuries. The residents we observed being restrained with siderails did not have such a plan.

ii. Restorative Care

Claudette Box also fails to provide adequate restorative care to its residents. Federal standards require nursing facilities to maximize residents' mobility, range of motion and function. See 42 U.S.C. § 483.25(e). To meet this standard, the facility needs to devise restorative care plans that cover areas

such as toileting, range of motion, therapeutic activity and the promotion of self care through meals and personal care.

Eight of the 25 residents we evaluated did not have a restorative plan even though they suffered loss of function and had a predisposition for further such losses. All eight residents demonstrated some ability to exercise, to use a toilet with assistance, and to assist with their oral care and bathing. All eight residents were incontinent, relied on wheelchairs for mobility, and were not involved in the activity of bathing, dressing or grooming in any manner. Three of the eight residents demonstrated some degree of joint contracture, a complication caused by a lack of exercise. Yet, each resident lacked a restorative care plan to address these debilitating conditions.

The staff's ability to promote restorative care is hampered by the absence of a facility policy that facilitates consistent, ongoing assessment of rehabilitative and restorative needs. Officials at Claudette Box told us that a recently revised policy provides for residents to be screened by the physical therapist upon admission and thereafter annually to assess their rehabilitative needs. The generally accepted standard of practice in nursing homes is to assess residents for these needs on a quarterly basis, rather than annually, and more often when staff detects a change in function and/or physical and cognitive loss.

While we were told that the facility has recently adopted a policy to have a nurse and two nursing assistants provide restorative care seven days a week, when we were at the facility only half of the residents appeared to have received such care. In addition, there are no clear policies and procedures governing the content of restorative plans, ensuring staff accountability for those plans and requiring adequate evaluation of restorative care.

Finally, there are deficiencies in the implementation of resident plans for those who have such plans. During our first site visit, nursing assistants we talked to were unaware of the restorative care plans of the residents under their care. This further hampers the facility's restorative care efforts.

iii. Psychosocial and Activity Services

a. Assessment Issues

In violation of generally accepted standards of care, the facility fails to assess the need for, and provide, required psychosocial and activity services. See 42 C.F.R. § 483.25(f). Residents need these assessments and services to address wandering, weight loss, loss of function, fall and injury risk, anxiety, and depression. Ten of the 25 residents whose records we reviewed were not provided needed activity and psychosocial plans.

One resident, who was assessed to be at risk for wandering and attempting to leave the facility, did not have an activity plan. This resident should have had a supervised walking and exercise plan to provide a physical outlet for her inclination to wander. Moreover, the facility had not attempted to devise a means of identifying and addressing the meaning behind her inclination to wander. Instead of developing a care plan that would adequately meet her needs, this resident was prescribed a psychotropic medication. Such use of medication is inappropriate if a non-pharmacological approach, that does not pose any risks of side effects, could be effective.

In general, in the records we reviewed, we found cases where activity interventions were neither prescribed nor implemented to provide strengthening, exercise, and supervision to residents who had sustained falls. Similarly, we identified cases in which residents who had sustained significant weight loss were not screened for depression, anxiety or other potential social causes for this clinical change. Moreover, residents who had sustained weight loss were not assessed for an activity plan to support an increase in appetite and food intake. Such assessment is generally accepted as a standard required intervention in such cases. Finally, residents at Claudette Box are prescribed psychotropic medication without the assessment input of the social worker, and social workers do not evaluate the resident's response to such medication. These practices do not meet generally accepted standards of care.

There are also deficiencies in the activity plans that have been created for residents. Residents' cognition, mood, and physical challenges have not been integrated into the assessment process to determine the need for modifications in equipment, environment, or program design. Moreover, care plans do not describe individualized, therapeutic approaches, including adaptation for hearing loss, vision loss, cognitive loss, and

physical challenges. Instead, care plans describe attendance goals at "activities" with no description of specific programs or individual pursuits that should be furnished. The plans provide a goal of only two to three activities a week, which is not sufficient to promote a normal, healthy routine.

ii. Unavailability of Activity

The deficiencies in the provision of meaningful activity at Claudette Box are not limited to those residents who need such activity to address a specific clinical need. Overall, there is a shortage of meaningful activity for residents that violates 42 C.F.R. § 483.15(f). The majority of the residents spend most of their time in large day rooms. In one of these areas, a television was playing almost continuously. The residents did not appear to be watching the television, and the majority have cognitive loss sufficient to preclude their ability to comprehend television shows. In general, the facility's high direct care staff to resident ratio (as compared to national averages) was not reflected in greater time spent with residents. In fact, throughout our visits to the facility, staff were frequently seen sitting near or with residents but not interacting with them or engaging them in activity.

Deficiencies in activities are also reflected in the facility's activity calendar. Only one activity per week was planned for evening hours. Despite the fact that the majority of residents are dealing with depression and/or other mental health problems, there were no support groups described on the activity calendar. The activity calendar does not provide the structure and frequency of programs required for residents with cognitive loss. Exercise is not provided for residents who are not able to follow directions. The lack of furniture in the facility deprives residents of the benefits of getting out of their wheelchairs and interferes with the ability of residents to engage in activities. Similarly, most residents were observed not wearing shoes, which impairs their ability to ambulate and engage in activities.

iv. Discharge Planning

As stated above, the law requires Claudette Box to provide community-based treatment for persons with mental illnesses when such placements are appropriate. Because of deficiencies in Claudette Box's on-going assessment of residents for transfer to

more integrated environments, and in its efforts to implement such transfers, Claudette Box fails to meet this requirement.

The facility policy states that the social workers are responsible for coordinating the discharge plan, which is to be developed within seven days of admission and then reevaluated at least on a quarterly basis. When interviewed, however, social work staff were unable to describe the residents who were deemed appropriate for discharge to a more integrated environment. Two residents informed us that they had discussed discharge planning in the past, but had not spoken to the social worker about the issue in many months.

During our limited time at the facility, we observed five residents who appeared to require minimal assistance with activities of daily living and to be medically and psychiatrically stable. While all five appeared to have received an initial assessment, four of the five residents had not received adequate, ongoing evaluation to identify discharge options. In addition, adequate arrangements to facilitate discharge were not provided for these residents.

For example, for one of these residents, there was no dispute that she was an appropriate candidate for transfer to a different setting, and that she wanted such a transfer. Facility administrators told us that she had not been discharged because she wanted to go home and her family was not prepared to house her. However, the resident informed us that she was willing to live in an assisted living unit as long as the residence was close to her church. The social worker responsible for this resident's discharge evaluation was not aware of this alternative placement option. Nor was the social worker aware that this resident had enlisted the services of an attorney to facilitate her discharge from Claudette Box.

Another of these five residents was refused admission to a community nursing home. The facility had not, however, pursued alternative placements (such as a personal care home or a boarding home serving those with mental illnesses) for this resident.

v. Implementation of Care Plans

In addition to deficiencies in assessment and care planning, we identified shortcomings in Claudette Box's implementation of

care plans. One fifth of the residents whose care plans we examined were not receiving the care described in their plan. For example, two residents did not receive the positioning called for by their plan to prevent aspiration. Two other residents did not receive the assistance with toileting provided for in their care plan.

The facility also fails to provide adequate education and training to its employees regarding patient care. For example, the training for nursing assistants does not address the needs of residents with dementia, Parkinson's Disease, depression or diabetes. The nursing staff does not receive training on the management of common clinical problems such as falls, pain, depression, mental health challenges, dementia, delirium, or pressure sore prevention and treatment. Moreover, in-service training provided to staff does not include the care of residents with dementia or communication with residents with cognitive loss. Finally, social workers and activity staff do not receive role-specific clinical orientation. In general, there is a paucity of education available to staff on aging issues, which is essential given the lack of formal gerontologic training of staff. The effect of this lack of education and training is to put residents at risk for undetected medical conditions and loss of function.

C. DIETARY SERVICES

The dietary services currently provided at Claudette Box are inadequate and do not comply with generally accepted standards of care for residents in long-term care facilities. Claudette Box fails to provide adequate therapeutic diets or furnish proper nutrition and hydration. Moreover, Claudette Box fails to include adequately its dietitian in clinical care decisions. Finally, the facility fails to provide proper feeding services to its residents.

i. Therapeutic Diets

The facility offers a variety of therapeutic diets (e.g., a sugar in moderation "diabetic" diet, a cardiac prudent diet, a 4-gram "low" sodium diet, and a texture modified diet) to residents. However, for a number of reasons, these diets fail to meet the needs of Claudette Box residents.

Because the facility has not standardized its recipes,

there is no way to ensure that these diets consistently contain the appropriate nutritive value for a given resident. Although individual requirements for nutrients differ based on age, height, weight, gender and activity level, the actual preparation of food comprising the menu for residents on a therapeutic diet must be uniform to ensure that the residents receive the appropriate amount of nutrients. Standardized recipes should be developed to make sure that the meals are prepared in a uniform manner.

In addition, Claudette Box uses therapeutic diets that do not adequately treat the conditions they are designed to remedy. For example, the sugar in moderation diet is not effective because it does not incorporate generally accepted scientific knowledge regarding the treatment of diabetes, that diabetes is a metabolic disorder involving all three of the energy nutrients (i.e., carbohydrate, protein, and fat). A diet manual which describes the rationale and use for therapeutic diets should be developed for the facility. This manual would objectively address issues pertaining to diet-related diseases and would reflect the most current scientific knowledge regarding treatment.

There are also deficiencies in the ability of Claudette Box to identify the need for therapeutic diets to accommodate a decreased level of oral motor skills (i.e., chewing and swallowing). While at the facility, we observed a resident, who was not on a texture modified diet, having difficulty chewing her meal. Although the mental health worker who was assisting this resident noted that the resident had been experiencing problems with her oral motor skills for some time, no recommendation was made to place this resident on a therapeutic diet. The assessment of oral motor skills is very important for this population because they are at increased risk for dysphagia. Dysphagia is a swallowing disorder which can have serious consequences for the elderly, including, dehydration and malnutrition. Moreover, Claudette Box lacks a protocol for the direct care staff who provide feeding assistance. The protocol should provide instruction on useful methods that encourage safe consumption of food and liquids as well as guidance on symptoms that the direct care staff can look for to identify those residents who are experiencing problems with their oral motor skills.

Finally, delays in modifying therapeutic diets undermine

their effectiveness. For example, a resident we observed during the tour refused to eat her lunch. While this resident was already on a therapeutic diet, the texture of her meal was clearly inadequate, given her decreased level of oral motor ability. We brought this situation to the attention of the registered dietician and she agreed that the texture needed to be changed to pureed. However, the change had not been made for this resident by meal time on the following day, despite the fact that a written request for a change in diet texture was submitted to the physician the previous day. Such a delay in modifying therapeutic diets can cause serious complications. Residents on modified diets should be continually re-assessed to ensure that no adjustments are needed. Moreover, when changes to a therapeutic diet are required, they should be taken care of immediately.

ii. Nutrition and Hydration

Claudette Box fails to provide nutritious meals to its residents. Several factors contribute to this deficiency, including an inaccurate nutrient analysis of the current menu, the absence of a standard nutritional assessment for the facility, the absence of a hydration protocol and the failure to provide appropriate nutritional substitutes.

a. Nutrient Analysis of the Menu

The menu for Claudette Box is prepared by a State board that prepares the menus for all the mental health facilities in Alabama. The software package that the State board uses to prepare the menus relies on a dietary analysis that is based on the nutritional needs of a 25 year old male. Many of the Recommended Dietary Allowances for a 25 year old male differ drastically from those recommended for the population served at Claudette Box. For example, women over the age of 50 and men over the age of 60 should be provided calcium fortified beverages to reduce the rate of spontaneous fractures that are prevalent in these age groups. In order to address this deficiency, Claudette Box should immediately develop a menu for this facility that is based on the Recommended Dietary Allowances for adults over the age of 65.

b. Standard Nutritional Assessment

Claudette Box does not have a clinical protocol in place that can be used to identify accurately those individuals who are

at risk for malnutrition. Our review of resident records indicates that very limited information is gathered to identify such individuals. If a comprehensive nutritional assessment is not provided, residents will likely experience a myriad of complications (e.g., deteriorated oral motor skills, acute weight loss, aspiration and aspiration related illnesses, and chronic constipation). While there are some basic methods of nutritional surveillance in use at Claudette Box (i.e., weight loss focus), the facility needs to develop more sophisticated methods of assessing this elderly population, especially since weight loss alone may not provide an accurate indicator of malnourishment. A standard nutritional assessment should be developed which incorporates anthropometric measures (e.g., skinfold measurements and height/length measurements), an evaluation of oral motor ability, feeding skills, and biochemical and clinical markers.

c. Hydration

The residents at Claudette Box are at risk for dehydration because their fluid intake is not documented or monitored by the staff. There are several factors that contribute to a heightened risk of dehydration for Claudette Box residents, including the prescription of multiple medications (e.g., sedatives, anti-psychotics, tranquilizers and non-asteroidal anti-inflammatory drugs), dementia, incontinence and a lack of mobility. Although the direct care staff responsible for the residents' hydration indicated that residents are offered liquids six times a day, there is no documentation showing that fluids were actually offered at this rate, nor is there any documentation showing how much liquid the residents consumed on a daily basis. During the tour, the only time that we saw fluids dispensed to the residents outside of meals was during the distribution of medications. Dehydration is a serious concern for the elderly and can result in the development of urinary tract infections, bowel obstructions, delirium, and cardiovascular symptoms.

During our second visit to the facility, when staff used a thickening agent (i.e., Thicken-Up) to modify the consistency of a liquid, the product was used incorrectly. In fact, most of the liquids were so "over-thickened" that a solid substance was formed inside the glass. The misuse of this product is of great concern because a number of the residents are already at increased risk for dehydration and constipation. Inadequate fluid intake at mealtime only serves to exacerbate these problems. Moreover, most of the residents who received these

"over-thickened" liquids were not offered a replacement beverage.

d. Substitutes of Comparable Nutritional Value

Claudette Box also fails to provide substitutes of similar nutritive value to residents who refuse the food served. Federal regulations require that such substitutes be provided. See 42 C.F.R. § 485.35(d)(4).

During our second tour of the facility, we observed a resident being offered the choice between two calorie dense pastries, after she had refused to eat her lunch meal. Obviously these substitutes are an inadequate replacement for a meal, since they are void of any nutritive value. On another occasion, we observed a resident who had refused to eat her lunch but was not offered any substitute for that meal. While it is beyond question that a resident has the right to refuse the food served by the facility, there must be some substitution policy in place that ensures that the resident is given a replacement that is of similar or greater nutritive value. If residents are not being provided with substitutions that are the nutritional equivalent of a missed meal, they will be at a greater risk of developing all of the maladies that accompany malnourishment.

iii. Dietician Involvement in Care

Not only are there deficiencies in the dietary services provided to Claudette Box residents, but the facility's failure to include adequate dietetic expertise in care decisions has negative consequences for the overall care of residents. Claudette Box has "Standard of Care" meetings where members of the staff, including the facility director, psychiatrist, physician, and social worker, gather to address health related issues and plan intervention strategies that will be implemented. The failure to include the dietician in these meetings, however, impairs the facility's ability to address comprehensively each resident's risk of malnutrition, dysphagia, dehydration, fractures, pressure sores, chronic constipation and other maladies that plague a mentally ill geriatric population.

For example, a number of the residents have problems with constipation. If constipation goes untreated, it can lead to anorexia, confusion or dehydration. To address this problem, residents are often prescribed laxatives like lactulose. One resident was prescribed lactulose on a daily basis, but continued to suffer from chronic constipation. Despite the fact

that there was no improvement in this resident's ability to have consistent bowel movements, there are no notes in the chart to suggest that the physician and the registered dietician consulted with each other on alternative forms of treatment. Had they conferred they might have come to the conclusion that the ineffectiveness of the lactulose might be the result of a negative drug-nutrient interaction. Lactulose can actually make constipation worse unless a high fiber diet is prescribed in conjunction with a specific level of fluid intake. A protocol should be developed that requires a daily review of the bowel movement charts kept by the facility to ensure that the appropriate treatment is being prescribed for those residents who experience chronic constipation.

Additionally, the facility's treatment of pressure sores lacks an interdisciplinary approach that includes dietary services. The protocol for pressure sore prevention and care should be revised to include information about the role of nutrients in tissue repair and wound healing. Residents with pressure sores should be closely monitored to ensure that they are receiving the proper protein, fluid, and calorie requirements to speed their recovery.

iv. Feeding

Claudette Box fails to ensure that the actual feeding of residents occurs properly. This not only negatively affects resident nutrition, but contributes to the general lack of resident activity described above.

The facility fails to use meals as an opportunity to promote activity and optimal functioning. Resident dining areas do not have sufficient numbers of chairs, and therefore residents use wheelchairs for seating. This not only prevents residents from walking to the dining area, but the failure to transfer residents from wheelchairs to standard chairs can lead to decreased strength and immobility. In addition, keeping residents in their wheelchairs during meals leaves them poorly positioned to eat. Poor positioning prevents residents from gaining sufficient access to the table, which can predispose them to discomfort and make the dining experience less enjoyable. To the extent that residents can be taken out of their wheelchairs and seated at the table, every effort should be made to do so.

During meals, we observed a number of residents who could

have benefitted from adaptive measures that would assist them in self-feeding. For example, one resident with tremors, while able to feed himself without assistance from the staff, could have accomplished this task with more ease and dignity if the facility provided him with adaptive measures.

Adaptive measures are important because they provide residents with an opportunity to be involved with mealtime activities and thereby promote gross and fine motor skills. Claudette Box residents who rely on staff for feeding assistance should be evaluated to determine if they would benefit from the use of adaptive measures. If it is determined that a resident would benefit from these measures, an interdisciplinary team should conduct periodic evaluations to monitor the continued efficacy of these utensils.

Another problem that we observed with feeding assistance is the staff's failure to recognize feeding cues. As discussed above, there are a number of residents at Claudette Box who have dysphagia. These residents exhibited the full range of oral motor difficulty, including chewing abnormalities, coughing, gagging, spitting out food and choking. We also observed some residents who were taking some protective measures of their own to prevent choking and aspiration. For example, one resident turned her head away from the nurse assisting her with breakfast each time she needed to finish chewing and swallowing her food. Unfortunately, the nurse did not realize that the resident was trying to protect herself from choking and was indicating that she was not ready for another scoop of food. As a result, the nurse physically turned the resident's head back towards her before the resident was ready to consume more food. None of the staff who assisted these residents during mealtime reported that they had received training to identify oral motor difficulties, nor had they received training on the recognition of feeding cues.

v. Food Preparation, Service and Storage

The food at Claudette Box is not prepared, stored and served under adequate safety and sanitary conditions. As a result, Claudette Box residents are at an increased risk for developing food borne illnesses and infection.

The thermal trays that the facility uses to keep the food warm from the beginning of meal times until the later dining shifts does not keep the food appropriately heated. Food should

be kept at a temperature less than 40°F, if it is served cold, and above 140°F, if it is served hot. We noted that residents who ate during the later shifts were served food that was in the "danger zone" (i.e., between 40°F and 140°F). If food is served in the "danger zone," the growth rate of microorganisms may increase and cause infection. The food for these residents should not be brought to the dining room until they are seated in the dining room and ready to eat.

During our second tour, we also noticed that none of the members of the kitchen staff wore gloves while they were preparing the meals. One staff member was observed pureeing eggs in a blender without the use of latex gloves. After she finished the blending process, she scraped some eggs that had gotten on her bare hands back into the mixture that was going to be served to the residents. This particular worker stated that she did not wear gloves because she was allergic to latex, but some of the other workers that we approached about this issue indicated that they had simply forgotten to put them on. While it is advisable for kitchen staff to wear latex gloves, or a suitable alternative, when they perform certain tasks, the more important issue is that the kitchen staff should be required to wash their hands as they move from one task to the next. During the tour, we observed a number of kitchen staff members and dietary workers at Claudette Box, who failed to wash their hands after completing each task as required by generally accepted standards of care.

D. RESIDENT RIGHTS

Nursing home residents have the right to a dignified existence and to self-determination. See 42 C.F.R. § 483.10. Claudette Box violates this requirement.

Residents have a basic right to be involved in the development, evaluation, and revision of their care plans. Id. This includes making choices regarding clothing, spending money, activities, treatment decisions, and advance directives. Even the cognitively challenged resident can and should be included in decision making, through a careful assessment of past choices and values, as well as ongoing assessment of comfort and response to care. When the resident is unable to direct his or her care planning process, the facility must look to the designated surrogate decision maker. The resident or surrogate decision maker's choices are to be respected and, if the resident refuses care, it is incumbent upon the staff to develop alternative

approaches that both meet the needs of the resident and are acceptable to the resident. Claudette Box fails to provide these services.

During our site visit, we observed that physicians and nurses do not routinely inform residents about the medication they are being given. Such education is required to afford the resident or the resident's surrogate the opportunity to provide consent to pharmacological treatment, including the use of psychotropic medication. Similarly, all of the residents we interviewed told us that they did not attend care conferences and were not invited to do so. Residents who are able should attend these conferences, and for cognitively impaired residents a surrogate decision maker should be included in this process.

The facility also does not have a policy that defines the role of the resident or their surrogate in the treatment planning process. A policy needs to describe the methods of providing for the choice and self-direction of residents with cognitive challenges, including requiring a comprehensive social history that addresses, from a historical perspective, the values and choices of the resident.

During our visit, we also identified deficiencies in Claudette Box's ability to ensure that its residents' wishes are accounted for in case of a medical crisis. The facility does have an advance directive consent form that addresses the resuscitative status of the resident. However, this form does not include treatment options such as tube feedings, intravenous therapy, hospitalization, dialysis, etc. As a result, the resident's choices in those areas are probably not clearly expressed. When a medical crisis develops, the facility provides treatment that may or not be consistent with the resident's wishes.

For example, we reviewed the records of two residents who demonstrated advanced dementia, significant nutritional compromise and life-threatening wounds. Both were described by the physician and nurses as having a limited life expectancy. Despite their condition, neither resident had a social work assessment of their needs and desires around end of life issues, including choices for hospitalization, and preference between invasive procedures and palliative care. When we shared with the facility director our observation that many residents are missing up to date advance directive information, he stated that he had

already identified this as a problem. He further reported that the social work staff had audited all charts and had compiled a list of residents who required a review of their advance directive.

We observed some treatment of residents that did not meet the level of dignity and respect required by 42 C.F.R. § 483.10. During our visits to the facility, staff were regularly observed pulling on the residents' arms in an attempt to physically direct them. This physical pressure was utilized instead of attempting eye contact and providing appropriate physical and verbal cues. We also observed staff, including supervisors, talking over residents or talking about residents in their presence as if they were not there. For example, residents were described as "hostile," "violent" or abusive in their presence. In addition to being an affront to resident dignity, this behavior can have profound consequences for a population that is already fragile and suffering from mental illness. It can cause frustration, fear and anxiety. This treatment appears to result at least in part from the failure of the facility to provide direct care staff with the kind of personnel information about residents that not only aids in their care, but can personalize the resident to the staff.

E. QUALITY ASSURANCE/IMPROVEMENT

It is standard practice in facilities like Claudette Box 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.

Claudette Box fails to conduct necessary quality assurance and improvement activities. This is apparent from its difficulties in most of the foregoing areas, especially medication management. In addition, because it lacks adequate systems, Claudette Box potentially subjects its residents to harms that could be prevented if such systems were in place.

For example, incident reports from the facility indicate numerous altercations between residents. The facility has not used the reports to identify factors that are associated with these altercations. Such factors include the time of day, the residents' physical needs and cognitive status, the degree of

supervision provided by staff, resident involvement in activity, and facility routines. By identifying the factors that lead to such altercations, the facility can better prevent their recurrence.

Similarly, Claudette Box fails to analyze falls appropriately. Our record review demonstrated that aside from generic approaches, the facility has not developed and implemented measures to prevent falls. This deficiency needs to be remedied directly by providing staff with practice guidelines and education to devise targeted individual interventions, and by devising a policy to describe the process of conducting a post-fall assessment and revising the care plan. We understand that the facility is in the process of implementing some preliminary components of a fall/injury prevention and management program. The facility must go further, however, and use quality improvement tools to prevent future falls. Resident falls should be evaluated to determine trends related to, *inter alia*, staffing patterns, resident characteristics, and environmental factors. The facility should then modify organizational practices (such as its policy for assessment, and method of maintaining and checking assistive devices and provision of activities) to account for this analysis.

These are but two examples of clinical outcomes that should be tracked and analyzed by Claudette Box. Others include psychotropic medication use, pressure sores, lack of activity, and skin tears. The results of these analyses should be used to prevent future harm to residents through further staff training, changes in policy, management and supervision, or any other appropriate improvement in patient care.

III. MINIMUM REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and federal statutory rights of Claudette Box residents, the facility should implement promptly, at a minimum, the following measures:

A. MEDICATION

Every Claudette Box resident should receive prescription medications only after first having been thoroughly evaluated/worked up and diagnosed according to generally accepted standards of care. All diagnoses should result in sufficient

documentation to withstand clinical scrutiny. Each medication should be clinically justified as an appropriate treatment for the diagnosed medical condition for which it is prescribed. More particularly, Claudette Box should:

1. 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 and that prescribed medication accounts for the unique features of the facility's elderly population. This includes:

    a. limiting the use of anticholernergic and antihistaminic medications to those residents who show a clear and documented clinical need for such treatment; and
    b. replacing typical anti-psychotics with atypical anti-psychotics when appropriate.

2. Ensure that all medications are prescribed at optimum therapeutic levels and that all use of multiple medications is clinically justified. This includes:

    a. preventing the administration of high doses of Ativan when lower doses would be sufficient;
    b. eliminating the use of unnecessary multiple anticonvulsants;
    c. discontinuing administering two types of anti-psychotics when one would be sufficient; and
    d. refraining from providing residents with subtherapeutic doses of anti-seizure medication.

3. 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.

4. Provide the medical staff at Claudette Box with additional exposure to, and training on, established medical guidelines for the treatment of elderly patients who require mental health treatment.

5. To aid in meeting these medication requirements, Claudette Box should employ a Board Certified Geriatric Psychiatrist to augment existing pyschiatric services by providing additional training, and participating in treatment review discussions.

6. Monitor all medications for efficacy, side effects and continued appropriateness; and modify medication usage as monitoring warrants. This includes:

   a. checking medication orders on a systematic basis to prevent medication errors such as the administration of discontinued medication;
   b. reviewing standing orders such as blood tests to ensure that they reflect current drug therapy regimens; and
   c. providing copies of all lab reports directly to the attending physician to prevent subtherapeutic levels of medications, and to make sure that the levels of medications in residents correlate to the dosage they are supposed to be receiving.

B. CLINICAL SERVICES

Claudette Box, to assist its residents in attaining or maintaining the highest practicable physical, mental and psychosocial well-being, should develop and implement appropriate polices and protocols to ensure that all residents receive adequate needs assessments and care plans, and that all such plans are properly implemented. More specifically it should:

1. Ensure that any device, procedure or medication that restricts, limits or directs a person's freedom of movement 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 requiring that device, procedure or medication. This includes:

   a. ensuring that siderails are only used as a restraint when necessary and when alternatives are not appropriate; and
   b. providing all residents for whom siderails are used as a restraint with an appropriate care plan to prevent injury.

2. Develop restorative care plans that are consistent with federal regulations. This includes:

   a. providing ongoing and systematic evaluation, at least quarterly, of all residents to determine their needs

for rehabilitation and restoration;

b. producing an appropriate 24-hour plan for each client based on this evaluation designed to promote his or her mobility, continence, self-care, and involvement in meaningful activity;
c. instituting clear policies and procedures governing the content of restorative plans;
d. ensuring staff accountability for those plans; and
e. requiring adequate evaluation of restorative care.

3. Develop psychosocial and activity services that are consistent with federal regulations. This includes:

a. constructing and implementing appropriate activity and psychosocial plans for each and every resident that account for all of his/her assessed needs;
b. ensuring that the social work department is capable of providing all needed services to residents;
c. involving social workers in assessing, formulating, and implementing appropriate therapeutic psychosocial plans that address the resident's need for self-direction, and the clinical needs of the resident, including mood alternations, pain, psychoactive use, weight loss and functional loss;
d. ensuring that social workers provide appropriate screening and counseling for depression;
e. conducting an evaluation of the resident's preferred daily routine, values, spiritual needs and resources as part of social work assessments and sharing this information with direct care staff;
f. providing additional training to, and supervision of, social worker staff to ensure that they can fulfill the functions described above;
g. furnishing all residents the opportunity to participate in a sufficient number of activities appropriate to their needs;
h. redesigning facility furniture and providing resident footwear to encourage mobility and activity;
i. employing the expertise of a therapeutic recreational expert to develop individual activity plans and collate those plans into a facility-wide activity plan that meets residents' diverse level of functioning;
j. educating staff on the need for and value of therapeutic activity, and their respective responsibilities in supporting residents' activity

plans; and

k. including nursing assistants in the planning, provision and evaluation of activities.

4. Appropriately assess and re-assess all residents for discharge to a less restrictive care environment. 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 accomodated.

5. Develop inter-disciplinary, clinical practice guidelines to address common clinical issues, and create facility policies and procedures that ensure compliance with and accountability for these guidelines.

6. Provide additional staff education in critical clinical areas and on gerontological issues.

C. DIETARY SERVICES

Claudette Box should ensure that it provides its residents with a nourishing, palatable, well-balanced diet that meets the needs of its residents. More particularly, Claudette Box should[1]:

1. Develop a comprehensive nutritional assessment for each resident, evaluate residents who rely on staff for feeding assistance to determine if they would benefit from the use of adaptive measures, and develop a policy and procedure that uses meals and feeding to promote activity and optimal functioning.

2. Devise protocols and provide training to staff regarding the prevention and management of dysphagia, dehydration, and constipation.

3. Revise the master cycle menu based on the Recommended Dietary Allowances for adults over the age of 65, create a diet manual that provides practical guidelines for the facility's geriatric population, and develop a meal

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[1] More detailed guidance regarding how to accomplish these measures can be found in our dietician consultant's report.

substitution protocol which ensures that residents receive substitutes of similar nutritive value.

4. Ensure that kitchen staff wear gloves, as appropriate, when handling foods, and that staff wash their hands during breaks between food handling duties.

5. Appropriately wait to serve food until the residents are seated and ready to eat and all food items should be appropriately dated prior to storage.

D. RESIDENT RIGHTS

Claudette Box should protect and promote the right of each resident to a dignified existence, and to self-determination. More specifically, Claudette Box should:

1. Institute a policy that provides an appropriate role for residents and their surrogates in the care and treatment planning process.

2. Educate residents and their surrogates about all prescribed medications.

3. Complete and maintain the process of ensuring that appropriate advance directives are in place for all residents. As part of this process, the facility should:

   a. provide adequate information to residents or their surrogates regarding advance directives;
   b. implement an advance directive tool that addresses the various treatment options to properly ensure that the residents have the ability to direct their own care should a medical crisis arise; and
   c. conduct internal monitoring to ensure that residents or surrogates are provided with all necessary education regarding end of life issues.

4. Institute a program of staff sensitivity training that reinforces and promotes the rights of residents to dignity and privacy.

5. Develop a policy that describes practices associated with supporting resident rights and dignity, and provides for quality assurance activity that self-monitors and corrects

deviation from policy.

E. QUALITY ASSURANCE/IMPROVEMENT

Incidents involving injury and unusual incidents should be used appropriately as a quality assurance tool. More particularly, Claudette Box should:

1. Use incident reports regarding altercations between residents as a tool to prevent further altercations.

2. Use data derived from post-fall assessments to analyze the factors contributing to falls/injuries, and continue to develop a fall/injury prevention program.

3. Track clinical outcomes, including infections, psychoactive use, use of chemical and physical restraint, pressure sores, skin tears and lack of involvement in activities, and analyze the meaning of these outcomes to prevent future harm to residents.

4. Ensure that the results of the analyses described above are transmitted to the relevant disciplines and direct-care areas for responsive action, and that 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.

* * *

We hope to work with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding Claudette Box.

We will be sending our consultants' evaluations of the facility under separate cover. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

In the unexpected event that we are unable to reach a

resolution regarding our concerns, we are obligated to advise you that, the Attorney General may institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. Section 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorney to discuss this matter in further detail.

Sincerely,

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