U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

May 6, 2008

The Honorable Mark Sanford
Governor of South Carolina
Office of the Governor
1100 Gervais Street
Columbia, SC 29201

Re: CRIPA Investigation of C.M. Tucker, Jr., Nursing Care Center in Columbia, South Carolina

Dear Governor Sanford:

I write to report the findings of the Civil Rights Division's investigation of conditions and practices at the C.M. Tucker, Jr., Nursing Care Center ("Tucker" or "the facility") in Columbia, South Carolina. On July 25, 2006, we notified you of our intent to conduct an investigation of Tucker pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of nursing home residents who are served in public institutions.

In November and December 2006, we conducted on-site inspections of Tucker with expert consultants in the areas of protection from harm, environmental health and safety, geriatric medicine, psychiatry, and nursing. Before, during, and after our site visits, we reviewed a wide variety of relevant facility documents, including policies and procedures, and other records relating to the care and treatment of Tucker residents. During our visits, we also interviewed Tucker administrators, professionals, staff, and residents. In keeping with our pledge to share information and to provide technical assistance where

appropriate, we conveyed our preliminary findings to counsel for the South Carolina Department of Mental Health ("SCDMH") and Tucker administrators and staff at the close of each of our on-site visits.[1]

At the outset, we would like to express our appreciation to the State of South Carolina ("State") and to Tucker staff and administration for their complete cooperation and assistance throughout our investigation. We are confident that this cooperative relationship will help ensure an efficient resolution to this investigation.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies we have identified. 42 U.S.C. § 1997b. As described more fully below, we conclude that numerous conditions and practices at Tucker violate the constitutional and federal statutory rights of its residents. In particular, we find that residents of Tucker suffer significant harm and risk of harm due to inadequate nursing, medical, and mental health care; inadequate nutrition and hydration; inadequate behavioral programming; inadequate medical and nursing documentation; inadequate protection from harm; inadequate activities; failure to serve residents in the most integrated setting; and inadequate sanitation. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. §§ 1395, 1396r, and implementing regulations, 42 C.F.R. § 483 Subpart B (Medicaid and Medicare Program Provisions). As a result of these deficiencies, Tucker residents have suffered preventable injuries, illnesses, and deaths. In addition, we find that the State fails to provide services to certain Tucker residents in the most integrated setting, as required by the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

I. BACKGROUND

Tucker is a public nursing home operated by SCDMH. Tucker provides long term care to persons who have been approved by the South Carolina Department of Health and Human Services Regional Office, and approved by an Admissions Committee based on

[1] In addition, we re-visited Tucker, without experts, in September 2007, for the purpose of introducing additional DOJ staff to facility officials.

established criteria for skilled and intermediate nursing care. While the population is currently approximately 400 persons, the facility is certified by the Centers for Medicare and Medicaid Services ("CMS") to serve up to 560 residents. Tucker includes three pavilions which are located on a campus in downtown Columbia. The John M. Fewell Pavilion ("Fewell Pavilion") opened in 1970; the E. Roy Stone Veterans' Pavilion ("Stone Pavilion") opened in 1971; and the Frank L. Roddey Pavilion ("Roddey Pavilion") opened in 1983. The facility has two separate licensures under Medicare: one for the Roddey Pavilion and one for the Fewell and Stone Pavilions, collectively. Stone Pavilion primarily serves veterans. Tucker is an atypical nursing facility in that nearly all of its residents have one or more psychiatric diagnoses. Tucker is the nursing home of last resort for hundreds of patients with long-term psychiatric illnesses. Many Tucker residents were previously patients in the State psychiatric hospital system.

II. FINDINGS

A. INADEQUATE NURSING, MEDICAL, AND MENTAL HEALTH CARE

At issue is whether the State is providing Tucker residents with care and treatment in accordance with its constitutional and federal statutory obligations. Residents of publicly-operated institutions, such as Tucker, have a Fourteenth Amendment due process right to adequate health care. Youngberg, 457 U.S. at 315 (adequate medical care required in institutions housing individuals with developmental disabilities); Patten v. Nichols, 274 F.3d 829, 842 (4th Cir. 2001) (Youngberg establishes right to adequate medical care in institution for individuals with mental illness); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1187 (W.D. N.C. 1988), aff'd 902 F.2d 250 (4th Cir. 1990)(finding breach of professional standards where state failed to periodically monitor adverse side effects of medication).

Federal regulations specify the generally accepted professional standards for health care in nursing homes.[2] Federal regulations require that each resident of a nursing home has a right to "necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of

[2] Generally accepted professional standards include those promulgated by the National Hospice and Palliative Care Organization, the American Cancer Society, and the American Geriatrics Society.

care." 42 C.F.R. § 483.25. Residents also have the right to an on-going re-evaluation of their health conditions. 42 C.F.R. § 483.20. Generally accepted professional standards require that licensed physicians and nurses understand the basic principles of medicine applicable to the population they serve. As such, professionals at Tucker have a responsibility to understand the unique diagnostic and treatment requirements of geriatric residents.

Tucker fails to provide residents with adequate nursing, medical, and mental health care, including psychiatric services. Our investigation revealed that these deficiencies have resulted in harm and, in some cases, death to residents. In each area, the care provided at Tucker substantially departs from generally accepted professional standards of practice and federal regulations. Specifically, Tucker fails to: a) provide adequate mental health assessments and diagnoses; b) provide adequate treatment for dysphagia; c) provide and monitor adequate and appropriate pharmacotherapy, including psychoactive medication; d) provide adequate psychiatric services; f) provide adequate treatment for pressure sores; g) provide adequate palliative and end-of-life care; and h) conduct adequate death reviews. These deficiencies place residents' health in serious jeopardy.

1. Inadequate Mental Health Assessment and Diagnosis

Federal regulations and generally accepted professional standards require nursing homes to establish a comprehensive care plan for each resident that specifically addresses individualized needs, including mental health needs. 42 C.F.R. § 483.20. Assessments must be conducted upon admission and periodically thereafter to ensure that there is a comprehensive, accurate, and standardized record of each resident's functional capacity. 42 C.F.R. § 483.20; see also In re Involuntary Discharge or Transfer of J.S., 512 N.W.2d 604, 609 (Minn. Ct. App. 1994) ("A nursing facility must initially and periodically conduct a comprehensive assessment of each resident's functional capacity."). These assessments are then used by staff to develop a comprehensive care plan specific to the needs of each resident. 42 C.F.R. § 483.20(a)(1). Adequate assessments include measurable objectives and timetables to assist the clinical and mental health staff in ensuring that all of the residents' needs are met in a timely manner. 42 C.F.R. § 483.20(k)(i). Physicians are required by federal regulations to take an active role in the care of each resident by reviewing, at each visit, the resident's total program of care, including medications and treatments. 42 C.F.R. § 483.40(b). The care plan must be

periodically reviewed and revised, using the results of the resident's regular assessments, to assure continued accuracy. 42 C.F.R. § 483.20(k)(2)(iii).

Nursing homes must provide resident-centered services which are individually tailored to meet the needs of each resident. 42 C.F.R. § 483.25. In order for this to successfully occur and be consistently maintained, interdisciplinary teams must know each resident's strengths, ambitions, preferences, and needs. This knowledge requires a relationship with the resident, annual assessments of the resident's status, and a plan of care which is proactively responsive to the resident's changing needs. Among other things, the plan should describe the services to be furnished in order to provide the resident with "the highest practicable physical, mental, and psychosocial well-being ..." 42 C.F.R. § 483.20(k)(1)(i).

We found that Tucker fails to adequately assess and care for residents' individual needs. This is especially evident in the lack of adequate assessment of mental illness. This issue is of great concern because, remarkably, nearly all residents whose charts we reviewed were noted to have one or more psychiatric diagnoses. This is far in excess of what is expected in a typical nursing home, but not completely unexpected in a nursing home such as Tucker that is a residence of last resort for hundreds of residents with long-term psychiatric illnesses.

We found that only approximately 50 percent of Tucker residents had been appropriately assessed by psychiatrists, despite the fact that nearly 100 percent of residents have one or more psychiatric diagnoses. A significant number of residents at Tucker were diagnosed with non-specific psychiatric illnesses, such as "psychosis not otherwise specified," "unspecified non-psychotic mental disorder," and, in one particularly egregious example, "organic brain syndrome," a diagnosis universally considered to be outdated and too non-specific to be meaningful. A non-specific diagnosis frequently leads to incorrect treatment which, in turn, can lead to serious injury or death.

2. Inadequate Treatment for Dysphagia

Generally accepted professional standards for the evaluation of dysphagia (difficulty in swallowing, commonly seen in nursing home residents)[3] include an assessment of the resident's ability

[3] Dysphagia is often caused by strokes, neurodegenerative conditions, and diseases of the esophagus, but can also be a

to chew food, drink fluids, and swallow safely. If dysphagia is present, nursing homes must provide appropriately textured foods and other necessary interventions to protect the resident from choking hazards, malnutrition, and dehydration.

We found a high prevalence of swallowing disorders at Tucker. We found a pattern of residents experiencing dysphagia for a long period before their symptoms were identified or addressed. We found that Tucker's nursing staff fail to recognize critical changes in residents' medical status, such as significant weight loss, malnutrition, and dehydration, in a timely manner. We also found that Tucker's nursing staff fail to alert attending physicians so that treatment options can be timely considered. Both doctors and nurses fail to follow up on required health care interventions to determine whether they are implemented and effective. This failure places residents at risk of serious, even life-threatening, harm. For example:

- A.A., a 59-year-old man suffering from dysphagia, showed symptoms of significant weight loss and swallowing difficulties.[4] His physician ordered a swallowing analysis, but no evaluation was completed for two months. In that period, A.A. continued to receive food in a texture and consistency that he was unable to chew and ingest safely. On the day after the swallowing evaluation, which determined that he needed to have pureed food and thickened liquids, A.A. was diagnosed with aspiration pneumonia[5] at the local hospital, and died four weeks later. His inadequately and untimely assessed swallowing problems, improper diet, and untreated loss of 20% of his body weight over a four month period may have contributed to his death by depriving him of a safe method by which to eat, the muscle strength and

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secondary result of side effects of medications, particularly psychotherapeutic medications, as well as by malnutrition and dehydration.

[4] Throughout this letter, we refer to Tucker residents by initials. To protect their privacy, we have changed their initials. We will provide a key to the residents' actual names under separate cover.

[5] Aspiration pneumonia is a lung infection caused by inhaling foreign particles, usually food or liquids, into the lungs. Aspiration pneumonia is often caused by a compromised swallowing mechanism common among elderly people and people suffering from neurological disorders or injury, such as stroke.

stamina needed to adequately chew and swallow safely, and, ultimately, the ability to cough effectively to clear his lungs and recover from the aspiration pneumonia.

- Similarly, it took four weeks after a doctor's order to conduct A.B.'s swallow evaluation. During that period, no nurses charted any progress notes regarding A.B.'s swallowing problems, even after the physician identified them. When it was finally conducted, the swallow study recommended that thickened liquids would be safer for him to swallow than textured or pureed foods. However, nursing staff failed to monitor whether he consumed the thickened fluids. Shortly thereafter, A.B.'s laboratory tests revealed severe dehydration that would not likely have occurred if he had consumed sufficient fluids. A.B. died one month later of aspiration pneumonia.

- Resident A.C. was supposed to receive thickened liquids pursuant to a diet order, but apparently did not receive them. Laboratory tests verified that A.C. was dehydrated. For four days after receiving the lab results, licensed nurses failed to enter any information about A.C.'s dehydration on his chart. A.C. was sent to the hospital in critical condition, and died four days later.

3. Inappropriate Use of Psychoactive Medication

Federal regulations and generally accepted professional standards require that nursing home residents be free from unnecessary drugs, which are defined as any drug that is used in an excessive dose, for an excessive duration, without adequate indications for its use, without adequate monitoring, or in the presence of adverse consequences indicating that the dose should be reduced or discontinued. 42 C.F.R. § 483.25(1); see also, Talbot v. Lucy Corr Nursing Home, 118 F.3d. 215 (4th Cir. 1997). With respect to psychoactive drugs, Tucker must ensure that residents who have not previously used psychoactive drugs are not given them unless the drugs are necessary to treat a diagnosed and documented condition. The regulation also requires that residents taking psychoactive drugs receive gradual dose reductions and behavioral interventions in an effort to discontinue the drugs, unless clinically contraindicated. Id.

We found that the psychoactive medication practices at Tucker substantially depart from generally accepted professional standards. In our review, we found that there was very little indication in the records that medical providers and nurses actually considered psychoactive drug side effects in evaluating

residents' changed conditions. We reviewed several charts where the relationship between increases in psychoactive drug dosages and changed clinical condition was obvious, yet nurses failed to document any observations or assessments after the dose was changed. Notably, Tucker was cited for deficiencies under this regulation in the September 21, 2006 survey conducted by the Centers for Medicaid/Medicare Services ("CMS").

We also found numerous instances where residents were prescribed psychoactive drugs absent an appropriate psychiatric diagnosis, where no apparent effort had been made at dose reduction, and where little or no monitoring had been undertaken of the appropriateness of the dose, drug interactions, or adverse side effects. For example:

- Resident A.D. was diagnosed with hypotension (low blood pressure) and was known to have a history of falls. She was prescribed a high dose of a psychoactive drug that, according to our expert consultant, should never be used in the geriatric population because it can cause orthostatic hypotension,[6] a major cause of falls in the geriatric population. Despite A.D.'s medical history and history of falls, she was administered this drug for over two years. In addition, there was no evidence in A.D.'s chart that any efforts were made to reduce the dosage, as required by federal regulations.

- Resident A.E. was on two psychoactive drugs for over one year without adequate monitoring for side effects. We found no evidence of attempts to reduce or eliminate these drugs. The medications, when used together, can cause serious side effects, including severe agitation.

- Residents A.F., A.G., and A.D. were given antidepressants with no diagnoses of depression. In resident A.D.'s case, the antidepressant was prescribed for sleep, which, according to our expert, is an inappropriate use of this powerful drug.

- At Tucker, anticonvulsants are routinely prescribed as mood stabilizers, psychoactives to control anxiety, and antidepressants for sleep problems, often without a clear rationale, and thus inappropriately.

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[6] Orthostatic hypotension is a sudden temporary drop in blood pressure upon standing up, and is common in elderly people.

- The psychoactive drug Seroquel is widely prescribed at Tucker, even for diabetic residents who are having problems controlling their blood sugar; a well-known side effect of Seroquel is to raise blood sugar levels.

4. Inadequate Psychiatric Services

Federal regulations and generally accepted professional standards require nursing homes to provide sufficient specialized services, including psychiatric services, to meet the needs of residents with mental health problems. 42 C.F.R. § 483.45; Or. Advocacy Ctr. V. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003); see also, Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000). We found that Tucker does not provide adequate psychiatric services to its residents.

We found that Tucker residents are not receiving psychiatric consultations on a timely basis. Moreover, when residents do receive psychiatric consultations, it typically takes up to two weeks for the recommendations resulting from the consultations to be implemented in residents' treatment plans. The generally accepted professional standard of care requires response to recommendations within 24 hours. Similarly, psychiatrists' notes are often not placed in the resident's chart for up to two weeks; the generally accepted professional standard dictates that the psychiatrist's note be placed in the chart immediately following the evaluation. These deficiencies create a serious risk of harm for residents, as, during the significant period of delay, the resident is receiving no mental health treatment, or inadequate treatment.

In addition, our expert noted that, at the time of the tour, Tucker did not provide psychiatric staffing adequate to meet the needs of its population. The clinical psychiatric staffing level at the time of our tour was limited to 12 hours per week. This insufficient staffing translates to only one brief visit every three months, per resident, which is grossly inadequate. We understand that Tucker intends to increase staffing by the addition of a psychiatric resident and/or fellow rotating through Tucker. Even this additional proposed psychiatric staffing is insufficient. Tucker needs one or more additional full-time equivalent psychiatrist positions.

5. Inadequate Treatment for Pressure Sores

Federal regulations and generally accepted professional standards require that nursing homes ensure that "[a] resident who enters the facility without pressure sores does not develop

pressure sores unless the individual's clinical condition demonstrates that they were unavoidable." 42 C.F.R. § 483.25(c)(1); see also, Crestview Parke Care Center v. Thompson, 373 F.3d 743, 745 (6th Cir. 2004). Federal regulations and generally accepted professional standards also require Tucker to take steps to prevent and treat pressure sores, including keeping the resident's skin clean and dry, monitoring the condition of the skin to detect the earliest sign of a pressure injury, and repositioning the resident at regular intervals. 42 C.F.R. § 483.25(c). With proper attention, most pressure injuries are widely considered to be avoidable.

We found that Tucker substantially departs from the standard of care for avoiding pressure sores. Several Tucker residents suffered severe stage IV pressure sores[7] that should have been prevented with appropriate care, including regularly turning and re-positioning the resident.

For example, one week after a resident A.H. began treatment with 5 mg. of Haldol (the maximum dosage recommended in long term care facilities is 3 mg. per day), he developed a stage II pressure sore that progressed to a stage IV sore that took six more months to heal. It is likely that medical staff did not recognize that this resident's mobility was impaired by the sedating effect of the high dose of Haldol, and therefore did not reposition him sufficiently to avoid the pressure sore.

We understand that Tucker is beginning to make improvements to prevent and treat pressure sores with pressure-relieving beds and by hiring a full-time certified wound-ostomy-continence nurse. These steps are commendable.

6. Inadequate Palliative and End-of-Life Care

Federal regulations and generally accepted professional standards require nursing homes to assess residents for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d). Generally accepted professional standards of care for the management of pain and other distressing symptoms at the end-of-life include: development of an educational program for

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[7] Pressure sores are labeled in four stages that relate to their depth. Stage I represents the most superficial pressure injury, whereas stage IV represents a full thickness skin loss with damage extending into muscle, tendon or bone. Full thickness pressure sores, stages III and IV, take months to heal or may never heal.

nurses and other medical care providers with an emphasis on pain assessment and treatment; use of standardized pain assessment tools; familiarity with opiate drug dosing and titration; use of palliative interventions, particularly medications, for treatment of such end-of-life symptoms as nausea, anxiety, and delirium; and, a focus on symptom management.

Tucker residents are not adequately treated for pain and end-of-life symptoms. Orders for pain medication, nausea control, and terminal agitation/anxiety medications were absent or inadequate in a majority of the cases reviewed. Tucker medical staff appear to lack knowledge of basic end-of-life management principles. In one egregious case, as a result of inadequate pain medication, a resident was found "groaning, in the fetal position" as death approached. Another resident, dying of metastatic colon cancer, vomited blood several times in the hours before his death, but no nausea medication was requested by the nurse on duty. Moreover, even though a tranquilizer had been ordered for this resident, it was not administered, a violation of generally accepted professional standards.

7. Inadequate Death Reviews

Generally accepted professional standards dictate that healthcare facilities typically conduct management reviews of care whenever a resident dies in order to analyze the adequacy of care provided and to develop strategies to improve medical performance in future cases. Tucker mortality reviews, conducted by a nurse practitioner, are inadequate and do not uncover quality of care problems that need to be addressed. In our sample of 12 reviews, not one review found any contributory deficiencies of health care. However, there were several instances where we found that care was deficient. For example, resident A.I. died, after being transferred to an acute care hospital, from complications of an infected, dislodged gastrostomy feeding tube. During the four days prior to his hospitalization, Tucker staff failed to assess whether the tube was properly placed, even though there was obvious leakage from the site of the incision and redness had been present for the prior 11 days. Infection of the G-tube site likely contributed to the resident's death. If Tucker medical staff had properly assessed this resident's condition when leaking was first observed, steps could have been taken to treat the problem. The death review of this case did not comment on the lack of assessments of the G-tube site.

Additional death reviews that we read similarly failed to identify basic care deficits such as the absence of licensed nurse charting for many days prior to a resident being "discovered" to be critically ill, hospitalized, and dying within a period of days. In many cases, resident records reflect that nurses failed to assess residents prior to sending them to the hospital. These failures were not identified by the death reviews or raised as issues to be addressed in medical staff meetings. The following examples illustrate these deficiencies:

- Resident A.C. was admitted to a local hospital intensive care unit from Tucker in critical condition from sepsis[8] and aspiration pneumonia. Tucker documents indicate that A.C. was not receiving thickened liquids to assist in proper hydration. A.C.'s condition appears to have worsened, though during A.C.'s last four days at Tucker, nurses apparently charted nothing regarding A.C.'s clinical condition. A.C. was subsequently sent to an emergency room without explanation, and died four days later.

- According to Tucker records, A.J. was sent from Tucker to a local hospital due to "acute onset of dyspnea."[9] Ultimately, the hospital concluded that A.J. suffered from acute respiratory failure from sepsis. A.J. died less than 24 hours after transfer from Tucker. Our review of Tucker's records did not yield evidence that Tucker staff adequately identified, diagnosed, or treated A.J.'s sepsis. Accordingly, the hospital's discovery of A.J.'s condition was too late to preserve A.J.'s life.

In a number of the charts of deceased residents that we reviewed, the death certificate did not accurately reflect the cause of the resident's death. One Tucker physician told us that because information about the actual deaths at the local hospital was unavailable to him, he bases his certification of the death on his general knowledge of the resident. We noted two Tucker

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[8] Sepsis is a medical term used to describe infection. While most cases of sepsis are treatable, if unchecked, sepsis can be fatal.

[9] Dyspnea is a term that generally identifies the symptom of shortness of breath, and is often the product of another illness.

deaths certified to be from "inanition"[10] from end stage Alzheimer's disease, one after only three weeks in Tucker residence and the other from septic shock. In neither case was there documentation that those residents had Alzheimer's or that they had regressed severely as implied by the term inanition. Tucker's failure to accurately determine the cause of its residents' deaths limits its ability to adequately evaluate how Tucker's health care services addressed the condition that caused the death.

B. INADEQUATE NUTRITION AND HYDRATION

Federal regulations and generally accepted professional standards of care require that adequate food and fluids be provided to nursing home residents. Federal regulations require that the facility provide each resident with "a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs of each resident." 42 C.F.R. § 483.35. Regulations also require "sufficient fluid intake to maintain proper hydration and health." 42 C.F.R. § 483.25(j).

Our review found that Tucker residents do not consistently receive appropriate therapeutic diets. Nurses do not verify diet orders with the physician's order; ensure that proper diets are served;[11] or accurately chart meal consumption. For example, resident A.C. should have received thickened liquids, but the dietitian observed that he was not receiving them. For four days, no licensed nurse charted any notes about his condition or meals. Laboratory tests showed that he became dehydrated, likely because he could not swallow unthickened liquids. He was hospitalized in critical condition with sepsis (a system-wide infection) and aspiration pneumonia, and died four days later.

At Tucker, nursing assistants are responsible for providing nutritional supplements and charting their consumption, but fail to do so on a regular basis. Tucker's systemic failure to document true consumption of meals, fluids, and supplements was observed in every unit during our visit. Nursing personnel routinely fail to assess for basic health issues, such as weight loss and diet, and do not consistently bring such concerns to the attention of physicians. As a result of these practices, Tucker

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[10] Inanition refers to pronounced weakness, extreme weight loss, and decreased metabolism due to prolonged severe insufficiency of food (starvation).

[11] See 42 C.F.R. § 483.25(i),(j).

residents have experienced avoidable episodes of malnutrition and dehydration that frequently have resulted in serious outcomes, often including the placement of feeding tubes that otherwise would not have been necessary.

Federal regulations and generally accepted professional standards require that facilities provide sufficient fluids to maintain proper health and hydration.[12] At Tucker, dietitians do not adequately calculate residents' fluid needs and communicate that information to nursing staff. Tucker's nurses do not adequately monitor residents' hydration status. In some cases, neither the dietitians nor the nurses recognized that the resident was at risk for dehydration. One resident, who experienced weight loss, dysphagia, and recurring urinary tract infections over a three month period, had no chart notes on her fluid consumption for three days. The next day, she was hospitalized and found to be severely dehydrated with a fluid deficit of over six liters. In every record we reviewed related to hydration problems, nurses charted inaccurately that adequate fluids were consumed.[13] In most of these cases, there was no documentation that the physician was alerted to any possible dehydration problem.

Generally accepted professional standards to address weight loss require an evaluation of the resident, looking at potential disease processes, functional problems, and medication side effects. Tucker's failure to evaluate weight loss for possible underlying and potentially remediable causes places residents at risk of harm. For example, A.K., a resident who had previously been diagnosed and treated for tuberculosis ("TB"), experienced a 15 lb. weight loss during a two month period in which he was treated three times for a respiratory infection. Despite the history of TB, no chest x-rays were done. His weight loss was not addressed by his medical caregivers. He was then hospitalized, diagnosed with an active case of TB, and died. Had his staff completed an adequate case review and analysis of his weight loss, it is probable that the diagnosis of active TB would have been made sooner, possibly averting his death from a treatable condition.

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[12] 42 C.F.R. § 483.25(j).

[13] If adequate fluids were consumed, dehydration would not occur.

We also found examples in which residents who were losing weight were not seen by the dietician for four to six weeks. In one egregious case, resident A.L., who had experienced weight loss, was not seen by a dietician for nearly seven weeks. According to our consultant, the generally accepted professional standard of care for residents experiencing weight loss is to have the dietician's input in assessing the nutritional problem, as well as to assist in the ongoing care. This requires that, for residents in the acute phase of significant weight loss, a dietician see the resident weekly or bi-weekly, with a reduction in frequency once the resident stabilizes.

C. INADEQUATE BEHAVIORAL PROGRAMMING

Federal regulations and generally accepted professional standards require that nursing homes provide adequate treatment and services to correct an assessed difficulty with mental or psychological adjustment. 42 C.F.R. § 483.25(f). Nursing homes are also required to provide behavioral interventions for residents using psychoactive drugs. 42 C.F.R. § 483.25(l). We found that the behavioral program at Tucker is inadequate and substantially departs from generally accepted professional standards. This deficiency is especially acute given the high percentage of residents with psychiatric diagnoses who are exhibiting behavior problems at Tucker.

Tucker does not have a formal behavioral program. Although there are two full-time psychologists available, it does not appear that Tucker addresses behavioral issues in an organized fashion. For example, there appears to be no formal behavior program for residents diagnosed with Alzheimer's disease, placing residents at heightened risk for the use of physical or chemical restraints to control behavior, and placing them at heightened risk of physical assault by other residents who may become frustrated at their repetitive speech or wandering. The following example illustrates the inadequacy of the behavioral support program at Tucker:

- Resident A.M. has a documented history of attempting to swallow non-food items. Accordingly, A.M. was placed under a one-on-one intensive staffing assignment during a particular course of scalp treatment that required her to wear a plastic shower cap. Reportedly, A.M. had tried several times to take the shower cap off her head and swallow it. Despite A.M.'s clear risk of choking, Tucker

did not assess A.M. for pica[14] and did not provide her with a behavioral support to help ensure her safety in the future. Moreover, the one-on-one intensive staffing assignment ended as soon as A.M.'s scalp treatment was over, leaving A.M. exposed to further risks of her pica condition.

D. INADEQUATE MEDICAL AND NURSING DOCUMENTATION

Tucker fails to ensure that residents' medical records completely and accurately reflect their care. This is a substantial departure from federal regulations and generally accepted professional standards. Federal regulations require that clinical records be complete, accurately documented, readily accessible, and systematically organized. 42 C.F.R. § 483.75(l); id. at § 483.20. The records should be sufficiently detailed to provide for continuity of care. Our investigation revealed numerous instances of inadequate or absent documentation by medical and nursing staff, leading to harm or the risk of harm to Tucker residents.

For example, we found a widespread pattern of omissions where documentation of nutritional supplementation was concerned. Our nurse consultant reviewed 15 resident charts that lacked documentation that such nutrition was ever provided, even though it had been ordered by the physician, including the charts of residents A.M., A.N., A.O., A.P., A.Q., A.R., A.S., A.T., A.U., A.V., A.A., A.W., A.X., A.B., and A.Y. Our physician consultant further noted that in all cases reviewed where residents were subsequently determined to have severe dehydration, documentation in the chart inaccurately reflected that fluid intake had been adequate. Clearly, the failure to provide nutritional supplements creates an unreasonable risk of harm by creating or exacerbating weight loss and, as noted above, deaths due to inadequate nutrition and hydration have been documented at Tucker. According to our physician consultant, either nursing assistants are not charting truthfully, or are not being adequately supervised by licensed staff.

In addition, we found multiple examples where the record indicated that residents had not been given full baths or sponge baths over a one week period. Nursing staff indicated that the practice at Tucker was to bathe residents twice a week, but when

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[14] Pica is the medical term for eating substances that are non-nutritive (e.g. pencils, glass, and plastic). While commonly seen in young children, pica may be of particular concern in adults, especially among seniors.

asked for documentation of this in the medical record, nurses were unable to find the required documentation.

We found that, in addition to lapses in completing medical records, Tucker also failed to provide training on the importance of record-keeping to staff. We learned that only 176 out of approximately 250 nursing assistants at Tucker had been trained on the use of a newly revised form being used in residents' charts.

E. INADEQUATE PROTECTION FROM HARM

Tucker residents have a right to "conditions of reasonable care and safety." Youngberg, 457 U.S. at 324. Applicable Medicaid regulations and generally accepted professional standards dictate that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The facility must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Id. at § 483.13(c). Finally, a critical component in a system to keep residents safe is an effective incident management system for reporting and investigating incidents involving injuries to residents, tracking and trending these incidents, and implementing and monitoring corrective action to avoid future incidents. Id. at § 483.13 (c)(2),(3). Specifically, this regulation states that the facility must:

> ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials... [and] must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

Id.

Tucker residents are not adequately protected from harm. In particular, Tucker fails to: (1) protect residents from injury due to falls; (2) monitor and control use of certain restraints; (3) protect residents from abuse and neglect and investigate those incidents that do occur; and (4) employ appropriate quality assurance to monitor all these areas.

1. Lack of an Adequate Fall Prevention Program

Tucker staff fail to protect residents adequately from the risk of falling. The injuries that can result from falls, particularly fractures, pose a serious risk to elderly persons. Federal regulations and generally accepted professional standards require nursing homes to assess residents for risk of falls, make appropriate diagnoses related to fall risk, develop appropriate care plans to mitigate risk of falls, and supervise residents adequately to protect them from falling. 42 C.F.R. § 483.25(h); 483.20(a-k); accord, Asbury Center v. U.S. Dept. of HHSCMM, 77 Fed.Appx. 853, 2003 WL 22290204 (6th Cir. 2003) (unreported).

There were 278 falls reported at Tucker in the six months of data provided prior to our tour. Although Tucker policy does not specifically define a "fall," Tucker's interpretation appears to be appropriate and includes circumstances in which a resident falls out of bed, is pushed to the floor by a peer, is found on the floor without staff directly observing how he or she got there, or deliberately seats him or herself on the floor.

Of the 278 falls recorded by Tucker staff, 183 of them, or 66 percent, were not witnessed by staff. On 10 of the living units we reviewed, at least 75 percent of residents' falls were not witnessed. In five of those units, every fall went unwitnessed. The high percentage of unwitnessed falls at Tucker is alarming, and reflects an unacceptable lack of supervision. Moreover, many of the falls resulted in significant injuries. For example:

- A.Z. was found lying on a hallway floor, complaining of right leg pain. It was discovered that he had a fractured right hip.

- B.A. was found on the floor in the doorway of his room. He had been complaining of leg pain since the previous day. B.A. suffered a fractured right lower leg.

- A.N. was found lying face-down on the floor. She sustained a two and a quarter inch cut requiring six sutures above her eye.

- B.B. was also found lying face-down on the floor with a pool of blood around her head. She sustained a left shoulder dislocation and a wound to her head.

- B.C. was discovered to have a fractured right ankle after being found on the floor and complaining of right ankle pain. The origin was never determined.

- A.J. was found on the floor in a peer's room with a bleeding cut above his eye. The injury required five sutures to close.

Moreover, Tucker lacks a formal program to evaluate residents who have fallen. While Tucker's "falling star" program (which identifies residents with an increased fall risk) is commendable, generally accepted professional standards and federal regulations require Tucker to implement a comprehensive assessment process each time a resident falls. 42 C.F.R. § 483.25(h); 483.20(a-k). Tucker's staff fails to do so. Further, the nursing home lacks a multidisciplinary falls reduction team. Falls reduction teams investigate falls and make recommendations to reduce recurrence. Both processes are necessary in order to identify risk factors and implement individualized preventative measures.

2. Inappropriate Restraint Use and Inadequate Restraint Monitoring

Under federal regulations and generally accepted professional standards, Tucker residents must not be subjected to any physical or chemical restraints imposed for purposes of discipline or convenience unless the restraints are required to treat the resident's medical symptoms. 42 C.F.R. § 483.13(a); Youngberg, 457 U.S. at 316. Because Tucker fails to provide individualized behavioral support programs, Tucker instead uses restraints inappropriately to control residents' behavior. Thus, restraints are used for the convenience of staff and not for emergency intervention to protect individuals from risk of harm, in violation of residents' federal rights.

The use of mechanical restraints is excessive at Tucker. Strikingly, mechanical restraint use increased exponentially during the latter half of 2006.[15] Our record review further revealed that Tucker staff members either neglected to report all restraint use to us, or simply do not understand what constitutes

[15] The use of mechanical restraints at Tucker increased steadily from less than 10 in March 2006 to almost 160 by December of that year. These figures do not include the use of physical and chemical restraints, the frequency of which we could not determine from the documentation provided by the facility.

a restraint. Therefore, many restraints commonly used at Tucker go unreported because they are mistakenly not considered restraints by facility staff. These practices constitute significant departures from generally accepted professional standards.

Tucker apparently considers only mechanical protective devices like bed rails, trunk restraints, and restrictive chairs to be restraints. In providing pre-tour documents to us, the facility omitted restraint data to account for its use of all physical, mechanical, and chemical restraints for behavioral purposes. Tucker, in fact, uses sedatives and hypnotics, physical holds, and posey jackets to restrain residents, but does not include these uses in its restraint data. Indeed, when questioned, the facility inaccurately reported to us that it does not use chemical restraints at all. In the course of our review, however, we learned from a number of incident and security reports that physical and chemical restraints are being used on Tucker residents.

For example, the October 2006 security log indicates that resident B.D. was physically restrained on seven separate occasions while injections of sedatives or hypnotics were given; security also documented that it stood by while these injections were given seven additional times that month. Tucker officials failed to recognize these as episodes of physical and chemical restraint, however, and therefore failed to otherwise account for them. We found a number of other episodes of chemical restraint in our review. For instance, after attempting to elope on November 11, 2006, resident A.E. was given a 2 mg injection of Ativan, an antianxiety medication in this case used to treat acute agitation. This chemical restraint was not identified on the psychoactive medication reports we were provided, but a number of other such chemical restraints were. These included, in the months of October, November, and December alone, one or more chemical restraints ordered for residents A.E., B.E., A.B., A.Q., A.F., and B.F.

3. Inadequate Abuse/Neglect Prevention and Investigation

Tucker fails to provide its residents with adequate protection against abuse and neglect as required by federal regulations and generally accepted professional standards.[16] See

[16] As with restraint use, we were unable to definitively determine the number of incidents of abuse and neglect during the

42 C.F.R. § 483.13(b)(c); see also, Liberty Commons Nursing & Rehab Ctr. - Johnston v. Leavitt, 241 Fed. Appx. 76, 78 (4th Cir. 2007). First, autonomy is imperative to conducting investigations and monitoring restraint practices. However, at Tucker, the administrators who conduct these investigations are also responsible for managing residential and clinical services. As investigations and restraint monitoring implicate resident rights and protection from harm issues, they should be conducted by staff who have no vested interest in the outcome of the evaluations. Second, allegations of abuse or neglect are neither consistently reported nor thoroughly investigated at Tucker. See 42 C.F.R. § 483.13(c)(2). This lack of reporting and investigation is not only in contravention of generally accepted professional standards and federal regulations, but it is also inconsistent with Tucker's own policies. The following examples are illustrative:

- On April 19, 2006, resident B.G. reported that a staff member hit her while trying to help her out of bed. The facility classified this incident type as "behavioral," and no subsequent investigation was ever conducted.

- In June 2006, resident B.H. reported that a staff member had "cursed him out" after he requested that his sheets be changed. The incident was never investigated, apparently because B.H. had "a history of accusing staff of abuse on numerous occasions."

- On October 14, 2006, a staff member alleged that another staff member had stolen a resident's cigarettes. Apparently, no investigation was initiated.

- On November 25, 2006, resident B.H. was reportedly sexually inappropriate with an unidentified female resident. There is no evidence that this allegation was further investigated.

Where Tucker does investigate incidents, the investigations are often flawed. Tucker's investigations are inadequate both in their execution and follow-through. These deficiencies are due in large part to the lack of investigator training for Tucker administrators responsible for conducting the investigations.

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six-month period covered by our document requests. Documents provided before and during the tour reflected differing numbers of such incidents, and Tucker administrators were unable to explain the discrepancy or tell us which figure was accurate.

Administrators receive no specialized training in conducting an investigation; their training is limited to abuse prevention training, a curriculum provided to all employees.

Further, although the State conducts a parallel criminal investigatory process through the South Carolina Law Enforcement Division ("SLED"), Tucker defers its internal investigation and any ensuing necessary corrective action until after SLED has completed its investigation and determined whether to proceed with criminal charges. Even after Tucker finalizes its own investigation, the facility does not take corrective action to address all individual and systemic issues identified by the SLED investigation. These practices substantially depart from generally accepted professional standards.

In some instances, these deficient practices expose residents to the risk of significant harm. For example, in February 2006, resident B.I. struck a staff member several times while being assisted with his shower. One staff member reported that two other staff retaliated against B.I., punching him repeatedly about the back, chest, shoulder, and face. During subsequent exams, staff found a bleeding scratch on B.I.'s face and bruises on his upper chest and stomach. The SLED investigation revealed that the two alleged perpetrators witnessed (by signature) each other's preliminary statements, obtained immediately after the incident, and also witnessed five other staff members' statements, including one person identified as a potential witness. Tucker failed to conduct its investigation in a manner consistent with generally accepted professional standards. After Tucker received the SLED investigation results and was notified that criminal charges had not been initiated, the facility simply concluded that the allegation was unsubstantiated and returned the staff to regular duty. The facility failed to separately interview alleged perpetrators, witnesses, and reporting staff in order to prevent collusion, as is generally accepted practice. The facility also failed to identify and address critical information uncovered in the SLED investigation, such as the particular nature of B.I.'s injuries and the fact that one alleged perpetrator admittedly always wore large rings on both hands which would have explained the nature of B.I.'s injuries.

Moreover, corrective actions taken by the facility were counterintuitive. Although Tucker's investigation exonerated both staff members, the staff members were required to attend additional abuse training, formally cautioned that the appropriateness of their actions remained questionable, and one of the alleged perpetrators was reassigned to another building.

It is not clear how these actions were consistent with Tucker's determination that the allegations were unsubstantiated. Further, one of the alleged perpetrators was instructed to conduct a class for other staff on techniques for assisting combative residents. It is a substantial departure from generally accepted professional standards for a staff member whose actions in this regard are questionable to be training others.

4. Lack of Adequate Quality Assurance

Tucker does not systemically ensure provision of quality services as required under federal regulations, and in violation of generally accepted professional standards. See 42 C.F.R. § 483.75(o); see generally 42 C.F.R. § 483.25. That said, Tucker does have a quality assurance ("QA") department that, with the proper modifications, appears to have the capacity to adequately monitor quality of care issues.

We found that Tucker quality assurance staff members do not fully understand or utilize the quality assurance tools available to them. For example, when questioned, facility officials were confused about the policies and procedures in a number of important areas, including those governing data collection and retrieval, elopement, and restraints. Moreover, quality assurance staff members were unaware of the existence of certain types of documentation that would aid the self-evaluation process. For example, Tucker quality assurance staff was unaware of the existence of an elopement form used by the unit staff to report missing residents.

In addition, QA practices at Tucker are compromised because the QA director is also an administrator in charge of residential operations. This duality of roles contaminates the objectivity of the QA process. Tucker's QA department should be managed by someone who is separated from clinical and residential service delivery, but has equal status in the administration hierarchy.

Our review also revealed significant concerns in the area of data management. As previously discussed, Tucker provided us with inconsistent information on the number of investigations into allegations of abuse and neglect during a given six-month time frame. Facility officials could not account for or resolve the discrepancy. This lack of reliable data was not limited to investigations, however. In the course of our review, we discovered discrepant data regarding medications, allegations of abuse or neglect, and restraint and fall reporting. This lack of

reliable data make trend tracking and analysis, necessary to quality improvement, virtually impossible.

F. INADEQUATE ACTIVITIES

Federal regulations and generally accepted professional standards recognize the critical importance that activities and mental stimulation play in maintaining good psychological health among nursing home residents. See, e.g., 42 C.F.R. § 483.15(f); Talbot, *supra*. Nursing homes like Tucker "must provide for an ongoing program of activities designed to meet ... the interests and the physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.15(f)(1).

We found that Tucker offers substandard activity programs to its residents. Activity programs at Tucker are not varied and have not been adjusted to meet the diverse needs of the resident population. We found that activities provided for residents with psychiatric diagnoses, particularly Alzheimer's disease, were inadequate. We encountered several instances where Alzheimer's residents were sleeping, watching TV, or otherwise not being properly engaged.

While Tucker has psychologists and activity managers on staff, currently the target for resident participation is one to two activities per week. This target appears overly general, woefully infrequent, and not based on each resident's comprehensive assessment. One or two activities per week is insufficient to ensure residents' psychological good health. Moreover, Tucker's activity planning process failed to show that activities were tailored to meet the needs of specific populations. For example, no tailored activities appear to have been provided for such groups, generally, as residents with Huntington's Chorea.

G. FAILURE TO SERVE RESIDENTS IN THE MOST INTEGRATED SETTING APPROPRIATE TO RESIDENTS' NEEDS

South Carolina fails to serve Tucker residents in the most integrated setting appropriate to their needs in violation of Title II of the Americans with Disabilities Act ("ADA"). See 28 C.F.R. § 35.130(d) (public entities must provide services in the most integrated setting appropriate to the needs of qualified individuals). The preamble to the ADA regulations defines "the most integrated setting" to mean a setting "that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. A at 450.

In construing the anti-discrimination provision contained within the public services portion (Title II) of the ADA, the Supreme Court held that "[u]njustified [institutional] isolation ... is properly regarded as discrimination based on disability." Olmstead v. L.C., 527 U.S. 581, 597 (1999). Specifically, the Court established that States are required to provide community-based treatment for persons with 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 the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities. Id. at 602, 607.

Further, with the New Freedom Initiative, President George W. Bush announced that it was a high priority for his Administration to tear down barriers to equality and to expand opportunities available to Americans living with disabilities. As one step in implementing the New Freedom Initiative, on June 18, 2001, the President signed Executive Order No. 13217, entitled "Community-Based Alternatives for Individuals with Disabilities." Specifically, the President emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities. Exec. Order No. 13217, §§ 1(a)-(c), 66 Fed. Reg. 33155 (June 18, 2001). The President directed the Attorney General to "fully enforce" Title II of the ADA, especially for the victims of unjustified institutionalization. Id. at § 2(c).

The State appears to be failing to comply with the ADA in that it is neglecting to place certain persons now living at Tucker in the most integrated setting appropriate to their individualized needs. We would expect a facility of this size to have a greater number of residents ready for community placement. Our expert was surprised to learn that there was no process in place to refer such residents to the Palmetto Senior Care program, a Program of All-inclusive Care for the Elderly ("PACE") which accepts persons who would otherwise have no options for community placement other than a nursing home. Tucker personnel may be unaware of the availability of the program and consequently are not thinking in terms of less-restrictive

placements, which in turn suggests to us that there may be many more residents at Tucker who would qualify for less-restrictive placement.

Even our brief review revealed these two illustrative examples wherein Tucker residents did not require the level of nursing care provided at Tucker, and could be appropriately placed in a less restrictive setting:

- Resident B.J., 66, admitted to Tucker in February 2006 with a diagnosis of schizophrenia and depression but intact cognition, threatened suicide because of a desire to go home. His tranquilizer dose was increased, but there was no investigation of possible community placement.

- Resident B.K., 78, was admitted from her own home in April 2006, with mild dementia and depression. According to Tucker records, she developed "visual hallucinations" which were treated with psychoactive drugs. The psychiatrist determined later, however, that the visual disturbances B.K. was experiencing were side effects resulting from recent eye surgery, and the psychoactive medication was discontinued. According to our expert, this resident was very high-functioning and needed no assistance with any of her activities of daily living. However, her niece did not want her removed from Tucker until she had had a second cataract operation. This resident should clearly have been evaluated for placement, and placed, at a lower level of care.

H. INADEQUATE SANITATION

Tucker is required by federal regulations and generally accepted professional standards to provide residents with adequately prepared meals and a clean environment. 42 C.F.R. §§ 35, 65, 70. We found deficiencies in food service, infection control, and housekeeping.

With respect to food service, we found that Tucker fails to serve food at proper temperatures on a consistent basis. Food maintained at inadequate hot or cold temperatures poses a significant health risk of food-borne illnesses to Tucker residents. In addition, we observed many of the food trays to be grossly unsanitary. Many are covered with a layer of dark soot or film, and are worn beyond their ability to be adequately cleaned and sanitized. This issue was previously brought to the facility's attention in the September 21, 2006 survey conducted by CMS.

We also found that Tucker provides inadequate infection control. Specifically, we are most concerned about the risk of bacterial infection Tucker residents may face due to inadequate and unsanitary laundry practices. The laundry machines used at Tucker are domestic-type washers and dryers, which cannot achieve adequate temperature, wash, and rinse cycles required for adequate nursing home sanitation. Moreover, we observed the washers and dryers being overloaded with laundry. This further exacerbates the risk of resident pathogen infection due to inadequate sanitation. Given that methicillin-resistant staphylococcus aureus ("MRSA") has been identified at Tucker, the risk to residents for infection is unacceptably high.[17] This risk may be heightened by the fact that Tucker's policies do not adequately address pathogen infection control.

Finally, we found that Tucker's housekeeping practices are inadequate. We found that some of the utility closets were used to store flammable materials, creating a fire hazard and accompanying risk of harm to residents. Overall facility cleanliness was lacking. The problems were particularly acute at Fewell and Stone. We were especially concerned after observing that medical equipment used by Tucker residents (e.g. wheelchairs, IV poles, recliners, and blue floor mats) were generally unclean. Staff reported that the cleaning supplies used at Tucker are diluted as a cost-savings measure. Improper dilution of cleaning supplies poses a substantial risk of harm to Tucker residents, as it may lead to an increased risk of disease outbreaks due to incomplete eradication of pathogens.

III. MINIMAL REMEDIAL MEASURES

To remedy the identified deficiencies and protect the constitutional and statutory rights of Tucker residents, the State should implement promptly, at a minimum, the following measures set forth below:

A. NURSING, MEDICAL, AND MENTAL HEALTH CARE

1. Mental Health Care Assessments and Diagnoses

Tucker should ensure that its patients receive accurate, complete, and timely mental health assessments and diagnoses, consistent with generally accepted professional standards, and

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[17] MRSA is potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death.

that these assessments and diagnoses drive treatment interventions. More particularly, Tucker should:

a. Develop and implement comprehensive policies and procedures regarding the adequate diagnosis of mental illness and the timeliness and content of initial psychiatric assessments and ongoing reassessments.

b. Ensure that initial mental health assessments include a plan of care that outlines specific strategies, with rationales, including adjustments of medication regimens and initiation of specific treatment interventions.

2. Dysphagia

Tucker should ensure that residents suffering from dysphagia are adequately treated. At minimum, Tucker should:

a. Observe and document residents' symptoms of dysphagia, and alert attending physicians in a timely manner so that treatment options can be considered.

b. Perform physician-ordered swallow evaluations in a timely manner.

c. Follow up on health care interventions to determine whether the treatments are properly implemented and effective.

3. Psychoactive Medication

Tucker staff should ensure that residents remain free from unnecessary psychoactive drugs unless necessary to treat a diagnosed and documented condition. Tucker must also ensure that residents using psychoactive drugs receive gradual dose reductions, where appropriate. More particularly, Tucker should:

a. Ensure that all psychoactive medications are:

i. prescribed in therapeutic amounts;

ii. tailored to each patient's individual symptoms; and

iii. properly documented.

b. Ensure that the psychiatric progress note documentation includes:

i. the rationale for the choice and continued use of drug treatments;

ii. careful review and critical assessment of the side effects of all medications and the use of this information in timely and appropriate adjustment of regular drug treatment.

4. Psychiatric Services

Tucker must ensure that residents receive adequate, timely psychiatric evaluations and consultations. At minimum, Tucker should:

a. Ensure that psychiatric assessments and reassessments are completed within time-frames that reflect the resident's needs.

b. Implement recommendations resulting from psychiatric consultations in a timely manner.

c. Adequately document psychiatrist notes in residents' charts in a timely manner.

d. Provide sufficient psychiatrist staffing to ensure residents receive adequate psychiatrist services.

5. Pressure Sores

Tucker must ensure that residents do not develop pressure sores, where avoidable. In particular, Tucker should:

a. Adequately document the development of pressure sores.

b. Document, where applicable, interventions attempted and reasons why the development of pressure sores were unavoidable.

c. At the earliest sign of pressure sore development, document and implement individualized treatment plans to combat the development or further deterioration of pressure sores.

6. Palliative and End-of-Life Care

Tucker must ensure that its residents receive comprehensive care for pain and end-of-life symptoms. At minimum, Tucker should:

a. Implement policies and procedures to ensure that residents receive adequate assessment and treatment for pain, particularly at the end-of-life.

b. Adequately ensure that staff are trained in palliative and end-of-life care, consistent with generally accepted professional standards.

7. Death Reviews

Tucker must conduct quality management reviews of care whenever a resident dies to determine the adequacy of care provided and develop care improvement strategies. At minimum, Tucker should:

a. Develop and implement a comprehensive death review system consistent with generally accepted professional standards of care.

i. Collect information related to the adequacy of the treatments, services, and supports provided by Tucker, including hospital information, if available and appropriate;

ii. Analyze the information collected in order to identify strengths and weaknesses within the current system; and

iii. Identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

B. NUTRITION AND HYDRATION

Tucker must provide adequate nutritional management services, including:

1. Conduct adequate nutritional assessments of individual residents' specific nutritional needs;

2. Ensure that residents receive appropriate diets, as medically necessary;

3. Monitor residents' nutritional status, weight, and food intake, as medically necessary;

4. Ensure that residents who need assistance in eating are assisted by adequately trained staff;

5. Ensure that residents are not exposed to undue risk of aspiration pneumonia; and,

6. Provide residents with adequate amounts of fluids to ensure proper hydration.

C. BEHAVIORAL PROGRAMMING

Tucker must develop an adequate behavioral intervention and assessment program. At minimum, Tucker should:

1. Provide adequate and appropriate behavioral services in accordance with generally accepted professional standards.

D. DOCUMENTATION

Tucker should adequately document treatment provided for its residents. At minimum, the Tucker should:

1. Adequately document nutritional supplementation;

2. Adequately record residents' bathing; and

3. Adequately train staff regarding the importance of record keeping.

E. PROTECTION FROM HARM

Tucker should provide its residents with a safe and humane environment and protect them from harm. At a minimum, Tucker should:

1. <u>Fall Prevention</u>

   a. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards;

i. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding documenting requirements and the categorization of incidents, including falls, restraints, and allegations of abuse and neglect;

2. Restraint Use and Monitoring

a. Develop a policy and procedure that adequately defines what constitutes a restraint;

b. Require all staff to complete successfully competency-based training in the revised reporting requirements;

c. Ensure that restraints are not used for the convenience of staff;

3. Abuse/Neglect Prevention and Investigation

a. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, such as abuse and neglect. Such policies and procedures shall include requirements that such incidents are to be thoroughly investigated by unbiased staff members, and that the investigations will include consideration of staff's adherence to programmatic requirements;

b. Monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents;

c. Develop and implement a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations; and

d. Review, revise, as appropriate, and implement policies and procedures related to the

tracking and trending of incident data, including data from the abuse and neglect allegations, to ensure that appropriate corrective actions are identified and implemented in response to problematic trends.

4. Quality Assurance

a. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards of care. At a minimum, such a system should:

i. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by Tucker, as well as the outcomes being achieved by patients;

ii. Analyze the information collected in order to identify strengths and weaknesses within the current system; and

iii. Identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

F. ACTIVITIES

Tucker should provide adequate activities for its residents. At minimum, the facility should:

1. Provide sufficient and meaningful activities for all residents, and make efforts to get residents involved in activities.

2. Ensure that nursing staff monitor, document, and report accurately and routinely, patients' participation in behavioral programming activities and on patients' responses, or lack thereof, to behavioral interventions.

G. SERVING RESIDENTS IN THE MOST INTEGRATED SETTING APPROPRIATE TO RESIDENTS' NEEDS

Tucker should provide residents with the most integrated setting appropriate to their needs, in compliance with the ADA. At minimum, Tucker should:

1. Ensure staff adequately review the level of nursing care each resident requires, so as to ensure that the proper level is applied.

H. SANITATION

To remedy the identified deficiencies in food service and sanitation, the Tucker should implement promptly, at a minimum, the following measures set forth below:

1. Provide each resident with safe food services;

2. Provide adequate infection control; and

3. Provide adequate housekeeping services.

* * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

We have every confidence that we will continue to work collaboratively with the State to resolve our outstanding concerns regarding conditions at Tucker. Provided that our relationship remains cooperative, we will forward our expert consultants' reports under separate cover. The reports are not public documents. Although their reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the relevant concerns and offer practical, technical assistance in addressing them.[18] We hope that you will give this information careful

[18] The expert reports contain more detailed information regarding the specific medications that we found problematic, as discussed in this letter.

consideration and that it will assist in your efforts at prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, we will soon contact State officials to discuss this matter in further detail. If you have any questions regarding this letter, you may call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker
Grace Chung Becker
Acting Assistant Attorney General

cc: The Honorable Henry McMaster
Attorney General
State of South Carolina

Ms. Alison Y. Evans, Chair
Mental Health Commission
South Carolina Department of Mental Health

Mr. John H. Magill
State Director
South Carolina Department of Mental Health

Laura S. Hughes, R.N., B.S.N., M.P.H.
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