U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, DC 20530*

August 3, 2004

The Honorable George E. Pataki
Governor of New York
State Capitol
Albany, NY 12224

Re: CRIPA Investigation of A. Holly Patterson Geriatric Center in Uniondale, New York

Dear Governor Pataki:

On January 16, 2003, we notified you that we were initiating an investigation of conditions at the A. Holly Patterson Geriatric Center ("Patterson")[1] pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Patterson, Long Island's largest nursing home,[2] is owned and operated by the Nassau Health Care Corporation, a public benefit corporation, which is a state agency under New York law.[3] As part of our investigation, we conducted two tours of Patterson, one in May 2003 and another in November 2003. Accompanied by expert consultants in various disciplines, our first tour focused on the general care and treatment of residents, while our second tour examined the facility's discharge planning and community integration practices.

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[1] The facility is also known as "A. Holly Patterson Extended Care Facility."

[2] Patterson has an 889-bed capacity. At the time of our initial tour in May 2003, the census was approximately 670 residents.

[3] The corporation was created "for the benefit of the people of the state of New York and the county of Nassau [for] a state, county and public purpose [and for] the performance of an essential public and government function." N.Y. PUB. AUTH. § 3401(2)(McKinney 2004).

We conducted our on-site visits of Patterson with expert consultants in psychiatry, psychology, geriatric nursing, geriatric medicine, nutrition, social work, and medical administration. Our on-site investigation included reviewing medical and other records related to the care and treatment of individuals, as well as interviewing administrators, staff, and residents. Consistent with the requirements of CRIPA, we are now writing to inform you of our findings, along with the minimal actions that we believe are necessary to remedy the deficiencies we found.

Before outlining our findings, we wish to acknowledge and express our appreciation for the level of assistance provided to us by Patterson's administrators and staff, virtually all of whom appeared extremely receptive to the observations and recommendations articulated by our expert consultants at the conclusion of site visits. It was readily apparent to us that Patterson staff are dedicated individuals who are genuinely concerned for the well-being of the persons in their care. We also would like to thank specifically the facility's director, Larry Slatky, for his assistance throughout our investigation. We hope to work with the State of New York and the Patterson administration and staff in the same cooperative manner in the future.

I. INTRODUCTION

In undertaking any CRIPA investigation, our directive is to probe for the presence of a pattern or practice of "egregious or flagrant conditions which deprive [the facility's residents] of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm." 42 U.S.C. § 1997a(a). It is well-established under both the Constitution and federal law that residents of public nursing facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure not only their safety and freedom from unreasonable restraint, but also to prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Society for Good Will to Retarded Children Inc. v. Cuomo, 737 F.2d 1239 (2d Cir. 1984). Similar protections are accorded by federal statute. See Title XIX of the Social Security Act, 42 U.S.C. §§ 1396r, 1395hh; 42 C.F.R. Part 483 (Medicare and Medicaid Program Provisions). The State is also obligated to provide services in

the most integrated setting appropriate to individual residents' needs. See Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.

II. FINDINGS

Our investigation revealed a number of serious constitutional and federal statutory violations at Patterson. The deficiencies we discovered encompass: (i) mental health care; (ii) use of restraints; (iii) clinical care; (iv) nutritional services; (v) quality assurance and incident management; and (vi) discharge planning/community integration.

A. MENTAL HEALTH CARE

Patterson clearly does not provide its residents with adequate mental health care services and thereby exposes them to a significant risk of harm. In particular, Patterson consistently neglects to provide appropriate justification for use of psychotropic medications, frequently fails to monitor appropriately medication side effects and usefulness, and often exercises inadequate integrated treatment and coordination of care.

1. Unjustified Use of Psychotropic Medications

Federal regulations as well as generally accepted professional standards of care require that all uses of medications, especially those having potentially harmful side effects such as psychotropic medications, be clinically justified. See 42 C.F.R. § 483.25(l)(1); id. § 483.25(l)(2)(i) ("Based on a comprehensive assessment of a resident, the facility must ensure that . . . [r]esidents . . . are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record."). The need for clinical justification is particularly acute when drugs are used in combinations that increase the risk of harm, or when drugs are used that pose particular risks for the elderly. Federal regulations similarly require that residents be free from unnecessary or excessive antipsychotic medication. Id. § 483.25(l)(1).[4]

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[4] An unnecessary medication is any medication that is: excessive in dose; excessive in duration; without adequate monitoring or indication for use; used in the presence of adverse

Patterson fails to justify the use of psychotropic medications with an appropriate clinical diagnosis, as evidenced in the majority of files we reviewed. In several instances, the medications prescribed were entirely inappropriate for treating the assigned diagnosis. In other cases, medication was dispensed to address psychiatric problems without due consideration to the effect those medications have on a frail, elderly population. We set forth a number of illustrative examples below:

- H.C.[5] was assigned multiple psychiatric diagnoses, including schizophrenia, bipolar disorder, dementia with psychosis, and chronic anxiety. His symptoms included having psychotic thoughts, banging his fists and head repeatedly, screaming, and throwing objects at staff. His chart, however, failed to identify which disorders might be responsible for certain behaviors and which treatments might be appropriate. Despite this deficiency, his medication regimen included: two antipsychotics (divalproex and olanzapine) as well as haloperidol (prescribed for agitation) on an "as needed" basis; benzotropine and zolpidem (prescribed for sleep); and Aricept (prescribed as a starting dose for Alzheimer's disease). The use of two antipsychotic medications concurrently, and the long-term use of "as needed" antipsychotic medications, is contrary to generally accepted professional practice. Moreover, nowhere did his chart indicate that he had a sleep disorder or a diagnosis for Alzheimer's disease. The medication was, in any event, largely ineffective because H.C. continued to be disruptive. We found no notes in the resident's records indicating that the facility ever considered a psychological alternative approach with a behavioral management plan.

- J.P. was receiving Sertraline (an antidepressant, generic of Zoloft) and Reminyl (medication used to treat a form of dementia). His chart, however, did not contain historical and examination data or a diagnosis of depression or

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consequences; or without specific target symptoms. 42 C.F.R. § 483.25(l)(1). Residents must receive both gradual dose reductions and, unless contraindicated, behavioral interventions aimed at reducing medication use. Id. § 483.25(l)(2)(ii).

[5] To protect residents' identities, we use pseudonyms throughout this letter.

dementia to justify such medication. The chart also failed to include an assessment for the potential Reminyl side effects - urinary and bowel incontinence - that J.P. did, in fact, experience.

- M.G., a resident with a history of drug abuse and depression with suicidal ideation, was receiving a long-acting benzodiazapine without any documentation justifying its use or assessment for reducing the dosage.

We express our particular concern for Patterson's unjustified use of benzodiazapines, as noted in the above example. There are federally mandated restrictions regarding the use of drugs such as benzodiazapines in long-term facilities because of the serious side effects. See id. § 483.25(l). High doses of benzodiazapines are well-known to have a high potential for addiction, and their use is required to be closely regulated. Such medications often precipitate increased risk for falls, and worsen memory functioning among residents with dementia. Clonazapam, a benzodiazapine, is of particular concern because it leads to accumulation of medication and places residents at an even greater risk for sedation, falls, and diminished memory. Ten percent of residents at Patterson receive Clonazapam, 30 percent of whom are 65-years-old or older. But in the records we reviewed, the psychiatric notes failed to reflect consideration of whether use of such benzodiazapine is necessary.

We also found a number of residents who had been diagnosed with some psychiatric disorder, but who had been prescribed inappropriate medications for such a diagnosis. For example:

- K.D., a resident diagnosed with dementia due to alcoholism, was prescribed a regular administration of Lorazepam, a benzodiazapine used for anxiety disorders. It is widely known by professionals, however, that the regular administration of Lorazepam is habit-forming and that Lorazepam is detrimental for patients with a history of severe alcohol abuse. K.D. was also receiving olanzapine, an antipsychotic. Yet we found no chart evidence that he has a psychiatric diagnosis justifying the use of this medication, which can have very serious side effects.

- E.N., an 80-year-old female with dementia was receiving Risperdal (an antipsychotic) and Zoloft (an antidepressant) without evidence of any identified targeted symptoms to justify such use.

- S.O., diagnosed with chronic schizophrenia, was receiving ongoing divalproex treatment (used to treat bipolar mood disorder), which most likely caused her multiple bruises and skin discolorations. We found no psychiatric notes in the resident's records indicating why this medication was necessary. We also found no explanation of why this 78-year-old resident was receiving the long-acting benzodiazapine, Clonazapam (an antidepressant). Nor did we find any assessment of the efficacy of these medications or explanation of why tapering had not been considered.

2. Inadequate Side Effect Monitoring

Generally accepted professional standards of care further dictate that, for drugs having therapeutic ranges (i.e., below which the drug is ineffective or above which it is potentially toxic), monitoring be conducted so as to ensure that the drug is helping, not harming, the resident. Consideration also must be given to whether the continued use or dosage of the prescribed drugs remains appropriate. Nowhere is this more true than with psychotropic drugs because of the physically debilitating conditions they can cause. Based on our investigation, Patterson substantially violates these mandates.

As an initial matter, we observed that psychiatrists often fail to follow-up with residents regarding medication that has been prescribed. And even when such follow-up does occur, it is seriously delayed. Forty-six percent of the notes generated to the doctors from October 2002 to February 2003 by the Pharmacy Consultant were because a psychiatric evaluation for medications was due or overdue.[6] Long intervals between psychiatric assessments of the propriety, efficacy, and dosage of prescribed medications can result in potentially unnecessary and harmful side effects, medication errors, resident use of clinically contraindicated medications, and unnecessary drug use. In addition, this practice deprives residents of continuity of care in their treatment.

Compounding the psychiatrists' failure to monitor medication appropriately, is the Pharmacy Consultant's failure to monitor each resident's drug regimen at least monthly as required by federal regulations. See id. § 483.60(c)(1). Facility staff,

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[6] Although Patterson does not have an in-house pharmacy that provides residents with all medications, it is required by regulation to have a licensed pharmacist review resident medication on a monthly basis. 42 C.F.R. § 483.60.

however, were largely unaware of such requirements. The Pharmacy Consultant, for example, stated he did not know that the charts for residents receiving antidepressants or benzodiazapine medications must be reviewed at regular intervals so that medication reductions can be attempted or justification given for not ordering such a reduction.

Disturbingly, the Pharmacy Consultant revealed that the decision whether or not to recommend dose reductions for most medications was inconsistent and often based only on random discussions with nursing staff. Nurses similarly reported that Patterson does not routinely evaluate for dose reductions. It therefore came as no surprise when we found that many residents do not receive the required dose reductions or review. Consider the following examples:

- R.B. has a long-standing history of bipolar disorder and is chronically manic. He has a psychotropic regimen of Depakote, Klonopin, and olanzapine. His chart suggested that he might have been suffering from serious metabolic and other side effects resulting in obesity, hyperlipidemia (the presence of an excess of fat or lipids in the blood), and non-insulin-dependent diabetes mellitus (a known side effect of olanzapine treatment). This resident faced the risk of cardiovascular disease. Yet we found no notes in his chart assessing these side effects or appropriately considering alternative medication treatment options.

- J.P. developed urinary and bowel incontinence a week after initiation of Reminyl, a medication used to treat the dementia of Alzheimer's disease. Reminyl is known to cause such side effects. However, we found no record of follow-up monitoring visits or an awareness that the side effects may have been caused by his medication. Also, J.P.'s medication was prescribed at an ineffective dosage, 4 mg. twice a day, when generally accepted professional standards provide more than 16 mg. per day for effectiveness in dementia. We found no documentation justifying the low dosage.

- L.C. returned from hospitalization with a note that he was lethargic and hypotensive (low blood pressure). Despite the possibility that his condition may have been caused by his olanzapine treatment, his dosage was increased to treat increased hostility. We found no documented consideration of the risks involved in increasing his dosage.

- M.S., a 92-year-old with dementia was also receiving Risperdal (an antipsychotic) for an undefined symptom. This resident had not been evaluated by psychiatry for over six months and had a history of falls. Not only was Risperdal's potential for causing falls as a side effect not evaluated, but full siderails were implemented for this resident, which limited her mobility and placed her at high risk for functional decline.

We also found that nurses fail to monitor routinely residents for side effects or important target symptoms. Medical records generally lack notes regarding the monitoring of possible side effects. In fact, when interviewed, nursing staff indicated that they were often unaware of residents' psychiatric diagnoses and anticipated side effects of psychotropic medication. This is not altogether unsurprising given that Patterson's nursing staff and aides receive little or no training with respect to major psychiatric diagnoses, associated symptoms, or the common side effects caused by psychotropic medications.

Failure to consider potential side effects and alternative medication treatment options (should such problems develop), and to monitor adequately for side effects could place residents at serious risk of developing a whole host of illnesses including cardiovascular disease, diabetes, obesity, respiratory infection, abdominal pain, and convulsions, to name a few.

3. Lack of Integrated Treatment and Coordinated Care Across Medical Disciplines

Another deficiency in Patterson's mental health care is the absence of a coordinated care approach, a problem that is most apparent in psychiatry. In contravention of generally accepted professional practice, residents are not treated consistently by the same psychiatrist; they are instead seen by more than one of the psychiatrists on staff. Generally accepted professional standards of care require ongoing communication between psychiatry and the other health care disciplines to ensure that there is a coordinated, integrated treatment team. Patterson substantially deviates from this standard. Psychiatrists rarely attend the monthly care management meetings, and there is no procedure in place requiring them to review or respond to the care management meeting notes.[7] The psychiatrists' notes also

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[7] We learned prior to our tour in November that one full-time psychiatrist had begun meeting weekly with other mental

fail to refer to the psychologists' consultation notes regarding the residents' psychological well-being. To complete this unfortunate cycle, the two full-time psychologists rarely address issues raised in the psychiatrists' notes. As a result, the psychologists' notes do not indicate residents' major psychiatric diagnoses or describe how residents' diagnoses may be impacting their behavior on the unit. This lack of communication and continuity of care renders residents vulnerable to serious harm.

We observed two residents in particular who remained in chronically psychotic states. Not only did Patterson fail to develop comprehensive assessments of these residents' complicated psychiatric conditions, but the facility never developed or implemented an integrated treatment plan designed to provide these residents with the opportunity of obtaining significant relief.

D.S., for example, who was diagnosed with HIV and bipolar disorder, has seizures, demonstrates grandiose delusions, and exhibits belligerent behavior. He required two hospitalizations for treatment of his seizures, and is at risk for more in light of his refusal to take his anti-seizure medication. Yet we found limited psychiatric notes in his chart addressing these problems or the possible alternatives to medication to treat his severe, active psychiatric disorder (e.g., improving his mood disorder might result in his acceptance of appropriate treatment for his HIV and seizure disorder). The facility's treatment of his psychiatric condition was essentially one of tolerating his psychosis.

R.B., meanwhile, has had a long-standing history of bipolar disorder and has demonstrated pressured speech, mood fluctuations, grandiose ideations, and was in a chronically manic state. In addition, he was highly distressed due to medical conditions he was experiencing, including diabetes, which was likely caused by psychotropic medications. Despite these significant psychiatric problems, by mid-2003, R.B. had been seen only once by a psychiatrist that year, as evidenced by the single psychiatric note in his record. There was also no documentation in his chart reflecting that the psychiatrist had reviewed his case or that various treatment options had been considered to

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health staff. This clearly is an improvement and should be commended. But much more remains to be done to integrate the mental health disciplines.

address symptoms resulting from his bipolar disorder. Nor was there documentation that a new treatment plan had been considered.

The poor communication between the psychiatrists and psychologists on staff can have serious consequences. Indeed, residents who demonstrate severe behavioral difficulties due to disorders such as schizophrenia or dementia receive intensive psycho-pharmacological treatment from the psychiatrist, but are deprived of the potential benefits that result from psychological behavioral intervention. For instance, residents housed in Units 44 and 46, which are designated for residents with behavioral disturbances, are treated with multiple psychiatric medications. However, they receive limited psychological treatment of their behavior, thus depriving them of a more comprehensive, and perhaps less intrusive, intervention. Similarly, although E.R.'s psychotherapist noted that E.R. was experiencing distressing auditory hallucinations that "bad things" will happen, there was no indication in the chart of psychiatric follow-up or psychiatrist-psychologist coordination regarding treatment. Such coordination should be critical considering the potential that E.R.'s hallucinations could result in harmful behavior.

We also found a lack of communication between the mental health and other health disciplines. There were repeated instances in which neurological consultation notes indicated that a resident was suffering neurological side effects from psychiatric medications. Yet, there was no evidence from the psychiatric notes of any awareness of these observations. For example, a neurologist noted that G.M. was suffering from ongoing dizziness, possibly due to her olanzapine treatment, and that she was unable to eat or walk steadily. Her chart reflected no monitoring of these side effects, and the psychiatric notes failed to acknowledge the neurologist's notes.

4. Poor Maintenance of Mental Health Documentation

Clinical records must be complete, accurately documented, readily accessible, and systematically organized. Id. § 483.75(l). The records must also be sufficiently detailed to ensure the safe and coordinated provision of care. Patterson falls far short of the mark in this area.

Patterson consistently fails to maintain organized mental health notes in residents' charts. Resident files were unorganized and did not reflect any particular system of order. Many charts we reviewed had loose papers placed in the front of the chart in no particular order. In addition, the charts we

reviewed of residents with psychiatric issues often were completely missing the mental health notes. When the mental health notes were included, we found that they often were not in chronological sequence, making it difficult to chart residents' medical status. Given the serious mental illnesses suffered by many of Patterson's residents, it is essential that the mental health care providers maintain documentation sufficient to explain clinical decisions. The documentation is particularly critical at Patterson in light of the fact that residents are not assigned a particular psychiatrist, and the psychiatrists on staff do not communicate routinely with one another.

B. USE OF RESTRAINTS

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 resident's medical symptoms." Id. § 483.13(a). Moreover, generally accepted professional practices dictate that restraints may only be used when it is clinically justified. Such justifications include situations where restraint is necessary: (i) to facilitate the provision of medical care; (ii) to control a resident's unanticipated violent or aggressive behavior that places either the resident or others in imminent danger; or (iii) as a last resort to provide safety when all other less restrictive methods have been attempted and failed.

We observed a significant number of residents with restraints whose medical charts in no way justified their use. Improper use of restraints can have disastrous consequences, including loss of function, depression, falls and injuries, loss of dignity, weight loss, pressure sores, serious injury, and even death. If it is to adhere to well-established professional practices, Patterson must conduct assessments of residents' fall risk factors and develop individualized care plans as alternatives to restraints. The facility also should continually reassess its use of restraints and attempt to eliminate or reduce them where appropriate. Finally, residents should be educated about the potential adverse effects of restraints, and given the opportunity to provide their informed consent before restraints are implemented. See id. §§ 483.10(b)(4), 483.20(k)(2).

1. Physical Restraints

Physical restraints include bed siderails, chair lap cushions or lap trays that the resident cannot remove, and vail

beds.[8] Patterson fails to use such physical (or mechanical) devices in a manner that protects residents' health and safety and properly re-evaluates and plans for reduction. Patterson also neglects to provide sufficient alternatives - e.g., low beds and adapted furniture - and thus resorts to restraints that are less appropriate and less effective. And the facility seems to employ restraints in lieu of consistent provision of restorative care, such as regular toileting, exercise, and meaningful activities.

We assessed a significant number of residents who were physically restrained, including 21 in full- or half-bed siderails, four with lap buddies,[9] three in vail beds, and four in geri-chairs with trays. None of the records we reviewed had a signed consent form for the use of these restraints. This is a substantial departure from generally accepted professional standards.

During the four hours we observed the residents restrained in lap buddies and lap trays, the residents were not released — even to use the toilet — nor were they assisted to exercise. None of the residents we reviewed had a care plan that addressed the stated reason for the restraint. Many of the restrained residents did not have restorative care plans designed to prevent functional decline that may result from the use of the restraints. For the residents we reviewed, there was also no evidence that the facility had re-evaluated the continued restraint use with attempts to eliminate use. Many residents in restraints were described to us by the staff, or noted in medical charts, as requiring restraints to prevent sliding out of their chairs or falls. The facility imposed these restraints without evaluating or demonstrating whether restorative treatment or environmental manipulation could address these occurrences more, or at least as, effectively. This practice is a substantial departure from generally accepted professional practices.

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[8] A vail bed is a bed enclosure system, which incorporates a vinyl, netting design to completely enclose the bed frame and mattress, utilized to prevent residents from exiting the bed independently.

[9] Lap buddies are soft cushions secured in the arms of the wheelchair that prevent residents from moving forward and from rising.

As noted, we observed a number of residents restrained with siderails (both full- and half-bed siderails), whose care plans did not include a physician's order justifying such restraint use. W.B., for example, was provided four half siderails in response to a fall. Soon thereafter, he demonstrated impaired cognition, decreased physical strength, and lethargy. Although the average layperson might think siderails prevent falls, the truth is just the opposite. Indeed, the use of siderails to prevent falls is generally contraindicated in circumstances like that of W.B. Not only are siderails generally deemed ineffective in such situations, but they actually pose a risk of serious injury by limiting a patient's mobility. What happens is that weak and impaired residents who are provided siderails as a restraint become vulnerable to entrapment between the rail and mattress or head and footboards, asphyxiation by having their head or neck caught between the rails and mattress or head and footboards, and soft tissue injury and fractures from attempting to go over, around, or through the rails. Such residents can also suffer other well-documented complications from restraint use such as loss of function, depression, skin breakdown, and malnutrition.

Our own observation of residents during tours highlights the safety issues posed by the use of restraints. For example, we noticed J.R. attempt to climb over the rails by swinging both legs over the siderails. A fall from several feet to the floor could have greatly injured him. Similarly, we observed L.H. in her bed with her head dangerously close to the gap between the siderail and the mattress, placing her at high risk for asphyxiation.

Because of the potential dangers in using these restraints, the facility must develop a care plan that: (i) provides the clinical justification for use of a restraint; (ii) is designed to prevent injury; and (iii) requires periodic re-evaluation of siderail use. Residents should also be assessed to determine the specific risk factors that predispose the resident for nighttime and bed-related falls or injuries. The care plan should provide for a safer alternative to siderails if medically appropriate. Options might include a low bed, mats beside the bed, use of an alarm, a toileting plan, increased supervision, analgesia, or a combination of these alternatives. Finally, restraint reduction activities should involve an interdisciplinary team, and keep both the resident and family members fully informed of the restraint plan at all times.

2. Chemical Restraints

Patterson utilizes chemical restraints – e.g., mood inhibitors and antipsychotics – for residents who present common behavioral problems associated with memory loss, such as wandering, refusing care, and yelling. The facility, however, often employs such restraints without providing adequate clinical justification and without trying less intrusive alternatives – e.g., psychosocial intervention, environmental manipulations, and activities – to address behavioral issues. This practice amounts to an excessive use of chemical restraints for the purpose of addressing anti-social behavior, which is a substantial departure from generally accepted professional standards.

We found many examples of Patterson's failure to justify clinically the use of antipsychotics. For instance, D.E., a 77-year-old resident, was assessed as irritable and combative, and he presented severe management problems. His record contained no psychiatric diagnosis, just a description of his behavior. Yet despite the absence of a psychiatric diagnosis, D.E. was receiving an unusual treatment of two different antipsychotic medications, risperidone (occasionally referred to as Risperal, it is used to treat schizophrenia and psychotic disorders) and olanzapine (used to treat Alzheimer's disease and agitation).

Similarly, as discussed earlier, K.D. suffered from dementia due to alcoholism, and his chart reflected a single psychiatric disturbance when he eloped off the grounds in his wheelchair. After his elopement, his chart reflected he had "aggressive behavior," and he was prescribed olanzapine. Not only was this diagnosis inappropriate based on the information in his medical charts, but the administration of olanzapine was improper for an episodic event or generic behavioral issues, absent some additional documented clinical justification.

C. CLINICAL CARE

Nursing facilities like Patterson are required to provide appropriate clinical assessment and care planning to prevent physical and psychological harm, and must also offer medical, nursing, and related services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being . . . " of each resident. 42 U.S.C. § 1395i-3(b)(2); 42 C.F.R. § 483.25.

Before detailing the deficiencies we observed, we note that, based on our assessment, Patterson has adequate preventive skin care and management of pressure sores and treatment of wounds, all of which are serious issues for nursing home care. See id. § 483.25(c). Consistent with generally accepted professional standards of care, Patterson evaluates residents' risk for pressure sores upon admission and on at least a quarterly basis thereafter. The facility develops and implements plans to address the risk and to prevent any pressure sore development. For residents with wounds, the facility provides pressure-relieving devices and wound treatments as ordered by the physician. These practices are consistent with the regulations and professional practice. Nevertheless, our investigation revealed that Patterson fails to provide its residents with adequate care in the areas of assessment, implementation of care plans, restorative care, and psychosocial treatment and activity services.

1. Failure to Assess Adequately Residents' Needs

The care plans at Patterson often are not individualized to residents' needs, thereby reducing their effectiveness significantly. To provide adequate care, facilities must assess individual residents' needs and preferences, develop comprehensive care plans based on this assessment, and accurately implement the care plans. See id. § 483.20. The assessment process must include consideration of the residents' physical condition, emotional status, and "functional status," which measures the residents' ability to conduct the activities of daily living. Id. Residents also must be assessed on an ongoing basis for changes in health and functioning. Id.

Furthermore, federal regulations recognize the critical importance that activities and mental stimulation play in maintaining good psychological health among nursing home residents. See id. § 483.15(f)(1). Accordingly, residents' cognition, mood, and physical challenges should be integrated into the assessment process to determine the need for modifications in equipment, environment, or program design. Activity plans should describe therapeutic approaches, including adaptation for hearing loss, vision loss, cognitive loss, and physical challenges.

These activity plans and the overall assessment of which they are a part, promote an established and healthy routine for residents. They also form the basis of a "care plan" that serves as a blueprint for meeting residents' needs. Critical to

these care plans is the involvement of interdisciplinary teams, which must collaborate and develop measurable goals for evaluating residents' progress.

The failure to conduct adequate needs assessments or to address properly identified needs through the care plan can have profound negative consequences for nursing home residents. For example, a significant and well-established 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 (abnormal, often permanent, shortening of tissue resulting in deformity), incontinence, and a general lack of involvement in meaningful activity are among the common manifestations of this threat. These functional losses are also correlated with medical complications such as pressure sores, falls, and psychological impairment (including depression and cognitive loss). Such harm to residents is frequently preventable with proper assessment and care.

In our review of Patterson's provision of clinical services, we found serious deficiencies in assessments, as well as in the areas of care plan development and implementation. The assessments and care plans we reviewed were generic in content and failed to provide individualized approaches for chemical restraint use, wandering, weight loss, loss of function, fall or injury risk, and anxiety or depression. We also found cases in which Patterson completely failed to develop any care plans for residents who presented clinical issues that warranted activity and social work intervention.

Of equal concern to us, we observed that members of the interdisciplinary team generally do not collaborate in the development or implementation of resident assessments and care plans. This is particularly true in the case of social workers. These practices do not meet generally accepted professional standards of care. Some specific examples include:

- M.J. did not leave her room and remained bed-bound and socially isolated for approximately six months. During this time, she suffered severe lower extremity contractures. Her records, however, did not contain a care plan that addressed the associated risks for her conditions of dysphoria or depression, sensory deprivation, and altered cognition.

- W.B. was diagnosed with Senile Dementia, Alzheimer's Type, and seizure disorder. After suffering a fall, he experienced a significant change in status and became lethargic. The facility did not assess or develop a

modified care plan based on that change. Nor did the facility monitor W.B.'s vital signs on an ongoing basis or reassess the continued use of multiple psychotropics that cause sedation. (Continuing to administer sedating medications to a resident who is already sedated places him at risk for aspiration and neurological changes.) After our expert consultant identified W.B.'s declining condition, the facility transferred W.B. to another unit for intravenous hydration as he had not had any significant oral intake for 18 hours.

- E.N. was described in her care plan as "refusing care" (e.g., walking). However, her plan failed to assess E.N.'s reason for refusing to walk (e.g., pain or fear). As a result, she was wheelchair bound. In addition, E.N.'s care plan failed to address her ongoing anxiety and did not include approaches to improving her understanding of situations to reduce her anxiety. We found documented episodes of emotional distress.

- S.O. was diagnosed with schizophrenia and dementia, refused to wear shoes, demonstrated an ulceration of her lower extremity, and experienced a ten-pound weight loss over six months. We found no assessment of the effectiveness of her psychoactive medications, and no psychosocial assessment of her refusal to wear shoes or her weight loss. No interventions were developed.

We further observed that Patterson appears to disregard the rights of residents to participate in decisions regarding their psychiatric treatment and living conditions, despite documentation of capacity. As federal regulations make clear, nursing home facilities should ensure residents' involvement in the development, evaluation, and revision of their care plans. See id. § 483.10. Even cognitively challenged residents 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 a resident is unable to direct his or her care planning process, the facility must look to the designated surrogate decision maker.

Consider the case of R.B.: R.B. informed us of his concern regarding his recent development of diabetes, and he expressed fear regarding the possible complications. He also suffered from a tremor, another possible side effect from the antipsychotic, olanzapine. R.B. was unaware that the olanzapine may have contributed to or caused his conditions. Meanwhile, we found no record of any conversation – and R.B. insists no such discussion

ever took place – in which facility staff provided him with sufficient information about the potential benefits and risks involved in his medications. This resident clearly had the capacity to make health care decisions. Thus, the regulations required that R.B. be included in decision making regarding his psychiatric treatment.

2. Inadequate Implementation of Care Plans

We also identified deficiencies in Patterson's implementation of the developed care plans. A significant sample of the residents whose care plans we examined were not receiving the care described in their plans. For example:

- We observed residents who were not positioned properly in their beds and wheelchairs, predisposing them to aspiration or choking, falls, pain, injury, and contractures. Likewise, we observed potentially harmful conditions for a number of residents slumped over in wheelchairs, including residents in the respiratory unit.

- L.D. was not provided with supervision or the use of a smoking apron per his care plan, placing him at risk for injury. We observed this resident with a lit cigarette in his hand as he was falling asleep in his wheelchair.

- Numerous residents did not receive assistance with toileting care and hygienic care as provided in their care plans or as necessitated, leaving them wheelchair- or bed-bound or unnecessarily restrained, and greatly impacting their rehabilitation potential.

- Several residents did not have physician's orders in their care plans warranting the use of full bed siderails as restraining devices, yet we observed the use of such devices on these residents. As noted above, the use of such devices increases risk of harm.

- Some bed-bound residents did not have their call bells within reach per their care plans or as necessitated in emergency situations, increasing the likelihood of falls or other injuries.

3. Inadequate Restorative Care

Another problem we observed was Patterson's frequent failure to implement adequate restorative care to its residents who have sustained loss of function and/or are clearly at risk for further

loss of function. Nursing facilities must maximize residents' mobility, range of motion, and function. See id. § 483.25(e). To meet this standard, the facility must devise restorative care plans that cover areas designed to maintain function, prevent avoidable loss of function, and improve health, function, and sense of well-being. Restorative approaches include promoting continence, self-care, self-expression, and involvement in activities.

In the records we reviewed, we found many residents who were incontinent, relied on wheelchairs for mobility, or who were dependent in other areas of daily living, but did not have restorative care plans in place. These residents, however, demonstrated the ability to receive exercise, to use a toilet with assistance, and assist with their oral care and bathing.

The staff's ability to promote restorative care is hampered by the absence of a policy that facilitates consistent, ongoing assessment of rehabilitative and restorative needs. The generally accepted professional practice in nursing homes is to assess residents for these needs on a quarterly basis, as well as when staff detects a change in function or a physical/cognitive loss. Patterson has not developed or implemented clear operating procedures describing the content, accountability, and evaluation of restorative care, including toileting, range of motion, therapeutic activity, and promotion of self-care with meals and personal care.

In addition, there are deficiencies in the implementation of resident restorative plans for those who have such plans. During our visit, none of the nursing assistants we interviewed was aware of the residents' restorative care plans. We reviewed residential restorative care plans regarding plans to restore or maintain continence, mobility, or self-care. We also reviewed residents whose records demonstrated some degree of joint contracture, a complication arising from the absence of range of motion exercise. Although their care plans required "passive range of motion,"[10] residents and the assigned nursing assistants stated that these plans were not being implemented to address these debilitating conditions. No reason for this failure was provided.

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[10] "Passive range of motion" indicates that the care giver provides the range of motion for the resident, instead of the resident doing it independently, which is called "active range of motion."

Nursing facilities like Patterson must provide a "safe, clean, comfortable and homelike environment." Id. § 483.15(h)(1). The physical environment of Patterson is "institutionalized" and further exacerbates a lack of restorative care. Smoke odor, non-personalized living space, lack of comfortable and functional furniture, lack of positioning and assistive devices, and lack of designated functional living spaces have created an environment that fails to promote the physical and emotional comfort of the residents.

For instance, we observed on numerous occasions that residents had to remain in their wheelchairs and geri-chairs[11] during mealtimes and activities due to an insufficient number of chairs, thereby placing the residents at avoidable risk for pressure sores, joint contractures, and loss of strength and comfort. A lack of transferring from wheelchairs to standard chairs also leads to decreased strength and immobility. Similarly, a lack of appropriate positioning devices may lead to dangerous medical conditions, such as asphyxiation. The shortage of furniture, such as functional tables, sturdy chairs, or pillows, also discourages resident involvement in activity.

We also observed many residents walking about the facility, without shoes. Such practices are a concern not only for resident dignity, but because they predispose residents to foot-drop,[12] impaired mobility, falls, and injuries.

4. Inadequate Therapeutic Treatment and Activity Services

Finally, Patterson fails to provide its residents with therapeutic activities that are sufficient in number or diversity to address the residents' needs. See id. § 483.15(f)(1). Nursing home residents should receive regularly scheduled therapeutic activity as required. Id. Residents must be permitted to choose activities consistent with their interests, assessments, and care plans. Id. § 483.15(b)(1).

Patterson generally does not implement care plans that address residents' needs for meaningful activities and mental stimulation. In observing activities, reviewing charts, and

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[11] Geri-chairs are reclining chairs on wheels with trays that prevent forward movement and rising.

[12] "Foot drop" is a painful, deforming condition in which the foot ends up permanently extended forward.

interviewing staff and residents, we found that the facility fails to accommodate its residents with specific physical problems such as memory loss, physical weakness, vision loss, and hearing loss. For example, there appear to be no particular activities for residents with Alzheimer's disease. Overall, the activity plans for residents were generic. In a significant sample of records reviewed, the stated recreational goal is for the resident to attend three activities a week. Yet the plans failed to elaborate on appropriate activities, describe pursuits that should be encouraged, or provide goals.

During our entire initial tour in May 2003, there were no activities provided on the supervised units serving residents with cognitive loss. Most of these residents are on psychoactive drugs for anxiety, depression, and behavioral disturbances; therapeutic activity plans are therefore essential.

The majority of residents we observed on the other units were also not involved in any activities during our initial tour. We observed on numerous occasions and at various times throughout each day, residents seated in their wheelchairs or lined up outside their rooms, without any interaction or activity for substantial periods of time. No exercise was provided to residents who could not follow directions, and activities were rarely planned in the evening hours. Residents stated that they were "bored" and were not provided with sufficient activities. Staff members were not able to describe which residents could attend activities on each unit, nor did they know the residents' preferences.

D. NUTRITIONAL SERVICES

Turning to nutritional services, it is beyond cavil that nursing home residents are at high risk for dehydration and malnutrition. It is thus critical that residents are provided adequate nutritional services and that such services are administered in a safe manner. Yet we found that Patterson substantially departs from generally accepted professional practices in these areas as set forth below.

1. Unsafe Administration of Feeding Tubes

Standard practice provides that residents who are fed by naso-gastric tubes must be closely monitored and assessed in order to prevent complications including aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Treatment should be aimed at restoring, if possible, normal eating skills. Id. § 483.25(g). Patterson

fails to meet this treatment standard. For example, during our tour, we observed numerous residents who were not properly elevated in their beds while receiving tube feedings. These residents were thus exposed to a high risk of aspiration into the lungs, a potentially life threatening problem.

2. Inadequate Assessment and Monitoring of Nutritional Status

Federal regulations require institutions like Patterson to develop comprehensive care plans for each resident that include measurable objectives and timetables to meet residents' identified medical, nursing, mental health, and psychosocial needs. See id. § 483.20(k)(1). Nutritional and hydration needs are critical components of the care plan. Id. §§ 483.25(i), (j). Our review revealed, however, that care plans at Patterson are rarely interdisciplinary and typically do not contain measurable goals. Where goals are identified, they are generally non-measurable and mostly subjective.

We also found that staff at the facility fail to follow physicians' orders regarding resident nutrition. For example, B.P.'s chart contained physician's orders specifying that she be fed thickened liquids without a straw. Nonetheless, we observed a nurse intending to feed B.P. thin liquids with a straw. We also learned that B.P. regularly drinks water (thin liquids) from the water fountain. The failure to follow physician's orders in such circumstances could result in choking and aspiration (taking fluid into the lungs), and even death.

Patterson is also deficient in its tracking of residents' nutritional status. While Patterson does monitor residents' weight changes, the facility has no clear guidelines for recording weights or sharing such information with the interdisciplinary care team. Most of the charts we reviewed, in fact, did not indicate the specific date on which a resident was weighed. Without knowing exactly when a particular weight loss or gain occurred, there is no way to ensure a timely interdisciplinary response to the weight change.

According to generally accepted professional standards, a weight loss or gain of five percent or more over 30 days, or a ten percent change over 180 days indicates a "significant" weight change. During our tour, we identified several residents who had "significant" weight changes that were not appropriately assessed or addressed in a timely manner. For example:

- R.S. lost 12 pounds (an eight percent weight loss) in what appeared from the chart to be approximately one week. We found no indication in his chart that the interdisciplinary care team had either assessed this significant weight loss, or attempted to address it.

- W.B. lost 19 pounds in approximately one month (a 14 percent weight loss). While the weight loss was noted in his chart, the interdisciplinary care team failed to respond.

- K.C. lost approximately 12 pounds in approximately one month. Despite this significant weight loss, her chart reflected a restricted diet of low fat and low sodium puree. Her chart also contained a physician's order for Ensure pudding (which contains high fat and sodium) that appears to have been ordered after her weight loss. But not surprisingly, staff confusion meant K.C. continued to receive both diets.

- T.W., a resident with pulmonary hypertension and cellulitis, gained 47 pounds in approximately one month. While the weight increase was noted, chart notes stated only that the weight gain was likely the result of the resident's non-compliance with his diet. There was no referral to the physician or an assessment of how to address such a significant weight gain.

3. Inadequate Hydration System

The provision of sufficient fluids to maintain residents' proper hydration and health is an obvious necessity at any geriatric facility. See id. § 483.25(j). Dehydration is a serious concern for the elderly and can result in the development of urinary tract infections, bowel obstructions, delirium, cardiovascular symptoms, functional impairments, renal disease, and even death. Unfortunately, Patterson appears to have no system in place to safeguard against such potential eventualities. Nor does the facility identify appropriately those residents with risk factors for fluid deficiency or dehydration.

4. Unsupportive Meal Services

Federal regulations and professional standards require nursing homes to serve food to residents in a manner that

preserves their dignity and quality of life while ensuring their safety. See id. § 483.15. We observed breakfast, lunch, and dinner services that were illustrative of harmful practices.

As noted in the section on restorative care above, many residents were poorly positioned in wheelchairs, preventing sufficient access to the table and increasing the likelihood of choking or aspiration pneumonia. We also noted that most units serving food did not have suction machines readily available to assist residents who may choke while eating.

We noticed many residents with physical weaknesses wearing bibs and being hand-fed by staff who were standing over them. Yet if the facility would have provided assistive devices, such as plate guards and built-up utensils, many of these individuals could have fed themselves. Similarly, if the facility had considered alternative meal items such as finger foods, many of the residents with certain cognitive losses could have fed themselves and enhanced their independence as well.

E. INADEQUATE QUALITY ASSURANCE AND INCIDENT MANAGEMENT

Another problem we identified was Patterson's quality assurance program. It is customary for such programs to: (i) collect data relating to the quality of services; (ii) assess that data for trends; (iii) initiate inquiries regarding problematic trends and identify corrective action; and (iv) monitor to ensure that appropriate remedies are achieved.[13] See id. § 483.75(o).

While the facility documents a variety of incidents, including falls with no injury, resident altercations, and serious injuries, there is no system for analyzing this data, identifying areas for priority action, or developing and implementing remedial measures. Moreover, medical, nursing, and

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[13] We understand that Patterson plans to implement some nursing quality improvement initiatives, including: improved monitoring and assessment for dysphagia; improved risk assessment for pressure sores and implementation of preventive plans; improved identification of wounds at an early stage; and reduction of physical restraint use. In addition, the facility has recently developed a system to identify residents who have the potential to be victimized, as well as those who have the potential to harm others. The effectiveness of this recent system, however, has not yet been tested.

therapeutic activity staff overall fail to conduct ongoing reviews of compliance with facility policy, regulations, or generally accepted professional practice guidelines.

In the area of fall analysis in particular, we were disturbed at Patterson's failure to collect accident and incident report data in any organized fashion. As a result, there is no mechanism for meaningfully analyzing trends. Patterson's post-fall assessments consistently fail to address the activity needs, medical conditions, pharmacologic factors, and routines of the residents. Patterson generally does not consider, for example, underlying causal factors, including the use of chemical and physical restraints, pressure sores, and the lack of resident involvement in activities. Nor was it evident that Patterson's Quality Improvement Committee evaluates the significance of aggregate data related to falls, establishes acceptable fall thresholds, or tracks these numbers monthly to identify trends.

Patterson similarly has not implemented preventive approaches for falls that target the individual risk factors of the residents. And the facility has not adopted clinical practice guidelines that promote linking the identified risk — such as poor balance or use of a medication that causes orthostasis, or a drop in blood pressure — with appropriate interventions to prevent falls.

However, we acknowledge that Patterson has taken steps towards developing a fall and fall-related injury prevention and management program. The facility also has incorporated into its fall management plan resident safety devices, including bed and chair alarms, to reduce and/or eliminate restraint utilization. In fact, Patterson's immediate response to falls is generally adequate; at the time of a fall, a physical exam, including vital signs and assessment for injury, is conducted, the attending physician is notified, and the resident's family is notified. We also found that individual, post-fall interventions were implemented per the physician's order.

F. DISCHARGE PLANNING AND SERVING PERSONS IN THE MOST INTEGRATED SETTING

Title II of the ADA and its implementing regulations require public entities to administer their programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities," i.e., a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. See 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d).

The Supreme Court has held that the discrimination forbidden under Title II of the ADA includes the unnecessary institutionalization of individuals with disabilities. Olmstead, 527 U.S. at 597, 600. The Court explained that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601. To that end, the Court held that a State is required to provide community-based treatment for persons with developmental disabilities when the State's treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected individual and that the placement can be reasonably accommodated. Id. at 602. The resources available to the State and the needs of others with disabilities are part of this calculus. Id. at 607.

For many of the residents, Patterson is not the most integrated setting appropriate to their needs. We recognize that Patterson's senior staff is aware of the facility's obligations with regard to community placement. Nonetheless, the placement of residents in appropriate community settings is impeded by deficiencies in the facility's discharge policies and practices. Discharge planning should begin upon admission and should involve an interdisciplinary review of appropriate and adequate assessments, as well as medical conditions status and barriers to discharge.

1. Inadequate Interdisciplinary Assessments for Community Placement

Federal law requires Patterson to assess on an ongoing basis residents' discharge potential and the appropriateness and clinical necessity of residents' continued stay at the facility. See 42 C.F.R. § 483.20(b)(2)(viii). Medical officials, however, routinely fail to conduct meaningful and timely assessments to determine whether the facility is the most integrated setting to meet residents' needs. Such assessments are a critical component of the interdisciplinary discharge process. The following examples are illustrative of the problems we identified in this area:

- E.D. is a 51-year-old resident who receives peritoneal dialysis daily, but regularly leaves Patterson's grounds on passes independently. E.D. has expressed an interest in living in the community and in possibly sharing an apartment with a friend. At the time of our November 2003 visit,

however, his care plan, which had not been updated in almost a year, did not address his discharge potential or discuss the need for referral for dialysis should he be discharged.

- W.F., a 57-year-old resident with schizophrenia requires no assistance with activities of daily living. However, Patterson's treating professionals failed to establish goals and objectives to get W.F. to a point of medical stability and discharge.

- K.S. is a 51-year-old resident with a history of depression and schizo-affective disorder. The physician's notes do not address discharge potential at all. Although a social work note of July 2003 states that K.S. "is too mentally ill to return to living arrangement," we found no medical or psychiatric evaluation to support this statement.

In a substantial number of other charts, the physician's assessment consisted of a single conclusory statement, such as "No discharge potential," "Not a candidate for discharge at this time," or "Not medically cleared for discharge." Such non-individualized determinations fail to identify the clinical obstacles to discharge, the interventions necessary to overcome such obstacles, or the changes in the residents' health and functional status relative to discharge, as dictated by generally accepted professional practice. Consequently, the assessments serve as little more than vehicles for determining residents unfit for community placement, rather than as tools to assist staff in furthering opportunities for discharge. Consider the following examples:

- D.J. was admitted to Patterson in 2000 with a history of seizure disorder and schizophrenia. The physician progress notes from January 2003 through September 2003 indicate that D.J. is not a candidate for a lower level of care because of the seizure disorder. There was no indication in his chart, however, that seizure control has been a problem for him while at Patterson.

- J.M., a 52-year-old with bipolar disorder and asthma, wants to live in the community. A July 2002 physician's progress note states that she was "not a candidate for transfer to a lesser facility." A June 2003 note states that she has "no discharge potential." But J.M.'s chart revealed no medical indications precluding her discharge to a less restrictive environment. In fact, J.M.'s chart indicates that she has the ability to engage in activities of daily living with minimal assistance.

- T.K.'s chart indicates he is continent, ambulatory, and requires minimal assistance with dressing and bathing. T.K. would like to live in the community. Yet physician's progress notes dated July 2003 summarily state that he is not a candidate for a less restrictive setting. Nothing in his chart suggests any medical contraindication to placement into a more integrated setting, nor were the medical staff to whom we spoke able to identify any such limitation.

2. Failure to Develop and Implement Care Plans that Promote Independence

Another problem we observed is that Patterson's care plans do not reflect a coordinated, interdisciplinary effort designed to increase residents' independence and improve functioning. Indeed, residents' care plans generally fail to identify the specific training, skills, or rehabilitation necessary for residents to live successfully in the community.

The deficiency likely stems from the fact that Patterson's various disciplines inadequately engage residents in activities that promote independence or that teach skills necessary for living in the community. Individuals with mental illness, for example, are provided with little or no instruction on managing their symptoms in preparation for community life. Few, if any, activities are directed to teaching residents basic skills necessary for independent living, such as budgeting, cooking, shopping, and traveling. Instead, the facility's limited activities and interventions actually promote residents' adjustment to the routines at the facility rather than in the community.

Patterson's overall lack of coordination and communication among the interdisciplinary team also stymies the development and implementation of care plans that should facilitate residents' placement in the community. Nearly every record we reviewed illustrated the lack of a coordinated, integrated treatment team approach. Here are just two examples:

- A.B., a 49-year-old man diagnosed with degenerative disc, depression, anxiety, and drug withdrawal, stated a preference for long-term placement at the facility upon admission in May 2003. The initial social work assessment failed to explore with A.B. this stated preference, despite his young age and the fact that he had previously lived in his own apartment. The psychologist's notes, meanwhile, stated that staff should "reinforce future thinking."

No collaboration was evident in the record between the two disciplines, and there appears to have been no efforts undertaken towards encouraging A.B.'s discharge. Importantly, though, we discovered that A.B. had expressed an interest to a Patterson volunteer in returning home once confident of his physical mobility.

- C.P., a 53-year-old resident diagnosed with schizophrenia and bipolar disorder, described to us her eagerness to return to the community and her self-initiated efforts to secure housing. C.P. told us that she often discussed discharge with her psychologist. But the psychologist's notes — from September 2003 — state without any elaboration that C.P. was not medically cleared for discharge. C.P. seemed totally unaware of this determination. We found no notes documenting social worker involvement in investigating discharge options or supportive services, or referencing impediments to the resident's discharge. A lone note in the chart reflected that C.P. had set fire to her own apartment before admission to Patterson. There is no indication in the chart that the social worker and the psychologist ever discussed this significant fact, generally or in relation to C.P.'s discharge options.

3. Inadequate Discharge Planning

According to generally accepted professional practice, nursing homes should develop discharge plans that include action steps and time frames, and identify the persons responsible for each task for effective transition into the community. Patterson's discharge plans fall far short of these requirements. As a result, residents often remain at Patterson long after their level of medical acuity would seemingly dictate transfer to a lower level of care.

The basic problem appears to be that Patterson lacks any type of formalized system to ensure that discharge preparation and placement attempts are timely and adequately performed, and that residents are provided appropriate information regarding community options. For example, although residents' housing options often depend on eligibility for public benefits such as Supplemental Security Income ("SSI") and Social Security Disability ("SSD"), Patterson has no procedures in place for monitoring whether applications are filed and deadlines are met. Social work staff charged with the responsibility of developing and implementing discharge plans are likewise expected to be knowledgeable about public benefits, housing options, and other community supports. Patterson staff clearly lack this critical

knowledge and have not received adequate training in this area. We found that the facility's materials concerning housing providers are disorganized, incomplete, and out-of-date. Lacking a centralized data bank and training with regard to housing options, social work staff simply rely on the expertise of a senior social worker who carries a full caseload and is not Patterson's designated discharge coordinator. As a result, placement in the community is often delayed or blocked.

Our review of records indicated many instances in which staff failed to submit applications for benefits and housing. For example:

- G.H., a 19-year-old resident, was admitted to Patterson with a stab wound and diagnosed with depression. At the time of his admission, he was homeless and lacked health insurance. G.H.'s chart reflects that 30 days after his admission, his social worker still had not yet pursued any social service benefits, although obtaining such benefits would be a predicate to discharge into the community.

- J.A., a 67-year-old resident, was admitted to Patterson in 2002 for short-term rehabilitation for a fractured ankle. J.A. was medically cleared for discharge in July 2002 and wanted to return to the community. Social worker notes as of November 2003, however, indicated that he is not eligible for SSI or SSD because he has no birth certificate or proof of birth date. J.A.'s chart does not indicate that his social worker had advised his relatives of other ways to document proof of birth (e.g., census data, proof of baptism or other religious records), or that the social worker herself made any effort to obtain this proof.

For those residents who indicated a desire to return to the community, very few records documented effective discharge planning efforts to explore or locate appropriate alternatives to institutionalization. Discharge notes failed to indicate any active consideration of alternative housing opportunities or any follow-up in response to obstacles in discharge. There is a complete lack of discharge planning assistance for residents who desired discharge to the community and had neither skilled needs nor barriers to discharge. In fact, there was no written documentation of any interactions between residents and social workers on the subject of community living, even for those residents who had been identified by staff as potential candidates for placement. Many residents confirmed to us that they rarely interacted with a social worker to discuss community placement alternatives.

The effect of Patterson's failure to undertake adequate discharge planning is the unnecessary institutionalization of residents. The examples outlined below are indicative of the problem:

- O.W.'s October 2003 care plan states, "Discharge potential good when housing available." When interviewed, O.W. stated he has been searching for housing for approximately a year without any assistance from his social worker. We found no documentation that housing was being actively pursued by staff.

- S.K.'s care plan also states, "Discharge when housing available." S.K. explained that she is exploring discharge options herself because the social work staff would not help her find adequate housing. Once again, we found no documentation that housing was being actively pursued by staff.

- M.P., a 34-year-old resident who was admitted to Patterson in March 2002, wanted to be discharged to housing in Queens. His chart indicated that he is medically stable and has no behavioral issues. The social worker's notes suggest that a major impediment to M.P.'s discharge is the social worker's lack of familiarity with housing options in Queens.

- T.P. is a 69-year-old resident admitted to the facility in October 2001 for a leg fracture. His chart indicates that he has been on a waiting list for housing accessible to individuals who use wheelchairs or have a mobility impairment in Nassau County since June 2002. We found no indication in his chart that Patterson staff were making any attempts whatsoever to assist this resident to return to the community other than by having his name placed on a community housing list.

- G.P. is a 45-year-old resident whose discharge plan from October 2002 through November 2003 indicates that he is on a waiting list for housing in upstate New York. However, the chart reflects that in October 2002, the upstate housing provider stated that the resident would not be given placement preference since he is a non-resident. We found no documentation in the chart that the social work staff had followed-up with the provider regarding the feasibility of other housing options.

- J.G. is a 29-year-old Spanish speaking resident with a diagnosis of HIV. His initial discharge plan states he would be discharged into the community following completion of restorative physical therapy. Social work notes of October 2003 indicated the facility would contact the Hispanic Counseling Center. During our review in November 2003, however, we were unable to find any documentation in his chart indicating follow-up by the facility.

- G.S. is a 47-year-old resident with a primary diagnosis of bi-polar disorder. Social work notes indicated that G.S. needed to be more compliant with her psychological counseling and that her brother, who had expressed an interest in having her live with him, should explore day treatment services near his home. There was no further documentation indicating that the social worker had educated G.S. or her family regarding appropriate housing options and supportive services necessary for discharge.

- V.S., a 62-year-old, mentally ill resident, speaks no English. According to V.S.'s chart, a staff nurse acts as an interpreter when she is available. There was no documentation in her chart that the social worker had attempted to provide regular counseling opportunities with an interpreter present, or that discharge planning was provided. Nor do the social work notes document any efforts to identify or connect V.S. with community, mental health or social service organizations serving individuals who speak her language. Consequently, V.S. remains isolated by language and disability with no discharge plans developed or implemented.

III. MINIMUM REMEDIAL MEASURES

To rectify the identified deficiencies and protect the constitutional and federal statutory rights of Patterson residents, the facility should implement promptly, at a minimum, the following measures:

A. MENTAL HEALTH CARE

As part of its obligation to provide its residents with adequate health care, Patterson should provide its residents with adequate psychiatric supports and services. Patterson residents should receive psychotropic medications only after a thorough evaluation and diagnosis according to current generally accepted

professional standards of care. Such diagnosis and evaluation must include sufficient documentation to withstand clinical scrutiny. In particular, Patterson should:

1. Assure that its psychopharmacological practices comport with generally accepted professional standards. All use of drugs, including antidepressants, medication combinations, and benzodiazapines, should be professionally justified, carefully monitored, documented, and reviewed by qualified staff.

2. Provide adequate and appropriate psychiatric and mental health services in accordance with generally accepted professional standards.

3. Develop and implement an adequate education and training program for medical and nursing staff in the evaluation, diagnosis, and treatment of residents with psychiatric and/or behavioral problems, including the safe and proper administration and monitoring of psychiatric medications.

4. Assure that the Pharmacy Consultant complies with federal regulations that address the use of psychiatric medications in long-term-care facilities.

5. Obtain informed consent or proper authorization prior to administrating psychotropic medications and other invasive treatments.

6. Assure continuity and coordination of care in the provision of mental health services and medical care.

B. RESTRAINT USE

Any device, procedure or medication that restricts, limits or directs a person's freedom of movement (including, but not limited to, powerful sedatives), is a restraint, which must be clinically justified. Patterson should:

1. Use physical and chemical restraints only pursuant to generally accepted professional standards and federal law. Restraints should never be used for the convenience of staff, as a method of discipline, or as a substitute for treatment of the underlying causes of the condition provoking the restraint.

2. Assure that, prior to restraint application, residents receive a comprehensive assessment of the appropriateness of the restraint, and continue to monitor the restraint use in accordance with generally accepted professional standards of practice and federal law.

3. Monitor the use of siderails to ensure the siderails pose no undue risks to the residents' safety.

4. Obtain consent for restraint use, unless applied in emergency, physician-ordered circumstances.

C. CLINICAL CARE

Patterson, in assisting residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, should provide adequate medical care, consistent with current standards of care. In particular, regarding assessment and care plans, Patterson should:

1. Provide each resident with adequate medical and nursing care and provide ongoing assessments, individualized care plans, and health care interventions that protect the residents' health and safety.

2. Revise policy and practice to include residents with cognitive loss and their families in the care planning process.

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

4. Develop and implement appropriate training that reinforces, promotes, and protects the rights of residents to dignity, privacy, and self-determination.

Regarding restorative care, Patterson should:

5. Provide ongoing and systematic evaluation, as appropriate, of all residents to determine their needs for rehabilitation and restoration and produce an appropriate plan for each resident based on this evaluation designed to promote his or her mobility, continence, self-care, and involvement in meaningful activity.

6. Assure that appropriate functional body alignment and posture is provided for frail residents through the use of pillows and adapted chairs and develop a furniture plan that provides seating for all residents and tables to promote resident involvement in activities.

7. Assure that the residents are wearing proper footwear at all appropriate times.

Regarding therapeutic services, Patterson should:

8. Assure that activities meet the needs of all residents through individual design, implementation, and accessibility. Patterson should develop a therapeutic activity program in order to prevent the complications associated with inactivity (e.g., loss of function, depression, weight loss, and pressure sores).

9. Develop and implement an activity plan that addresses the behavior and specific needs of each resident with a psychiatric diagnosis and who is receiving psychoactive medication.

10. Develop and implement a therapeutic assessment process to provide adequate rehabilitative services.

11. Train staff in the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 and provide activities and services to individuals with disabilities consistent with the Acts' requirements.

D. NUTRITIONAL SERVICES

In order to provide adequate nutritional management services Patterson should:

1. Develop and implement adequate nutritional assessments of individual residents' specific nutritional needs as part of the care plan.

2. Assure that residents receive appropriate diets and adequate amounts of fluids to ensure proper hydration and ensure that residents who need assistance in eating are assisted by adequately trained staff.

3. Provide meal services in a manner that preserves resident dignity, promotes quality of life, and ensures resident safety.

4. Assure that residents are provided with appropriate equipment and devices necessary for safe eating.

E. QUALITY ASSURANCE AND INCIDENT MANAGEMENT

Incidents involving injury and unusual incidents should be evaluated and incorporated appropriately as a quality assurance tool. More particularly, Patterson should:

1. Track clinical outcomes, including psychoactive medication use, use of chemical and physical restraints, falls, and lack of involvement in activities, and analyze the meaning of these outcomes to prevent future harm to residents.

2. Address the root causes of falls and other injuries to minimize their occurrence, and provide appropriate, individualized intervention.

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

4. Assure 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.

F. DISCHARGE PLANNING AND MOST INTEGRATED SETTING

1. Patterson must assess adequately on an ongoing, timely basis residents' discharge potential, whether the transfer is not opposed by the affected individual, and the appropriateness and clinical necessity of residents' continued stay at the facility.

2. Patterson's development and implementation of care plans must be coordinated, interdisciplinary, and designed to increase residents' independence and improve functioning.

3. Patterson must develop and implement a policy for discharge planning that includes consideration of non-institutional care and more integrated settings.

4. The State and Patterson must provide residents with the support services and information regarding community placement.

5. Patterson must create and monitor comprehensive, up-to-date information relative to available housing options and other treatment services for its residents.

6. The State should ensure that Patterson residents are not unnecessarily isolated at Patterson and that the residents are provided treatment in the most integrated setting, when appropriate.

* * *

We hope to work with the State and the Nassau Health Care Corporation in an amicable and cooperative fashion to resolve our outstanding concerns regarding Patterson. Assuming there is a spirit of cooperation from the State and Nassau Health Care Corporation, we also would be willing to send our expert consultants' evaluations of the facility under separate cover. Although the expert 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.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned

to this investigation will be contacting the facility's attorney to discuss this matter in further detail. If you have any questions regarding this letter, you may call Pamela K. Chen, Chief of the U.S. Attorney's Office Civil Rights Litigation Section, at (718) 254-7575, or Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Roslynn R. Mauskopf
United States Attorney
Eastern District of New York

R. Alexander Acosta
Assistant Attorney General
Civil Rights Division

cc: The Honorable Eliot Spitzer
Attorney General
State of New York

Antonia C. Novello,
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Commissioner
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