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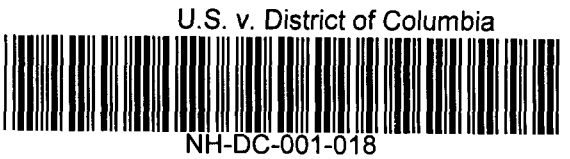

January 17, 1996

The Honorable Thomas F. Hogan
U.S. District Court for the District of Columbia
333 Constitution Avenue, NW, 4th Floor
Washington, DC 20001

Re: Court Order The United States of America v. The District of Columbia, et al., Civ. No. 95-948, TFH, D.C. Village Nursing Home (DCV);
November 7, Order Modifying Stipulated Order of July 6, 1995;
Order, December 22, 1995

Dear Judge Hogan:

The enclosed is the January Status Report to the Court.

It primarily addresses the December 22, 1995, Court Order.

Judge Hogan, it is a privilege to serve the Court for the best interests of the residents of D.C. Village Nursing Home.

Sincerely,

Harriet A. Fields

Harriet A. Fields, Ed.D., R.N.

encl.

cc: Mr. Richard J. Farano
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STATUS REPORT

United States of America v. The District of Columbia, et. Al.
Civ. No. 95-948 TFH, Re: D.C. Village Nursing Home;

November 7, Order Modifying Stipulated Order of July 6, 1995;

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Submitted by:

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Date:
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INTRODUCTION

This is the third monthly Status Report submitted by the Court Monitor to the Court. The first Status Report was submitted to the Court in October 1995, prior to the October 20 Status Hearing. The second Status Report was submitted November 30, 1995, prior to the December 4, 1995, Status Hearing.

Pursuant to the Stipulated Order of July 6, 1995, the Court Monitor was appointed August 1, 1995, the initial estimated budget was approved September 6, 1995, and monitoring activities commenced August 28, 1995. A Preliminary Status Report was submitted on September 5, 1995. On November 7, 1995, the Order Modifying Stipulated Order of July 6 was filed expanding the Court Monitors's duties to oversee the outplacement process of the residents of DCV. (The District of Columbia announced closing of DCV in early August, after the July 6 Stipulated Order was filed and after the appointment of the Court Monitor.)

On December 20, 1995, the Court found the District in contempt of the July 6 Stipulated

Order and the amended November Order. On December 22, 1995, the Court issued a remedial Order.

This January Status Report will concentrate on this remedial Order of December 22, 1995, and the Court Monitor's assessments of the ability of the District of Columbia to comply with this Order.

This Status Report is divided into five main areas: (1) brief review of the monitor's December 6 and December 10 letters to the Court subsequent to the November Status Report; (2) the monitor's conclusion as to what is immediately needed for the best interests and protection of the residents, to safeguard their welfare, and to prevent further violation of their rights; (3) assessment data supporting the need for new management; (4) action steps that must be implemented now by DCV in the interim; (5) potential models for new management;.

I. DECEMBER 6 AND DECEMBER 10, 1995, LETTERS TO THE COURT

After the November 30 Status Report and the December 4 Status Hearing it became necessary on two occasions to write the Court prior to the next scheduled Status Hearing of December 20, 1995.

The December 6, 1995, letter to the Court profiled the negative impact on the life of one resident in particular, who is wheelchair dependent, and the potential negative impact on the life of the residents in general, through termination of nursing services, due to lack of payment of vendors.

The December 10, 1995, letter to the Court profiled (1) non-maintenance of resident equipment-wheelchair; (2) unconscionable delays in the process of procuring purchase

orders for vendor services, so much so that essential supplies for resident care and treatment are lacking; (3) chronic non-compliance of payment of vendors so much so that essential services for resident care and treatment were lacking; (4) residents were denied their Personal Needs Allowance which was in the District of Columbia Treasury. Recommendations in the December 10 letter called for an (1) immediate audit of government funds earmarked for DCV; (2) requests for purchase orders be filled within two weeks; (3) an accounting of residents' personal funds; (4) establishment immediately of a separate account for residents' personal funds, including the residents' Personal Needs Allowance.

The December 6 and December 10, 1995, letters to the Court appear in Appendix A of this January Status Report.

II. CONCLUSION OF WHAT IS IMMEDIATELY NEEDED FOR THE BEST INTERESTS AND PROTECTION OF THE RESIDENTS, TO SAFEGUARD THEIR WELFARE, AND PREVENT FURTHER VIOLATION OF THEIR RIGHTS

It is with much thought; painful deliberations; data gathering; consultation with experts; input from staff and contract employees; interviews and observations of all the residents at DCV; meetings with District of Columbia government officials; and the employ of a nursing home systems expert consultant on January 3, 4, and 5, 1996, (who was also a consultant to the Court Monitor at DCV in September at the time of the Health Care Financing Administration (HCFA) survey and is a former HCFA Regional Survey Team Coordinator and currently serving as a consultant to a HCFA contractee and is conducting HCFA surveys throughout the country); that the Court Monitor comes to the following conclusion:

In order to protect the residents' health, ensure continuity of care, safeguard the residents' rights according to federal and District law and regulations, and protect the residents from the trauma of relocation, a new management team is needed immediately.

For the bests interests of the residents of DCV, I base my conclusion on current and ongoing conditons and practices which pose serious and widespread danger to the health and welfare of the residents.

III. ASSESSMENT DATA SUPPORTING NEED FOR NEW MANAGEMENT

The following assessment data relates to the Court Order of December 22, 1995, and when needed for clarification, the previous Court Orders of July 6 and November 7 are cited. The assessment data and recommendations profiled in the Court Monitor's October and November Status Reports are still current and valid unless otherwise indicated here and the recommendations still stand. This section of assessment data supporting the need for new management is in addition to the data already presented to the Court.

A. Outplacement of Residents with Mental Retardation

There is no constructive movement in this area. Currently there is an impasse between the group home providers and the Commission on Health Care Finance over a mutually agreed upon rate. There are not enough identified group homes to care for the particular, individual needs of the residents with mental retardation at DCV.

Group homes have not been paid for approximately one half year. As a result one resident with mental retardation, Mr. L.S., who was profiled in the November Status Report, has been waiting to be discharged to D.C. Family Services, a group home. D.C. Family Services is now in a budget crisis of its own and cannot accept this resident until

it is reimbursed for three residents it received from DCV in June. Within the last week, it came to the Court Monitor's attention that Mr. L.S. is still in Washington Nursing Facility, the nursing home to which he was discharged after he had an acute care procedure performed at Greater Southeast Hospital Center, where he was transferred from DCV in the autumn. The Washington Nursing Facility is not where he should be today.

Not only is this an example of the **financial problems which constitute barriers to placement,** but it is also an example of a systems breakdown at DCV. All those involved with Mr. L.S., including social service at DCV and the GUCDC assumed that Mr. L.S. was in his designated group home. However, it has not been determined if Mr. L.S.'s individualized habilitation plan has been sent anywhere. It is not known if the Washington Nursing Facility is capable of caring for the individualized needs of Mr. L.S. The Court Monitor, along with a staff person from the GUCDC group, will visit Mr. L.S. in his current setting, to determine appropriateness of care and level of staff knowledge. (A visit was scheduled last week, but was rendered impossible by the blizzard.)

There has been no movement in identifying and developing the **specialty consultation team** described in the November 30 Status Report to the Court and reiterated in the December 22, 1995, Court Order. At a meeting at DCV on Thursday, December 28, 1995, with Dr. Harvey Sloane, Commissioner of Public Health for the District of Columbia; Dr. Guido Zanni, Commissioner of Mental Health for the District of Columbia; Ms. Orlene Grant from the Commission of Mental Health Office; Ms. Gladys Fountain, Interim Administrator for Long Term Care from the Commission of Public Health; and the Executive Director of DCV, the Court Monitor reiterated this fact. The response from the Executive Director of DCV was that the residents with mental retardation have case managers at the Mental Retardation and Developmental Disabilities Administration (MRDDA) and they are handling this. The Court Monitor's October 16,

1995, Status Report to the Court on page 26-27 identifies the inadequacy of this situation. To this date, nothing has changed.

On the morning of December 29, 1995, I met in the hallway at DCV, the psychologist from the Georgetown University Child Development Center (GUCDC), who was dismayed and annoyed at the continued treatment GUCDC receives. He informed me that when the GUCDC staff left for work that morning, they had no idea if this would be their last day because the GUCDC contract expired that day and had not been renewed. In fact one GUCDC staff person began packing his books. It was only later that morning that GUCDC staff at DCV received a letter by courier stating that their contract was being renewed until January 12. The Court Monitor immediately went to the Executive Director of DCV with this staff person from GUCDC and reported this to her. The Executive Director's response was, "you do not understand bureaucracy." The Court Monitor reminded the Executive Director, "my role is to report the life of the residents to the Court, and this is detrimental to the life of the residents." I also reminded the Executive Director that the District is now in contempt of the Court Orders, and that she has to let the Court Monitor help her help the residents, stop defending a system that is not defensible, and defend the residents by being vocal and advocating for what is needed to protect and safeguard the residents health and welfare.

The Executive Director in the presence of the Court Monitor and the GUCDC staff person called MRDDA and was informed that the GUCDC contract had in fact expired and that GUCDC would be renewed after January 12, 1996, at 14 day increments.

I continue to remain greatly concerned about the adequacy of the group homes to appropriately provide for the individual needs of the remaining residents with mental retardation at DCV. On December 15, 1995, I visited one proposed group home

site with the president of the group home, Kennedy Institute. The plans were to rely on aides to provide the bulk of care and to be supervised by a Licensed Practical Nurse (LPN). The turnover rate for aides in group homes is generally acknowledged to be every three months. I asked what contingency plans do they have when aides do not show up for work, and was told that they have about a 95% success rate with a back-up list.

Factored into the staffing plans were the provisions that the residents would be away from the home for six hours a day at day programs. But in fact the group home provider admitted that there are not really adequate or appropriate day programs for the DCV population of residents with mental retardation. However, he did express that the group homes that do accept this population could be creative and perhaps share the resources of the specialty consult team to provide that appropriate day programs, much as GUCDC is now doing at DCV.

This group home provider said that given the severe health needs of the residents with mental retardation at DCV, group homes cannot accept these residents without access to a specialty consult team. He also said that Catholic Charities of D.C., which runs the Kennedy Institute, is approximately $1,000,000 in debt from lack of payment by the District for the seven group homes it runs.

Except for one resident currently on Unit 2B with a one to one nurse aide assignment, the remaining eleven residents with mental retardation are on Unit 5A. The total current census on Unit 5A is sixteen residents. The current usual staffing pattern for day, evening, and night shifts on Unit 5A is to have one licensed nurse staff and two nurse aides. Usually, in a nursing home with a resident population of 16, this would be adequate. However, given the individualized attention the residents with mental retardation need in accordance with their individual habilitation plans, I now believe this

staffing pattern is inadequate on the evening, night, and weekend shifts when the GUCDC staff are not present. Group home staffing patterns are planned at one aide to four residents.

The Court Monitor met with the program coordinator for the GUCDC, Mr. Richard Clevenger, on January 5, 1995, at DCV. We discussed the above situations. Mr. Clevenger suggested that GUCDC explore hiring their own aides to complement staffing on Unit 5A. It would be much more cost effective than the amount DCV is presently paying for nurse aides. In addition, GUCDC would have greater access to educating and supervising the aides in the care of the residents with mental retardation. Also, these residents would have assured continuity of care, which is so important and is not consistently the case now. According to Mr. Clevenger, GUCDC has considerable experience in hiring, training, and supervising "habilitation aides" for a similar population in other settings.

In a meeting that same afternoon with Mr. Silas Butler, the Deputy Administrator of DCV and Mr. Clevenger, the Court Monitor informed and discussed all the above with Mr. Butler. Mr. Clevenger recommended that the GUCDC offices be moved from the second floor of an attached building, for the most part inaccessible to the residents with mental retardation, to Unit 5A. Mr. Butler said he would immediately put those plans into effect.

Historically at DCV, the GUCDC staff has not been included as an integral part of the life of the residents with mental retardation, including full participation in care planning and the planning of the residents outplacement. It is my understanding from interviews and reading past memos and letters, including those from the Pratt Monitoring Program and Georgetown University to the administration at DCV, that the administration, nursing, and social services departments have been resistant to expertise beyond theirs.

The Court Monitor told Mr. Butler, who is charged with coordinating the outplacement process for all residents, that GUCDC should be attending the weekly, Wednesday morning outplacement meetings, and that I have invited Mr. Clevenger to do so. Mr. Butler has agreed to this.

The **medical assessments** for the three identified residents in the December 22, 1995, Court Order is a current example of lack of consultation with and integration of the program expertise in mental retardation supplied by the GUCDC at DCV. On January 5, 1996, I asked the Medical Director (MD) about these medical assessments. She informed me that the assessments had been conducted earlier in the week. The MD did not consult with nor ask GUCDC for references and names of medical doctors who know the residents, who have expertise in mental retardation, and who have knowledge of care that can be provided in group homes. Instead, without collaborating with the GUCDC experts, the MD sought out two medical doctors who do not know the residents. Not collaborating with and coordinating expertise is a detriment to the residents.

This is not an isolated example. There is virtually no interdisciplinary coordination and cooperation at DCV. Secrecy and defensiveness is rampant among department heads and trickles down to staff in most all departments. A notable exception was the fine team work of the physical therapists, and ironically, their contract has expired and to date has not been renewed. The outplacement of residents with mental illness provides another example.

B. <u>Issues with Respect to the Discharge and Outplacement of Residents with Mental Illness</u>

DCV has employed the services of Geriatric Psychological Systems (GPS) to conduct the psychosocial assessments of residents. GPS is a consulting firm with presence in several

nursing homes in the District.

GPS will review the Minimum Data Set which is the federally mandated individual assessment tool to be used as a basis for developing the individualized care plans, which are also mandated by federal law and regulations.

The GPS team consists of a nurse, social worker, psychologist, psychiatrist, and a finance person to determine Medicare Part B reimbursement eligibility. The psychologist is scheduled to conduct evaluations of residents with psychiatric diagnoses based on the findings from the Minimum Data Set assessments. Then the psychiatrist is scheduled to review psychotropic medications, based on the psychologist recommendations.

The ombudsperson has had concerns in the past with the psychiatrist chosen by GPS and and in July 1995, filed a complaint with the local licensing authority. These complaints concerned non-visits to residents and questioned appropriateness of medications ordered. The complaints were investigated by the local licensing authority and HCFA and were substantiated. These concerns were shared with the GPS administrator who said that he had heard concerns raised before about the psychiatrist . The GPS administrator went on to say that the psychiatrist has essentially a good Medicare reimbursement record.

On December 27, 1995, the GPS consulting team met with staff at DCV. After the meeting, the Court Monitor met with GPS staff and shared the Court Orders and the Status Reports to the Court. The regional president of GPS told the Court Monitor, "Your November 30 report outlines our work completely."

It is unclear to date how needed psychiatric therapies will be conducted on an ongoing basis as long as the residents remain at DCV. Further monitoring is required.

My concerns with the outplacement of residents with mental illness, in addition to those already presented to the Court in previous reports, are two-fold. (1) The manner in which the consulting firm was chosen is symptomatic of the pervasive attitude of non-collaboration among departments, defensiveness to constructive input, secrecy and lack of sharing of information; (2) I see no way under the current structure for outplacement of residents that the recommendations of GPS will be systematically incorporated into the interdisciplinary discharge plans and communicated to the outplacing facilities.

(1) On the afternoon of December 19, 1995, an outplacement meeting took place at DCV specifically to discuss the outplacement of residents with mental illness. Attending and chairing the meeting was the Deputy Administrator for DCV, the Chief of the Central Referral Bureau for the District of Columbia (who is a member of the outplacement and attends all the weekly meetings), the Ombudsperson, the Medical Director, and the Court Monitor.

The Deputy Administrator at DCV has been charged with overall oversight of the outplacement process. He in turn designated the Medical Director to oversee the outplacement of residents with mental illness primarily because, at the Deputy Administrator's own admission, he does not know much about mental illness. However, at her own admission, the Medical Director said she does not know much about mental illness either.

The Medical Director was asked to present an update on the outplacement of residents with mental illness. This presentation indicated little understanding of the seriousness of the deficiencies in the care at DCV and the deficiencies of the available resources within the District to adequately care for this population. This, despite the fact that the Court Monitor met with the Medical Director a month beforehand and outlined for her a path to

follow to appropriately outplace residents with mental illness. This information is outlined in the November Status Report in the section on 'Outplacement of Residents with Mental Illness'.

On my way out the door of the facility that evening, the Medical Director informed me that GPS was expected at DCV the next day for an interview. I do not understand the unwillingness to share this information in the appropriate meeting and to receive input for the best interests of the residents with mental illness. It was at the Court Monitor's insistence to the Deputy Administrator that the Ombudsperson and the Chief of the Central Referral Bureau attend this meeting. These two have years of knowledge of the difficulties in outplacing this population and are members of the outplacement team.

At a meeting at DCV on the evening of December 28 with Dr. Harvey Sloane, Commissioner of Public Health, District of Columbia; Dr. Guido Zanni, Commissioner of Mental Health, District of Columbia; the Executive Director of DCV; and the Interim Administrator for Long Term Care for the District, the Medical Director objected to the provisions in the December 22, 1995, Court Order specifically relating to providing consultation services to receiving facilities to ensure safe and effective transition to new residences. This objection demonstrates a lack of awareness of the seriousness of a contempt citation and a professional entrenchment which clouds objectivity.

I do believe that charging the Medical Director to oversee outplacement of the residents with mental illness is not a positive use of her considerable strengths in the areas of home care and hospice care. I, therefore, recommend that oversight of the outplacement of residents with mental illness be given to Ms. Corrie Kemp, Chief of the Central Referral Bureau for the District of Columbia. In this capacity, Ms. Kemp has current knowledge of all the caregiving sites in the District, their strengths and weaknesses, their abilities to

care for the residents with mental illness, and what licensure and regulatory requirements may be needed to facilitate the ability of certain sites to prepare to receive this special population.

(2) Current management structure at DCV does not provide for the incorporation of the data and recommendations expected from GPS into the interdisciplinary discharge plans and the follow up communication to the outplacing facilities.

The outplacement of residents is currently coordinated by the social services department. The head of the social services department has been observed telling clinical nurses on the units that psychosocial assessments have already been done. There have been virtually no current psychosocial assessments conducted for the residents, despite the protestations from the social services department. This leads me to the following additional concerns.

C. <u>General Discharge and Outplacement Issues</u>

The Action Steps described in the November 30 Status Report, which DCV initiated and, at that time, indicated a commitment to continue, have not been continued.

There have been no further meetings since the November meeting with residents, relatives, and responsible parties, although, DCV committed to scheduling these meetings for December and January.

Counseling residents and staff began and ended in December. There has been no involvement of other disciplines, such as, dietary and therapeutic recreation in the outplacement process.

The only leadership to date in the outplacement process has come from the Associate Director of Nursing, Ms. Disu. However, since she has been out on emergency medical leave, all the action steps identified in the November 30 Status Report have stopped. The social service department has taken no leadership in counseling residents and staff and in coordinating with other departments the individual interdisciplinary discharge care plans. Residents discharged from the hospital to a skilled unit within the same hospital have not had their discharge care plans sent from DCV. Ms. H.W. and Mr. H.J. are two recent examples. In these two instances, the ombudsperson was not notified of the residents outplacement.

On January 4, 1996, I received a telephone call from the nephew of resident Ms. H.D. The nephew, Mr. D.D., had received a call the week before from the administrator of the Skilled Nursing Facility a few blocks from DCV, pressuring the nephew to authorize outplacement of his aunt that day. Mr. D. wants his aunt outplaced to Carroll Manor which is near his home in Maryland. Mr. D. was told by the administrator that Mr. D's aunt could go the administrator's facility and when a bed opens at Carroll Manor, she could be transferred. Mr. D. wanted to know, if it was necessary to immediately outplace his aunt against his wishes, which would cause needless trauma to Ms. H.D. This is undue pressure on residents and family members and is a violation of their rights.

The nursing homes identified for outplacement have a primary motivation to receive reimbursement, therefore, the residents rights have to be protected.

D. <u>Measures to Remedy Shortages</u>

Under the current management structure, shortages continue to occur which pose serious harm to the health and welfare of the residents. A few examples follow.

Physical Therapy On December 14, I asked the Executive Director if she knew if the physical therapy contract had been renewed. She said that she did not. I asked if she knew that the physical therapist had not been paid. She said that she did not. The Executive Director said she would follow up on the matter and get back to me.

On Thursday late afternoon, December 28, 1995, the physical therapist, while leaving DCV, told the Court Monitor that she was on her way downtown to sign an extension until January 9, of her contract which expired that next day, December 29. The physical therapist told me that the contracts for physical therapy services would be up for open bidding; that she had no idea if she would be servicing DCV after January 9, 1996; and that TMS Management Services, the physical therapy vendor, had not been paid.

At the December 28 evening meeting described earlier with the Commissioner of Public Health for the District; the Interim Administrator for Long Term Care for the District; the Commissioner of Mental Health for the District; and the Executive Director of DCV, the Court Monitor raised the serious issue concerning physical therapy services. The Executive Director said she was "completely on top of it" and that the physical therapist was going to have her contract renewed today. I asked if the she knew for how long, and the Executive Director said until January 9. And then I asked what would happen after January 9. The Executive Director said, "I don't know." The Interim Administrator for Long Term Care said it is "contract procedure" to have open bidding and that the physical therapist may not be the same one, but that there would be physical therapy services.

The Court Monitor told the meeting attendees, that this means one of three scenarios. One, that there will be no physical therapy services at DCV after January 9, two, that there will be an interruption of services, and/or, three, that there will be a lack of continuity in services by supplying a new contract vendor. Any of the above is

unacceptable and intolerable for the health and welfare of the residents. Dr. Sloane, the Commissioner of Public Health for the District of Columbia shook his head and said to the Interim Administrator for Long Term Care, Ms. Gladys Fountain, "this isn't right, see what you can do."

As of this writing, there is no physical therapist at DCV.

Occupational Therapy Since October 24, 1995, there has been an outstanding request for a purchase order for needed supplies for hand splints to prevent further contractures in residents. The causes of contractures and the serious jeopardy contractures of both hands and legs pose to residents health have been profiled in previous Status Reports to the Court. Development of contractures stems from passive neglect which over time is chronic abuse. According to occupational therapy staff, the Medical Director and the Executive Director were given these requests for **purchase orders** in October. To date, there are no supplies at DCV to make hand splints to prevent further contractures of residents hands. Among many other normal daily human activities, contractures of hands have serious health consequences relating to preventing residents from feedings themselves, attending to personal hygiene, such as, grooming, toileting, brushing teeth, and drinking water for hydration.

Procurement In a meeting at DCV on December 22, 1995, with Mr.Vernon Hawkins, Director of the Department of Human Services for the District of Columbia; the Commissioner of Public Health for the District; the Interim Administrator for Long Term Care for the District; the Executive Director and the Deputy Administrator of DCV; and the Court Monitor, Mr. Hawkins said that he would be detailing Ms. Cheryl Perkins from the Procurement Office in the Department of Human Services of the District of Columbia to DCV two half days a week, Monday and Wednesday.

At a meeting in Mr. Hawkins office on the campus of St. Elizabeth's on December 26, 1995, attended by vendors, the dietary department head at DCV; the Executive Director and Deputy Administrator of DCV; the Commissioner of Public Health and the Interim Administrator of Public Health; the Chief of Staff for Mr. Hawkins; and the Court Monitor, Mr. Hawkins again reiterated that commencing the following Wednesday, January 3, 1996, a representative from the procurement office would be detailed to DCV to write purchase orders.

On Wednesday, January 3, 1996, the Procurement Office representative, Ms. Cheryl Perkins, did not come to DCV. When the Court Monitor inquired, I was told that Ms. Perkins took a leave day. On January 4, I left a message for Mr. Hawkins stating my disappointment that he did not send a representative from the Procurement Office as he had said that he would.

To date there has been no representative from the Procurement Office at DCV.

E. Food and Drink (Stipulated Court Order, July 6, 1995)

Defendants shall immediately ensure that sufficient supplies of nutritious and appropriate food and drink are consistently maintained at DCV and that each resident daily receives adequate, well-balanced, nutritious and appropriate food and drink according to their individual nutritional needs.

Status Re: Court Order Non-Compliance

Two experts in dietary services and nutrition from the Department of Nutritional Sciences, Howard University, in the District of Columbia, served as consultants to the Court Monitor. The expert consultants were at DCV on December 27, 28, 29, 1995, and January 2, 3, 4, and 5, 1996. I urge the reader of this Status Report to go to Appendix B for the complete report of the nutrition experts.

The major findings of the food and nutrition experts are the following.

Inservice

There is **No Inservice** on resident care, diet and nutrition. The last documented inservice in this area was in 1993. This is a violation of federal regulations and professional standards of practice.

Policies and Procedures

There are ***No Policies and Procedures.***

The Policy and Procedures Manual was incomplete and outdated.

Policies and Procedures were lacking in the following critical areas of resident care and food service management:

1. Decubitus ulcer protocol;
2. Documentation of food consumption;
3. Hydration schedule;
4. Unplanned weight loss;
5. Menu analysis;
6. Menu Substitutions;
7. Staffing pattern;
8. Job descriptions;
9. Employee scheduling;
10. Employee orientation;
11. Purchasing procedures;
12. Emergency food and beverage supplies;
13. Re-assessment of post-hospitalized residents.

There is a lack of uniformity in resident care management.

Food Service Systems

In order to **ensure that sufficient supplies of nutritious and appropriate food and drink are consistently maintained** an effective **procurement** system and an effective inventory control system are required. The food and nutrition experts found that DCV did not have inventory records which would: provide accurate information of food and supplies in stock; determine purchasing needs; provide data for food cost control; and prevent theft and pilferage. Findings also included no storeroom requisition files, no purchasing manual, and no policies and procedures concerning purchasing, including receiving, storage, and inventory control.

Menus

The food and nutrition experts found that in the area of the preparation of menu items in the needed quantity and with the desired quality, there are major violations of standards of professional practice. Three of the critical areas are the following:

(1) Food service personnel are not using recipes to determine portion sizes;

(2) Smaller portion serving utensils are being used for food items on resident trays, when larger portion sizes are necessary for adequate nutrition;

(3) Consistent with findings in the November 30 Status Report, portion sizes are not on menus, production sheets, nor recipes. Therefore, according to the food and nutrition experts the **nutritional status of the residents is at risk.**

Consistent with the findings of the HCFA surveyors in September 1995, there are more diets prescribed than probably any nursing home in the country. The experts found 20 different diets, many very restrictive. This is contrary to current dietary and nutrition practices in nursing homes today. Physician diet prescribing practices do not reflect current knowledge of nutritional health for nursing home residents. Restrictive diets lead to diminished food intake and increased use of supplements, and can lead to increased

use of gastric tubes prescribed for feeding. Whereas, resident satisfaction and improved food intake are associated with more liberal diet policies. I have yet to hear a resident express satisfaction with the meals at DCV.

There is a heavy prescribing of and reliance on gastric tubes at DCV. Gastric tubes are placed directly into the stomach for feeding. There is a body of literature on iatrogenic malnutrition, which is malnutrition induced by physicians.

Clinical Nutrition Care Management

Chart reviews for clinical nutrition care management provided the following findings.

(1) In all charts reviewed, there were no records of food consumption and fluid consumption, typically called intake and output records. The experts say that a record of food and fluid intake is a standard practice for nutrition care management. "With only an occasional notation, it is virtually impossible to assess the nutritional adequacy of a resident's food and fluid intake." Monitoring fluid intake is vital to adequate hydration of nursing home residents.

(2) There is an excessive reliance on dietary supplements which are associated with decreased appetite and food ingestion.

(3) Nearly half of the residents identified to receive increased fluid intake had no interventions listed on the care plan in their charts, and had no increased fluids on their meal trays.

(4) Significant weight loss or gain is not adequately addressed by dietary with no interdisciplinary collaboration and follow-up.

(5) A number of care plans were inaccurate or inadequate.

(6) One third of the annual nutrition assessments did not contain significant data about the residents.

Meal Observation and Tray Accuracy

A consistent pattern of tray inaccuracies was found. For example, Mr. C.F. is to receive a high fiber diet and cranberry juice, and yet he consistently receives white bread instead of wheat bread and rarely receives cranberry juice. He is often told by the dietary department that cranberry juice is "too expensive." The experts say that cranberry juice is not expensive.

Recommendations

Some of the recommendations from the experts based on critical deficiencies posing serious harm to residents health and welfare are the following .

(1) Needed ongoing continuing education by the professional community.

(2) "Establish and implement an effective and consistent program of **hydration** including a **Hydration Policy** to ensure uniform approaches in the prevention and treatment of dehydration. Both Nursing and Dietary Departments will need to collaborate to devise policy and procedures."

(3) Implement food and fluid intake assessment procedures.

(4) Comply with **Residents' Rights** by posting menus on each unit.

(5) Implement a "more uniform and aggressive approach to addressing significant unplanned weight changes."

(6) Adopt a "uniform and systematic interdisciplinary care program to reflect a more integrated approach" to resident care.

(7) Establish a Quality Assurance program reflective of professional standards of practice and federal and District law and regulations.

The food and nutrition experts and the Court Monitor found an alarming and troublesome attitude among staff which was also voiced by the Interim Administrator for Long Term Care for the District, when I introduced the nutrition experts to her. That is, that since

DCV is closing at the end of March, what is the point of looking at operations.

Another dismaying attitude is that instead of viewing the food and nutrition experts to the Court Monitor as possible sources of professional growth and as colleagues to learn from, especially the experts from Howard University here in the District of Columbia, the head of the dietary department called the Corporation Counsel complaining about the data they were being asked to review.

Summary

In summary, the food and nutrition expert consultants to the Court Monitor believe that nutrition can make a difference between life and death and that the lives of the residents of D.C. Village Nursing Home are at risk.

F. Provision of Health and Nursing Care

There is, once again, virtually no leadership in the nursing department. The Director of Nursing (DON) hired three months ago has left employ at DCV. A nurse from the Commission of Public Health has been detailed to serve as acting DON.

Although the District's goal for outplacement of over 220 residents is March 31, 1996, this is not realistic. I foresee the facility open through at least a good part of 1996. The Commissioner of Public Health concedes that there are approximately 70 residents who will be virtually impossible to outplace. It is not acceptable to have an acting DON. The residents need immediately competent, consistent, and stable nursing leadership and nursing staff for as long as they remain in their homes at DCV.

The one leader in nursing administration has been on emergency sick leave since before Christmas. Since her emergency surgery, the announcement over the public address

system every two hours to turn residents has stopped. The interdisciplinary counseling sessions regarding transfer trauma for staff and residents has stopped. The therapeutic music played over the public address system has stopped. A nursing facility cannot run on the strength of one committed, caring, knowledgeable leader alone.

There are few permanent licensed nurse staff left. The licensed nurse staff on the units are, for the most part, from contract agencies. I have found in discussions with the management of the contract nurse staffing agencies, that most of them are not aware of the Nursing Home Reform Law and the minimum standards for long term care as exemplified in the federal regulations.

The clinical contract nurses are not permanently assigned to units, and, therefore, are not involved in the life of the residents. They do not know the residents, nor do the residents know them. Two residents of DCV for many years, Mr. M.W. and Mr. C. F., the President of the Residents' Council, were asked who their clinical nurse coordinators are on their respective units. Neither one knew the answer. This is unacceptable for a long term care facility. To be sure, there are a few contract staff who are usually assigned to the same units and who are also providing good care.

The nurse aides on the units are essentially without supervision. The contract nurse staff do not supervise the nurse aides, and, when they try to, for the most part are ignored by the nurse aides. This is an intolerable practice and a danger for the health and welfare of the residents. All nursing staff, including nurse aides, must have job descriptions, performance evaluations, and expectations of performance for retention of position. In the December 22, 1995, meeting with Mr. Vernon Hawkins, Director of the Department of Human Services for the District of Columbia, Mr. Hawkins said that he realized there is a tension between contract staff and nurse aides.

Without leadership from nursing administration, the clinical coordinators do not receive the supervision they need. The rehabilitation potential of the residents is not realized. Examples of evidence of this is the presence of contractures, incontinence and the level of bowel and bladder rehab programs, as well as the lack of physical therapy professional services to provide leadership to the ten physical therapy aides in areas such as performing range of motion exercises. This is unacceptable for a long term care facility. This is all described in previous Status Reports to the Court.

It is time to enforce the Appropriate Nursing Staff provisions of the Stipulated Court Order of July 6, 1995.

Decubitus Ulcers Before the emergency medical leave of the Associate Director of Nursing (ADON), weekly decubitus ulcer care rounds were initiated on Wednesday mornings. These rounds consisted of the two ADON's, the clinical nurses on the units, the treatment nurses, the Medical Director, and the resident. It is my understanding that these rounds have now been scheduled to take place once a month because "they take too long." There are very few more important activities in a nursing home than the interdisciplinary care team rounds conducted at the bedside as frequently as possible.

Infection Control The infection control staff person should have her office on a resident care unit and should be constantly making rounds on the units and in residents' rooms.

Eighty percent of suction equipment placed at the bedside was observed to be dirty. Policies and Procedures for Tube feeding and Hydration must immediately be developed.

There are still monthly reports of hospital admissions due to dehydration, infections,

pneumonia, sepsis all of which are related to inadequate infection control procedures and follow-up continuous education. Hospitalizations for these causes also related to lack of hydration, lack of adequate hand washing, poor nursing care, and improper incontinent care. Hospitalizations for dehydration are considered "immediate jeopardy to resident health" according to federal regulations and can be grounds for the imposition of temporary management.

Residents are in need of better grooming. For example, residents were observed with dirty hair and dirty nails. On the units dirty wheelchairs and dirty geri-chairs were noted.

Personal care items must not be placed on the floor as observed.

Environmental rounds were conducted in the Nutrition department on December 13 and a form for corrective actions to be taken by December 20. The form was returned to Quality Assurance/Infection Control with no identified corrective action taken.

Pharmacy There are five pharmacists at DCV. Not one could provide information on what residents are on psychotropic medications and what the medications are and the dosages, despite the fact this information is required knowledge according to federal regulations.

The medication drug pass observations conducted by the pharmacists are frequently based on insufficient numbers of observations in which to make a conclusion on drug error percentages. The federal regulations state that observations are to be made on 20 to 25 doses of medications. For example, if five residents are on five medications, this would fulfill the requirement. In several instances, observations and conclusions are based on zero, two, or five doses of medications.

One resident, Ms. S.B, has been without a prescribed medication for her hands since September.

All the Court Monitor's nursing home systems expert consultants have assessed that throughout the country nursing homes the size of DCV have one pharmacist. Medications are obtained through a Medicaid contract vendor and are received within twenty-four hours. It is not necessary to have a cumbersome attachment to the pharmacy at St. Elizabeth's as is currently the case.

Quality assurance programs and policies and procedures reflective of a collaborative relationship with medicine, nursing and other departments are lacking. (This is true for all departments in other areas as well.)

All the Court Monitor's nursing home systems expert consultants have found DCV departments divided, isolated, and with no collaborative approach.

Social services These comments are in addition to comments about social services in the Outplacement sections of this report. One resident, a young man who is wheelchair bound, is in obvious need of dental attention. He has been a resident of DCV since 1982. The nursing homes systems expert consultant to the Court Monitor earlier this month asked him if he would like his teeth fixed. He said that if his teeth were fixed he would not have to repeat himself so much and tears came to his eyes. There is also a full-time Dentist at DCV. It is a violation of the medical social services requirements in the federal regulations not to have coordinated dental services for this young man.

IV. IMMEDIATE ACTION STEPS

A. Mental Retardation

GUCDC move their offices immediately to Unit 5A, where the residents with mental retardation live.

B. Mental Illness

The Chief of the Central Referral Bureau assume leadership for coordinating the outplacement of residents with mental illness.

C. Outplacement

The head of the Social Services Department be removed from involvement in the outplacement process and leadership for outplacement from the social services be transferred to Ms. Betty Blythe.

D. Nursing Care

Contract nurse staffing vendors and their contract staff receive immediate inservice from the professional community on the Nursing Home Reform Law and the federal regulations which outline the minimum requirements for standards of practice for nursing home care. The vendors will assure that no contract staff is sent to DCV without this continuing education. While at DCV, the contract staff must be supervised.

V. POTENTIAL MODELS FOR NEW MANAGEMENT

I am drawing upon the expertise of professionals in long term care and nursing home operations to propose models to the Court used in other parts of the country. Many of the consultants to the Court Monitor live in the District, know DCV, have local, national, and international reputations, and are vitally concerned about the health and welfare of the residents.

A new management team should have the ability to hire and fire personnel. Front

line caregiving staff should be given the opportunity to be retained if they meet and agree to specific performance criteria.

There are professional association lists of qualified management teams, as well as federal government teams, and the potential for a creative use of local talent. These will be researched and presented to the Court immediately.

On Saturday, January 13, 1996, I met with Dr. Harvey Sloane, Commissioner of Public Health for the District and shared with him my assessments and conclusion for the need of new management at DCV.

On Monday, January 15, 1996, at Dr. Sloane's initiative, Dr. Sloane and the Court Monitor met with Dr. Philip Lee, the Assistant Secretary of Health and Human Services in the U.S. Department of Health and Human Services. The purpose of the meeting was to share with Dr. Lee the situation at DCV. The D.C. Initiative, the intent of which is to explore how federal agencies may be of service to the District, is under Dr. Lee's Office. The Court Monitor gave copies of the Court Orders and the Status Reports to Dr. Lee, who said he would explore the use of Commissioned Corps personnel to serve at DCV.

On Tuesday, January 16, 1996, a conference call was held with Mr. Vernon Hawkins, Director of the Department of Human Services for the District, Dr. Sloane, the Commissioner of Public Health, and the Court Monitor. Mr. Hawkins shared with the Court Monitor his conceptual thinking regarding a management team for DCV. According to Mr. Hawkins, his thoughts include bringing in a management team to lead the nursing and dietary departments, and outside consultation for medical care. Mr. Hawkins' plans include detailing Ms. Sue Brown, currently with the Commission on Health Financing in the District, to supervise "day to day policy formulation and

direction,", to have authority to procure items and "sign off on personnel action," and to coordinate activities of a management team in nursing and dietary.

Mr. Hawkins also said he met with the Chief Financial Officer for the District, Mr. Anthony Williams, regarding payment issues at DCV. Mr. Hawkins was to hear from Mr. Williams at 5pm, Tuesday, January 16 regarding authorization of payment of vendors. The Court Monitor asked Mr. Hawkins to please call once he heard from Mr. Williams that day. As of this date, I have not heard from Mr. Hawkins.

The Court Monitor shared with Mr. Hawkins concerns about his plans. The first concern is that on December 19, 1995, the Court Monitor called Ms. Sue Brown to inquire about financial audits, which would be necessary in order to apply for home and community based waivers for the outplacement planning of residents with mental illness. Ms. Brown would not speak with the Court Monitor until a representative from the Corporation Counsel's office was also a participant in the phone conversation. I gave Ms. Brown the number of Ms. Barbara Mann, with whom I happened to have just spoken. At the end of the conversation, I told Ms. Brown that I look forward to meeting her. Ms. Brown told me that she does not want to meet any court monitor nor have anything to do with a court.

I also shared with Mr. Hawkins that more than two departments would need new management, and that I do not believe a management team will accept supervision from the District under a Contempt citation.

Conclusion

I believe the announced closure of DCV by the Mayor and the City Council after the Stipulated Order of July 6 was filed and the appointment of the Court Monitor, has

undermined the efforts of the Court to improve life for the residents in their homes at DCV.

My previous assessments of a motivated and caring staff were based on a model and assumption of staff independent and separate from the binds of the District government. However, it is now clear to me that DCV is micro-managed from outside its walls and campus; micro-managed from a framework that does not factor in the welfare of the residents. That the framework from which it is micro-managed is fueled by protection of itself and insulation of its member to the detriment of the object of its services - the residents of DCV. That it produces a closed system, not open to input and growth for the betterment of and improvement in resident care.

I now have serious concerns for the health and welfare of the residents. I believe new management at DCV under Court monitoring will protect the residents health and welfare and prevent further violation of their rights.

I do not believe that at present the District of Columbia is capable of directly caring for the residents of DCV nor following the Court Orders. My duty is to present to the Court the life of the residents and the status of compliance of the District with the Court Orders. The Court Orders merely profile decent care practices, which any of us would want for our loved ones, and which should be expected of a compassionate society and especially of a nursing home in our nation's capital.