Memorandum

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Subject	Date
Proposed CRIPA Investigation Landmark Learning Center Opa-Locka, Florida and G. Pierce Wood Memorial Hospital, Arcadia, Florida	March 23, 1995

To	From
Deval L. Patrick Assistant Attorney General Civil Rights Division	Arthur E. Peabody, Jr. Chief Special Litigation Section

INTRODUCTION

Pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., we recommend that the Department initiate an investigation into the conditions of confinement at the Landmark Learning Center ("Landmark"), previously known as Sunland Training Center, in Opa-Locka, Florida, and G. Pierce Wood Memorial Hospital ("Pierce") in Arcadia, Florida. 1/ Landmark is a state-operated institution housing approximately 300 developmentally disabled adults and children. Pierce is a state-operated institution housing approximately 445 mentally ill adults on both a short and long term basis.

Residents of state operated facilities for the developmentally disabled and mentally retarded have a fundamental Fourteenth Amendment due process right to reasonable safety, adequate medical care and training. Youngberg v. Romeo, 457 U.S. 307 (1982). Such training must be sufficient to protect each resident's liberty interests and permit each resident an opportunity to function as independently as their individual

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1/ Pierce is the subject of a 1989 consent decree filed in Johnson v. Bradley, C.A. No. 87-369 (M.D. Fla. 6/1/89) and of a monitor who ostensively evaluates compliance from time to time. Plaintiffs are represented by James K. Green, sole practitioner without adequate resources to address the multitude of compliance issues. State defendants have filed a series of motions to dismiss, motions to dismiss the monitor and other motions to terminate the case.

Conditions at Pierce, as described in the text, are especially egregious -- suicide by hanging, an unobserved patient cuts off both hands, and three patients die in a single week. In view of the protracted violations and the apparent inability of plaintiffs' lawyer to address these problems alone, our involvement is warranted. Obviously, compliance in Bradley has not been achieved and Mr. Green welcomes our participation.

handicapping conditions permit. See, e.g., Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D. N.C. 1988); United States v. Tennessee, No. 92-2062, slip op. at 12 (W.D. Tenn. Feb. 17, 1994); Halderman v. Pennhurst State School & Hospital, No. 74-1345, slip op. (E.D. Pa. March 29, 1994). See also 42 C.F.R. § 483.440.

We have obtained information that indicates residents of Landmark and Pierce are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. 2/ Alleged unconstitutional violations include the following: abuse and neglect of residents, inadequate medical and psychiatric care, and failure to provide residents with adequate training programs. See Youngberg v. Romeo, 457 U.S. 307 (1982). In addition, Landmark and Pierce are institutions that unduly segregate their residents from the rest of society solely on the basis of their disabilities. As a result, these facilities are failing to provide services to their residents in the least separate, most integrated setting as required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq.

POSSIBLE VIOLATIONS

A. The State of Florida Fails to Provide Landmark and Pierce Residents with Services in the Least Separate, Most Integrated Setting.

Landmark and Pierce are isolated, self-contained institutional environments that separate their residents from the rest of society on the basis of their disabilities. As such, state officials are subjecting these individuals to conditions that violate the ADA and Section 504. Landmark and Pierce also inappropriately discriminate against a certain class of their residents by allowing a double standard of care for residents within the facilities. Landmark and Pierce have a number of unlicensed beds, i.e., beds that do not meet the federal regulatory standards enacted pursuant to the medicaid and medicare programs. The unlicensed beds at Landmark and Pierce do not meet these minimum standards of care set to safeguard the care and protection of residents in state facilities. The practical result of this distinction is to set a dual standard of care within the institution between those residents in licensed

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2/ Conditions at Pierce were first brought to our attention by officials of the Health Care Financing Administration of the Department of Health and Human Services (HHS) in a telephone call several months ago. This is highly unusual and suggests the gravity of the deficiencies at Pierce. This is the first such call of this kind within memory.

beds protected by the standards set by licensing agencies and those in unlicensed beds for whom that protection is withheld. 3/ Such discrimination violates Section 504 and the ADA. In addition, at Pierce, Health Care Finance Administration ("HCFA") surveyors recently found that Pierce has inadequate nursing coverage for its licensed and unlicensed units and often pulls staff off the non-licensed units to cover nursing shortages in the licensed portion of the facility. 4/

The state has failed to provide Landmark residents with sufficient numbers of needed placements in a community setting. As a result, many Landmark residents who are suited for community placement continue to be isolated from the rest of society. Not only does the segregation violate the residents' statutory rights under Section 504 of the ADA, but the care and treatment afforded them in the institution does not rise to the level of care provided elsewhere in the community as required under the above statutes.

The state has also failed to provide Pierce residents with adequate mental health services in the community. 5/ Currently, Pierce houses between 50 and 100 residents who are suitable for immediate release into the community. 6/ Due to the lack of available community mental health services, residents continue to be segregated in a remote and isolated institution. The state's failure to provide services in the community violates Section 504 and the ADA.

3/ The Florida Department of Health and Rehabilitative Services undertook a study of four Florida ICF/MR facilities, including Landmark, that showed that .... "dual levels of care exist between licensed and unlicensed units in all facilities since some therapies are not available to persons in unlicensed units. . . . Many of the individuals in unlicensed homes have severe behavioral problems or self injurious behavior." Unlicensed Beds In Developmental Services Institutions Study (Department of Health and Rehabilitative Services), 1994, at 2.

4/ Health Care Financing Administration ("HCFA") Survey Information on G. Pierce Wood Memorial Hospital (August 17-18, 1994).

5/ A recent audit demonstrated that the community mental health services system fails to provide adequate clinical assessments, functional assessments, and treatment plans for its clients. Office of the Monitor, 1993 Joint Community Audit in Johnson v. Bradley.

6/ Telephone conversation with James K. Green, P.A., February 14, 1995.

B. <u>The State Fails to Ensure that Landmark and Pierce Residents are Free from Abuse and Neglect</u>.

A local advocacy group called the Advocacy Center for Persons with Disabilities published a report entitled the Landmark Learning Center Review ("The Review") that revealed rampant physical and mental abuse of Landmark residents. 7/ Landmark has a history of abuse dating back to at least 1987. One such incident that occurred in 1993 involved a severely dysfunctional resident who died as a result of a blow to the abdomen. 8/ The resident had suffered a fifty (50) pound weight loss in the month preceding his death. 9/ Landmark officials were unable to give a satisfactory explanation for the weight loss and death. 10/ In addition, a male resident died on November 18, 1991, at the hospital after experiencing severe internal bleeding. 11/ The resident broke his femur at 11:00 p.m. and was not brought to the hospital until 10:15 a.m. the next morning. 12/ He died at around noon that same day. The attending doctor reported that the resident suffered from numerous bruises. 13/ Such incidents indicate that the treatment and care of the mentally retarded at Landmark is directly and adversely affected by untrained and abusive staff.

The examples listed above demonstrate a continued pattern of abuse and neglect. From 1989-1994, five (5) residents have died and three of those deaths occurred in one eight day time period. 14/ A Health Care Quality Assurance ("HCQA") team of the Florida Department of Health and Rehabilitative Services

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7/ Advocacy Center for Persons with Disabilities, <u>Landmark Learning Center Review</u>, ("The Review"), 1992, at 6. Recent reports by the Advocacy Center indicate that conditions at Landmark have not improved since The Review was released. <u>Landmark Learning Center December 1993 Report</u>.

8/ Jacquee Petchel, <u>Unexplained Deaths Mount</u>, Miami Herald, Nov. 23, 1993, at A1.

9/ Telephone Conversation with Karen Curran, attorney for the resident's family, August, 1993.

10/ <u>Id</u>.

11/ Telephone Conversation with Mark Stokes, attorney for the resident's family, August 1993.

12/ <u>Id</u>.

13/ <u>Id</u>.

14/ <u>Id</u>.

("HRS") conducted a special visit to Landmark following the three deaths in eight days. 15/ The report stated:

> [T]he overall findings of the team indicate that each of the three deaths contained elements that could be viewed as demonstrating deficiencies in the quality of care delivered by the facility. Each case involved a series of systematic, technical, and administrative problems that, when taken together, created an environment making it possible for the deaths to occur. 16/

In 1992, the Review reported high mortality rates at Landmark where seven (7) residents died in a five month period starting October 1991 through March 1992. 17/ In 1994, Chris Schuh, with the Association for Retarded Citizens ("ARC"), stated that ". . . the death rate now (at Landmark) has not decreased since 1991". 18/

Pierce also fails to protect its patients from harm. Last summer, three patients died within one week. A 73 year old patient died by choking on food on August 14, 1994. Prior to his death, this patient had experienced a choking episode in March 1994. Following a medical evaluation, the patient was placed on a pureed diet. On the day of his death, the patient was observed by staff stumbling and falling outside the on-unit dining room after the evening meal at 5:17 p.m. Resuscitation efforts proved unsuccessful and the patient was declared dead at 5:50 p.m. 19/

The autopsy revealed masses of small fragments of food material throughout the trachea and bronchial tree and food throughout the lungs including "fragments as large as grains of rice . . . ." 20/ The medical examiner listed the official cause of death as "acute cardiorespiratory failure due to

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15/ Id.

16/ Id.

17/ The Review, at 6.

18/ Telephone Conversation with Chris Schuh, Association for Retarded Citizens, September 19, 1994.

19/ HCFA Adjunct Survey Report (September 20, 1994).

20/ Id.

aspiration of food into the larynx and trachea due to accidental causes." 21/

Four days later, a 25 year old female patient died while on one to one suicide precaution watch. Hospital policy provides that the assigned staff person must document the patient's activities and location every 15 minutes. Upon review of hospital records, HCFA found that from 5:45 a.m. until the resident was found unresponsive on a sofa at 6:55 a.m., there were no entries documenting observations of the patient. 22/

In addition, HCFA found that no RN's were assigned to the patient's unit on 6 of the 21 shifts during the week of her death resulting in inadequate nursing coverage. During the actual shift on which the patient died, there was a nursing complement of 4 aides and .5 RN. Three of the 23 patients on the unit were on 1:1 suicide watch. Such nurse staffing left the .5 RN and 1 aide responsible for the remaining 20 patients. 23/

On August 20, 1994, a 26 year old male was found hanging from a tree outside by a fellow patient and two staff persons who were looking for him to give him his evening medication. 24/ The resident had a long history of command hallucinations telling him to kill himself and had frequently been on 1:1 suicide watch. In fact, he had been on suicide watch up until 2 days prior to his death. The progress notes for the day of his death begin only at the time the resident was found hanged. The HCFA report on this death called for a review of the indications for maintaining patients on a suicide watch when they exhibit serious suicidal tendencies. 25/

In July 1994, a male resident at Pierce seriously injured himself. The patient scaled, unobserved, a 12 foot tall chain link fence and gate topped with 3 strands of barbed wire and slid through an 18 inch gap in the ceiling of a garage which housed, among other items, a circular saw. He was found at 6:15 p.m. by a security guard who saw him standing in the window of the garage holding up both bloody arms with his hands missing. The hands were found palm up on the table. The staff did not realize the

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21/ Id.

22/ Id.

23/ Id.

24/ Id.

25/ Id.

resident was missing until he was noted absent for his 6:00 p.m. medication. 26/

C. **The State Fails to Provide Landmark and Pierce Residents with Adequate Medical and Psychiatric Care.**

Landmark fails to provide its residents with adequate medical and psychiatric care. Landmark still does not have the systems in place to safeguard residents against over-medication, inadequate review of psychotropic medication, use of gastrostomy tubes for the convenience of staff, and misdiagnoses of serious illnesses that can and have led to death. 27/ For example, a resident died of cancer without ever being treated for that disease while another resident died from an allergic reaction to a drug. Both incidents indicate lack of systemic, adequate and consistent care. 28/ Landmark also has the highest ratio of residents in a ICF/DD facility with gastrostomy tubes in the country, many of which were inserted for the convenience of the staff or due to lack of adequate staffing. 29/ Monitoring of potentially harmful side effects of psychotropic medications with neurological testing and/or periodic review is sporadic. 30/

Pierce also fails to provide adequate psychiatric care to its residents. Progress notes must be recorded weekly for the first two months and at least once a month thereafter. The progress notes must contain recommendations for revisions in the treatment plan as indicated as well as precise assessments of the patient's progress in accordance with the original or revised treatment plan. 31/ HCFA surveyors found that the psychiatrist at Pierce failed to record progress notes in a timely manner for the first two months and thereafter. They also found that changes in medications, response to psychiatric treatments and changes in psychiatric treatment plans were not routinely

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26/ HCFA Complaint Investigation Survey (August 18, 1994); Don Moore, Month Took Toll at GPW, DeSoto Sun Herald, August 30, 1994, at 1.

27/ Id.

28/ Id.

29/ Id.

30/ Id.

31/ HCFA Statement of Deficiencies and Plan of Correction (August 18, 1994) at 2.

documented by progress notes in all cases. 32/ In addition, HCFA indicated that it is not clear whether the psychiatrist, who is responsible for 53 residents, is involved in the on-going care of every patient on the unit surveyed. 33/

D. **The State Fails to Provide Landmark Residents with an Adequately Safe Living Environment.**

Landmark's physical environment also impacts the health of the residents. The Health Care Financing Administration ("HCFA") found in August, 1992, that deficiencies in the kitchen areas included freezers and refrigerators that did not meet temperatures considered safe for the maintenance of food items, outdated food and rusty can openers, and numerous unsanitary and unsafe conditions. 34/ In June, 1993, HCFA again found the same deficiencies with regard to equipment and food. HCFA further found dirty food delivery containers, containers of uncovered rancid grease, rusting and peeling metal on ice machines, rotting boxes with nearby rodent excrement, leaking roof tiles that had allowed water to leak onto sugar that was currently being used and two large, dirty garbage containers of wilted lettuce intended for resident consumption. 35/ In December, 1993, the Advocacy Center for Persons with Disabilities found the following:

> [C]onditions in the kitchen were unsanitary . . . . [F]ood was observed falling on the floor and staff picking it up and placing it back on the serving trays. There was no attempt to keep food covered, and many flies were observed on the food. Furthermore, LLC is still using the meal trays and styrofoam take out boxes which were cited as problems in the November/December 1992 review of LLC Administration and Management structure by HRS.

32/ Id.

33/ HCFA Survey Information for G. Pierce Wood Memorial Hospital (August 17-18, 1994).

34/ Health Care Financing Agency Statement of Deficiencies and Plan of Correction, June 12, 1992, 1-4.

35/ Health Care Financing Administration Statement of Deficiencies and Plan of Correction, June 17, 1993, 1-10.

> He (Edward Dixon, Cafeteria Director) stated that the doors were kept open due to the heat, and that the flies, and at times 'bigger things', could not be avoided. When asked if he meant rats, he agreed. 36/

Environmental conditions of Landmark remain poor.

E. The State Fails to Provide Landmark and Pierce Residents With Adequate Programming and Treatment.

Landmark fails to provide training programs designed to meet the specific needs of individual residents and abate or eliminate self-injurious behaviors. The Advocacy Center reported negligible active treatment and "an unacceptable and astonishing number of residents who exhibit stereotypical and other institutional type behaviors." 37/ The Advocacy Center further stated that "the lack of behavioral programming remains a serious deficiency which has not been improved since 1992." 38/ Pre-vocational and other training programs are not well attended and are frequently cancelled. 39/ As a result, Landmark fails to prevent the regression and/or loss of skills of its residents.

Pierce also fails to provide adequate training programs to meet the specific needs of individual residents. Each patient must have a written treatment plan that includes short and long term goals. 40/ HCFA found that 13 of the 19 records it reviewed contained only short and long term goals for staff rather than measurable outcome goals for the patients. 41/ In addition, Pierce lacks adequate activities/training programs that promote optimal levels of the physical and psychosocial functioning. HCFA surveyors found the majority of residents

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36/ Advocacy Center for Persons with Disabilities, Inc. Report, December, 1993, 2-3.

37/ "The Review", 1992, at 10.

38/ Advocacy Center for Persons With Disabilities Report, June 10, 1993, at 1.

39/ Advocacy Center for Persons With Disabilities Report, December, 1993 Report, at 1.

40/ HCFA Statement of Deficiencies and Plan of Correction at 1.

41/ Id.

sit idly in day rooms or pace the halls. HCFA surveyors found the majority of residents either do not regularly attend programming or lack appropriate programs. 42/

CONCLUSION

The information gathered thus far indicates that the inadequate conditions at Landmark and Pierce deprive residents of their constitutional and statutory rights. We therefore recommend that an investigation of Landmark and Pierce be instituted under our CRIPA authority.

Approved:

Disapproved: ____________________

Comments:

42/ Id. at 4. In 1994, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) awarded Pierce accreditation subject to Type I Recommendations. Type I Recommendations refer to those compliance concerns found in a survey that an organization must resolve to retain accreditation. The Type I Recommendations issued to Pierce covered, among other things, treatment planning, patient management, life safety management, nursing policies and procedures, medical staff credentials, and staff orientation, training, and education. Letters from JCAHO to Max Schnier (October 21, 1994 & January 20, 1995).