U.S. Department of Justice

Civil Rights Division

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

February 8, 2008

The Honorable Phil Bredesen
Governor of Tennessee
Office of the Governor
State Capitol
Nashville, TN 37243-0001

Re: Tennessee State Veterans' Home - Humboldt
Tennessee State Veterans' Home - Murfreesboro

Dear Governor Bredesen:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Tennessee State Veterans' Homes in Humboldt and Murfreesboro, Tennessee ("TSVHs"). On February 12, 2007, we notified you of our intent to conduct an investigation of the TSVHs pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern and practice of conduct that violates the constitutional or federal statutory rights of nursing home residents who are served in public institutions.

As part of our investigation, on April 23-25, May 21-23, and July 23-24, 2007, we conducted on-site inspections of the TSVHs with expert consultants in various disciplines. Our tours focused on the general care and treatment of residents as well as the facilities' discharge planning and community integration practices. Before, during, and after our site visits, we reviewed a wide variety of relevant facility documents, including policies and procedures, and medical and other records relating to the care and treatment of TSVHs residents. During our visits, we also spoke with administrators, professionals, staff, and residents.

Before discussing our findings, we would like to express our appreciation to counsel for the State of Tennessee ("State"), and to the staff and administrators of the TSVHs, for the extensive cooperation and assistance provided to us throughout our investigation. We hope to continue to work with the State and the staff at the TSVHs in the same cooperative manner going forward.

In keeping with our pledge to share information and to provide technical assistance, we conveyed our preliminary findings to counsel for the State and the State's own retained consultants during exit presentations at the close of each of our on-site visits. Additionally, on May 4, 2007, Shanetta Y. Cutlar, Chief of the Special Litigation Section, sent a letter to counsel for the State memorializing our concerns and documenting dangerously inadequate medical and nursing care and dangerous psychotropic medication usage at TSVH-Humboldt and requesting that the State take immediate remedial action to address the most serious deficiencies. On June 4, 2007, Ms. Cutlar sent the State a similar letter regarding severely deficient nutritional and hydration care at TSVH-Murfreesboro and again requesting that the State take immediate remedial action at the nursing home.[1]

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at the TSVHs violate the constitutional and federal statutory rights of their residents. In particular, we find that residents of the TSVHs suffer significant harm and risk of harm from the facilities' inadequate medical and nursing care services; improper and dangerous psychotropic medication practices; failure to provide adequate safety; inadequate nutritional and hydration services; and inadequate restorative care and specialized rehabilitation services. 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). The deficiencies are evidenced through preventable injuries, illnesses, and deaths. In

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[1] In response, in letters dated July 25, September 5, and September 27, 2007, counsel for the State of Tennessee sent letters that detailed numerous steps the State has taken to address the deficiencies at the TSVHs, including the hiring of additional key clinical and administrative staff. The letters also set forth the State's disagreements with our findings. We, of course, respect the State's right to disagree with our findings. However, it is troubling that the State would take issue with such basic, and serious, deficiencies that have resulted in grievous harm to the veterans of the TSVHs. We strongly recommend that the State further review the conditions and practices discussed in those letters as well as in this letter and continue efforts to address these matters.

addition, we find that the State fails to provide services to certain TSVH 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

A. DESCRIPTION OF FACILITIES

The TSVHs are state-owned and -operated nursing homes serving Tennessee veterans or their family members. The Tennessee State Veterans' Home Board oversees operation of the TSVHs. The census of each TSVH was in the 120s during the time of our respective tours. Each facility is licensed for both intermediate and skilled nursing care. TSVH-Murfreesboro was opened in 1991, TSVH-Humboldt in 1996. The majority of residents of the TSVHs are elderly men, and most of the residents are veterans. Both TSVHs contain secured (locked) units and units designated for care of residents with dementia.

B. SERVING THOSE WHO SERVED US

As President George W. Bush recently conveyed in a statement before members of American Legion: "We have an obligation, we have a moral obligation to provide the best possible care and treatment to the men and women who have served our country. They deserve it, and they're going to get it."[2]

The State established the TSVHs to provide health care "to those who have served" and "made sacrifices for our country," and to "treat our veterans with the dignity and respect they deserve."[3] Unfortunately, the TSVHs are falling far short of their mission.

We are aware that you have been concerned about problems with the quality of care at the TSVHs. In June 2007, you took action, temporarily ordering that the TSVHs halt new admissions. Eventually the suspension was lifted at both facilities. However, in October 2007, only six weeks after the suspension was

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[2] White House Press Release of March 6, 2007, "President Bush Discusses Care for America's Returning Wounded Warriors, War on Terror at the American Legion."

[3] Tennessee State Veterans' Home website. Available at www.tsvh.org/index.html.

lifted at TSVH-Murfreesboro, you again suspended admissions to that facility after the Tennessee Department of Health cited several deficiencies there. We understand that you took these actions because of your concern regarding the quality of care at the TSVHs. We appreciate your leadership and efforts to improve conditions at the nursing homes.

II. FINDINGS

A. INADEQUATE HEALTH CARE SERVICES

Residents of publicly-operated institutions, such as the TSVHs, have a Fourteenth Amendment Due Process right to adequate health care. Youngberg, 457 U.S. at 315; see also United States v. Tennessee, 798 F. Supp. 483 (W.D. Tenn. 1992) (residents of the Arlington Developmental Center, a facility for persons with developmental disabilities, are entitled to Due Process protections, including adequate medical and nursing care). Federal regulations specify the generally accepted professional standards for health care in nursing homes. 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide nursing and medical services to "attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident").

We identified unconscionably poor health care at the TSVHS that is causing needless suffering and, in some cases, premature deaths. Health care at the TSVHs is so grossly deficient that residents are, among other things, practically being starved and dehydrated to death. The TSVHs are apparently unable or unwilling to meet the needs of residents, particularly those residents with serious medical issues such as diabetes, and, as a result, residents suffer from the uncontrolled effects of their illnesses. Psychotropic medications are being used in such reckless and unchecked ways as to potentially contribute to the untimely death of TSVHs residents. We also found residents who are suffering from needless pressure sores,[4] that in some instances are bone-deep. Residents receive little to no assistance with therapies to help them maintain basic abilities. Finally, and tragically, we found that many residents spend their

[4] Pressure sores are staged I-IV according to severity as follows: stage I - intact skin but reddened, non-blanching; stage II - partial thickness injury like an abrasion or blister; stage III - full-thickness pressure damage extending into subcutaneous tissue; stage IV - full-thickness tissue destruction to muscle, tendon or bone.

last days and hours often suffering needless pain. In many instances, we are forced to conclude that the TSVHs are simply neglecting the needs of the veterans entrusted to their care and the veterans are suffering, and sometimes dying, as a result.

1. Inadequate Nutritional and Hydration Care

Nursing homes, such as the TSVHs, are required by federal law to provide residents with adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 C.F.R. § 483.25(i-j). At both TSVHs, residents have been, and continue to be, the victims of egregious neglect from the nursing homes' failure to provide for the most basic of human needs - food and water. As a result, residents have suffered and, sometimes, have died needless and untimely deaths.

For example, we identified the following situations of dangerously inadequate nutritional and hydration care for TSVH residents:

- X.C.[5], an 83-year-old TSVH-Humboldt resident with diabetes, was admitted to the nursing home in December 2006 and died in March 2007. He was admitted to a local hospital in February 2007 after having lost a great deal of weight and becoming severely dehydrated while in the care of the nursing home. He was also suffering from severe skin breakdown, including a pressure sore on his left hip so deep that it exposed the bone. Hospital staff described him as "emaciated." During the time period between his admission to the TSVH and when he was sent to the hospital, Mr. C. began losing weight and his health status was declining. Mr. C. was also being prescribed psychotropic medication that hindered his ability to hydrate himself. However, TSVH-Humboldt staff failed to adequately monitor and respond to his deteriorating condition, which was avoidable with proper medical and nursing monitoring. The lack of medical and nursing interventions contributed to his untimely death.

- Another TSVH-Humboldt resident, H.D., died in January 2007 after also suffering from avoidable weight loss

[5] To protect residents' privacy, we identify residents by initials other than their own. We will separately transmit to the State a schedule that cross references the initials used in this letter with the residents' actual names.

and dehydration. Ms. D. began losing weight at the end of 2006, including a 12-pound weight loss during one month. During this same time, she was also becoming severely dehydrated. There were inadequate monitoring and interventions for her during the months before she died as she was losing weight and becoming dehydrated. When Ms. D. was admitted to a hospital, she was found to have dried medications, apparently administered at TSVH-Humboldt, in her mouth. Obviously, the nursing home had not been monitoring her intake of food, fluid, or even medicines adequately or this would not have happened.

- Q.M., an 84-year-old World War II Triple Bronze Star winner, was admitted to TSVH-Murfreesboro in March 2007 and died in May 2007. Although he suffered from Alzheimer's disease, at the time of his admittance, Mr. M. was able to communicate with staff and required limited assistance with his activities of daily living. During his first month at the facility, Mr. M. lost ten pounds. During this time, nursing staff continuously failed to note or act as his intake of food and fluid was clearly inadequate to meet his needs. Thus, he also became severely dehydrated and suffered at least two urinary tract infections before his death. In the opinion of our medical expert consultant, TSVH-Murfreesboro's failure to develop and implement an adequate hydration management program for Mr. M. likely directly contributed to his death.

- We also reviewed the chart of T.X., an 84-year-old TSVH-Murfreesboro resident with Parkinson's disease who was admitted to the nursing home in January 2007 and died in March 2007. During the latter part of February, Mr. X. was transferred from the nursing home to a local hospital for significant dehydration. Upon his return from the hospital, the nursing staff failed to ensure that he was receiving adequate fluids. His sodium level rose to 166 (mEq/l),[6] indicating that he was again severely dehydrated, less than two weeks

[6] The normal range for blood sodium is 135 to 145 (mEq/l).

after returning to the nursing home.[7] Mr. X. died four days after his sodium level hit 166 (mEq/L). Our expert consultants believe that TSVH-Murfreesboro's failure to provide basic bedside nursing care and to ensure that Mr. X. received adequate food and fluids were likely contributing factors to his untimely death.

- M.G. was admitted to TSVH-Murfreesboro in October 2006 and died in April 2007 after suffering from avoidable weight loss and dehydration. Again, there appears to have been an absence of critical medical and nursing monitoring during the months before he died, when he was losing weight and becoming dehydrated. He began losing weight in 2006, including a 15-pound weight loss during his first two months at the facility. During this same time, he was also becoming severely dehydrated. In the next three months, Mr. G. lost another 13 pounds and became severely debilitated, developing acute bronchitis and dehydration, necessitating hospitalization. Following his return from the hospital in March 2007, his condition began to deteriorate rapidly, and he died in April 2007. Again, our expert consultants believe that TSVH-Murfreesboro failed to adequately monitor and respond to Mr. G.'s deteriorating condition, and this substantial departure from generally accepted professional standards likely contributed to his untimely death.

The records we reviewed showed that many TSVH residents have been hospitalized or have died due to aspiration pneumonia. During our visits, we observed mealtimes on various units at both nursing homes to see the manner in which food was served. We observed several practices that put residents at risk of developing aspiration pneumonia. Staff left some residents at risk of choking unattended. We also observed numerous instances during which residents were improperly positioned and where staff were using inappropriate techniques to feed and hydrate residents. Staff also failed to take necessary precautions for residents at risk of aspiration pneumonia.

A major reason for the failures of nutritional and hydration care at the TSVHs is that the TSVHs lacked adequate professional oversight of dietary services. The dietician responsible for

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[7] Generally accepted professional standards define dehydration (hypernatremia) as a sodium concentration of over 145.

dietary services at both nursing homes lacked the level of education and experience needed to serve residents with needs such as those founds in the TSVHs' residents.[8]

Even though we provided extensive debriefings about the nursing homes' dangerous nutritional practices at the close of our tours, deficiencies with respect to nutritional care continued. Months after our tour, TSVH-Humboldt was cited by the Center for Medicare/Medicaid Services ("CMS") for failing to meet federal regulations regarding nutritional care.[9] Surveyors noted several nutrition-related failings including: failing to follow physicians' orders regarding residents' diets; serving inappropriate meals to diabetic residents on several occasions; serving milk products where a lactose-free diet had been ordered; and failing to ensure that substitutions were of proper nutritional value.

2. Inadequate Assessment and Planning for Health Care Needs

The TSVHs are required by federal regulations to establish a comprehensive care plan for each resident that specifically addresses individualized 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. Staff then must use these assessments to develop a comprehensive care plan specific to the needs of each resident. 42 C.F.R. § 483.20(a)(1). Adequate assessments must include measurable objectives and timetables to assist the clinical and mental health staff in ensuring that all of the resident's needs are met in a timely manner. 42 C.F.R. § 483.20(k)(i). The physician is required by federal regulations to take an active role in the care of each resident by reviewing the resident's total program of care, including medications and treatments. 42 C.F.R. § 483.40(b). This care plan must be periodically

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[8] During our July 2007 tour of TSVH-Murfreesboro, and in subsequent letters from State's counsel, we were informed that the State has since retained the services of registered dieticians to serve the TSVHs.

[9] CMS is responsible for ensuring that nursing homes comply with applicable federal regulations in order to participate in the Medicare/Medicaid program. As such, CMS is a sister federal agency and operates independently of the Department.

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).

At the TSVHs, assessments are often inadequate, inaccurate, and inconsistent. Care plan interventions are generic and not individualized to address each resident's unique needs. Where they exist, care plans are virtually useless as a guide to individual care. We found a pattern of the TSVHs' failing to assess adequately, plan, and respond to the serious medical and nursing needs of residents.

A major contributing factor to the nursing homes' inability to provide adequate care stems from the fact that the nursing staff are not adequately educated. Our review of the nursing staff's ability to recognize and react to changes in residents' conditions confirms that nursing staff are not practicing in accordance with generally accepted professional standards. Further, the nursing homes fail to provide adequate quality assurance and quality improvement mechanisms that would detect the deficient nursing care. Examples of deficient nursing care include:

- In 2006, a TSVH dietician determined that current TSVH-Humboldt resident, N.Q., needed approximately three quarts of fluids a day to be adequately hydrated. This amount of fluid is significantly more than is usually served at meals. Therefore, staff should have developed an individualized plan for this resident, detailing how he was to receive the fluids he needed. This was not done, and with no care plan addressing this need, in February 2007, Mr. Q. had to be admitted to a local hospital. He was severely dehydrated. The TSVH-Humboldt nurses' notes in the days and weeks prior to his transfer to the hospital contain no references to his fluid consumption and no clinical assessments of his hydration status, although his care plan did state that his hydration status was to be assessed. Thus, the facility's failure to assess and plan adequately for Mr. Q.'s worsening condition contributed to his hospitalization.

- Another TSVH-Humboldt resident, K.U., was admitted to a hospital in February 2007 due to unresponsiveness and low blood pressure as a result of being dehydrated and losing weight. Despite consuming less than half of his daily requirement of food and water on most days, and excreting amber colored urine (signs that the resident

was becoming dehydrated), no licensed nurse ever conducted a clinical assessment of Mr. U's hydration status, and none commented on his inadequate fluid intake. The resident's physician also was not notified of his declining health status until Mr. U. was near death. In our medical expert consultant's opinion, this case represents severe neglect in terms of not providing Mr. U. with adequate basic nursing care.

- B.N., a 78-year-old TSVH-Murfreesboro resident, was diagnosed in May 2007 with a Clostridium Difficile ("C.-Diff.") infection.[10] As a result of this infection, Ms. N. developed persistent diarrhea. She lost her appetite, began losing weight, and had increased delirium. However, the nursing care plan fails to address how staff were to ensure that she received adequate fluids or provide care for the other needs brought on by this serious infection. The resident was eventually hospitalized in July 2007, with, among things, complications from the infection.

- K.M., a TSVH-Humboldt resident, was at risk of dehydration because of poor oral intake. Mr. M.'s care plan neither identified the amount of fluid he needed nor were any methods identified in order to get him to eat or drink. There was also no plan to record Mr. M.'s fluid intake and output, which is critical in order to identify and respond to any potential fluid deficits.

- G.Q., a TSVH-Murfreesboro resident, was admitted to the nursing home in May 2007. Soon thereafter, she began to suffer from the effects of dehydration. The facility failed to implement a plan of care to improve her condition. Because of the effects of a diuretic and poor oral intake, Ms. Q. lost 24 pounds in one month. Although the nursing home's dietician assessed this resident on three different occasions, each time he failed to evaluate properly whether her fluid intake was sufficient to meet her needs. Furthermore, no licensed nurse documented any assessments of the resident's hydration status, her intake of fluids, her weight, or her overall condition. The resident declined extra fluid on several occasions, but nursing

[10] C.-Diff. is a severe infection of the colon and can be life-threatening, particularly in the elderly.

> staff failed to address why the resident was refusing fluid so that a plan could be developed for her. Thus, the facility's failure to assess and plan for increasing Ms. Q.'s fluid intake contributed to her dehydration and suffering. These failures are gross deviations from generally accepted professional standards.

We also noted numerous examples of TSVH staff failing to perform assessments, develop adequate care plans based on those assessments, and then implement interventions for residents with serious health issues, such as diabetes. In contravention of generally accepted professional standards, TSVH nursing staff do not use diabetic flow sheets, which are necessary to provide care givers with an adequate understanding of the condition of a resident with diabetes. For example, we found seriously deficient diabetes care in the weeks preceding the June 2007 death of, X.I., a 94-year-old TSVH-Murfreesboro resident. In the weeks before his death, Mr. I. suffered severe episodes of both hyperglycemia (excessive blood sugar) and hypoglycemia (low blood sugar). The nursing home failed to examine or care plan for this resident and allowed his blood sugar to remain uncontrolled. Prior to his death, he also suffered urinary tract infections, iron deficiencies, and chest pain, all of which were not managed adequately despite warning signs of these conditions.

K.U., a TSVH-Humboldt resident, is another example of inadequate care for a resident with diabetes. Mr. U. was admitted to a local hospital in February 2007 with out-of-control blood sugars. When we reviewed Mr. U.'s record, we discovered that he had been admitted to the hospital in April 2007, again with extreme hyperglycemia. Before his second hospital admission, nursing home staff had failed to develop care plans to address Mr. U.'s needs, and, as a result, he ended up in a crisis situation and had to be hospitalized a second time. In our nursing consultant's opinion, the lack of care given to Mr. U. amounts to neglect of his needs.

Staff also fail to interpret and respond adequately to unusual laboratory findings. This was a consistent failing throughout the records we reviewed at both nursing homes. Failure to adequately monitor and respond to unusual laboratory results that could warn of a resident's worsening condition and indicate the need for intervention could have life-threatening consequences. For example:

- The blood test of TSVH-Humboldt resident D.C. showed the resident's blood sugar to be 121 (21 points higher than the upper reference range approved by the American Diabetes Association), yet the resident's care plan had no appropriate intervention for hyperglycemia. One intervention did say "monitor labs," but nothing was said about what to do as a result of this monitoring. In February 2007, Mr. C. also had two high platelet count readings of 1138 and 1156. (Platelets assist the blood in clotting; normal range is 140-440. A high count is evidence of the possible presence of another disease.) He also had a leukocytosis[11] reading of 15.8 and 16.1. (Normal range for white blood cell count is 4.4-10.8). Again, a high count indicates the possible presence of a serious infection.) However, nursing staff failed to respond adequately to these "red flag" readings. Thus, no care plan was developed to meet Mr. C.'s needs.

- TSVH-Humboldt resident G.M. experienced an elevated white blood count (a sign of an infection). Mr. M.'s heart medication was also at a sub-therapeutic level. Again, nursing staff failed to respond or care plan adequately for either of these unusual laboratory findings, leaving the resident in harm's way from these illnesses.

Weeks after we toured the TSVHs, CMS surveyed both facilities and also found deficiencies in assessing, planning, and intervening in the health care of TSVHS residents, in both nursing homes. For example, at TSVH-Humboldt, CMS surveyors found that nursing staff were failing to ensure that critical physicians' orders were followed. For example, a resident had been ordered to receive 120 milligrams of a medication used to treat cardiac arrhythmia, however, for almost a month, the resident received only 80 milligrams of the medication, exposing the resident to great risk of heart illness. CMS also found that the facility failed to obtain a doctor's ordered chest x-ray and to comply with a doctor's orders to get laboratory values for a resident's anti-infection medication. Surveyors also found problems with the nursing home's care for residents with diabetes. For example, CMS found that TSVH-Humboldt nursing

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[11] Leukocytosis is an elevation of the white blood cell count. It is very common in acutely ill patients and occurs in response to a variety of conditions, including viral, bacterial, or fungal infections.

staff failed to notify a resident's physician when a resident suffered an extremely elevated blood sugar level. When CMS interviewed the resident's physician and the TSVH-Humboldt Director of Nursing, both acknowledged that the physician should have been notified.

At TSVH-Murfreesboro, CMS reviewed the record of a resident who lost 17 pounds from February 2007 through April 2007. During this three-month period, there was no evidence that the attending physician was notified of the resident's serious weight loss or that the physician monitored the resident's condition. Moreover, the April 12, 2007 physician's note erroneously states: "There are, from our Dietician, no issues of his/her weight or feedings." When CMS interviewed the Director of Nursing, she acknowledged that the physician should have been notified of the resident's weight loss.

These deficiencies found by CMS are consistent with the serious deficiencies that we found during our review; these deficiencies are a gross departure from generally accepted professional standards.

3. Dangerous Psychotropic Medication Practices

Because of the risks that psychotropic medications pose to nursing home residents, and the elderly in particular, their use is highly regulated and scrutinized under federal law. See 42 C.F.R. § 483.25(l)(1). Federal regulations require nursing home residents to be free from unnecessary anti-psychotic medication. 42 C.F.R. § 483.25(l)(1). Federal law defines an unnecessary medication as any medication that is: excessive in dose; excessive in duration; without adequate monitoring or indication for use; or without specific target symptoms. Id. Federal law also requires that nursing home residents receive gradual dose reductions and, unless contraindicated, behavioral interventions aimed at reducing medication use. 42 C.F.R. § 483.25(l)(2)(ii).

The TSVHs failed to meet these requirements in many of the cases we reviewed and, in a number of cases, TSVHs' dangerous psychotropic medication practices potentially contributed to the death of residents due to medication-related complications.

In many instances, we found inappropriate diagnoses or the absence of justification for exposing residents to the potentially dangerous effects of psychotropic medications. Often, the specific behaviors the medications were intended to address were absent or severely lacking.

For example, upon his admission to TSVH-Humboldt, M.M., an 82-year-old man with dementia, was prescribed one of the newer antipsychotic drug which carries with it a warning[12] due to the risk of sudden death associated with its use in elderly residents with dementia. The facility failed to identify any diagnosis to justify exposing Mr. M. to the risks associated with this medication. The facility also never identified any behaviors the medication was intended to treat.

Mr. M. began showing signs of dysphagia (a swallowing and chewing disorder) within three months of admission. A psychotropic medication and other antipsychotic drugs can cause dysphagia in elderly persons by affecting residents' cognition, saliva production, and the coordination of swallowing muscles. Professional standards require that the use of such drugs always be re-evaluated when swallowing difficulties become apparent. The nursing home failed to conduct any re-evaluations. A very large dose of the medication was continued without adequate review. Because Mr. M.'s dysphagia resulted in silent aspiration (inhalation of food/liquids into the lungs without overt symptoms), the speech therapist recommended tube feeding, which Mr. M.'s family declined. Mr. M. was evaluated by hospice,[13] but it was decided that he did not qualify for hospice. Mr. M. continued to cough during meals and began losing a significant amount of weight. Without explanation, the psychotropic medication dose was decreased. Shortly thereafter, Mr. M. was found dead in his chair.

The medication likely caused Mr. M.'s dysphagia and weight loss and may also have been a factor in his sudden death. Given the danger the medication regimen posed, generally accepted professional standards mandate that the medication's use be clearly justified and that side-effect monitoring be intense.

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[12] According to the manufacturer of the medication, it is not approved for the treatment of residents with dementia-related psychosis and warns that elderly residents, particularly those with a diagnosis of dementia, are at an increased risk of death from the medication. The medicine has also been associated with swallowing problems in the elderly. (We will provide State's counsel with further information regarding the specific medication at a later date).

[13] Hospice is a term referring to specialized end-of-life care offered to individuals and their families, often consisting of medical, nursing, spiritual, and psychological support.

Neither were done and, in the opinion of our medical expert consultant, these failures potentially contributed to Mr. M.'s untimely death.

We also reviewed the records of two deceased TSVH-Humboldt residents where excessive doses of a potentially dangerous psychotropic medication were used without adequate justification or monitoring. Another of the newer antipsychotic medications, which also carries warnings regarding its use in the elderly,[14] likely contributed to the death of both residents:

- The medication was inexplicably prescribed at twice the typical daily dosage for X.C., even though Mr. C. was already receiving another antipsychotic drug, Seroquel. The Seroquel also lacked an adequate justification or rationale for its use. Ultimately, Mr. C. had to be hospitalized with dehydration in February 2007, likely because of the dangerous side effects of both drugs. Mr. C. died a few weeks later.

- M.Q., an 84-year-old TSVH-Humboldt resident, was being treated with five different psychoactive medications, including the newer psychotropic, in the weeks prior to his death in January 2007. Five days before Mr. Q.'s death, the nursing home's Standards of Care committee discussed his 21-pound weight loss that had occurred in the preceding four months. The Committee's only recommendation was that Mr. Q. be referred to speech therapy for screening. Mr. Q.'s medication use was not addressed. The following day, Mr. Q. was short of breath, clammy, and not eating. His physician ordered Mr. Q. to be transferred to the hospital, where he was found to be dehydrated with multi-organ system failure and died four days later. In our medical expert consultant's opinion, the facility's psychoactive polypharmacy and excessive medication administration, without indication or monitoring, very likely contributed to Mr. Q.'s death.

Another example of the harmful effects of TSVH-Humboldt's dangerous medication practices is the case of K.X., a 76-year-old man who was at the nursing home just eight days before he died. He was admitted to TSVH-Humboldt for follow-up care for a fall.

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[14] As mentioned earlier, we will provide State's counsel with information regarding the specific medications at a later date.

Mr. X. was on a combination of four different medications when he was admitted to the nursing home. Each of these medications had potentially harmful side effects for Mr. X., including drowsiness, dizziness, confusion, behavioral changes, tremors, insomnia, headaches, suicidal tendencies, fatigue, and coughing, among others. In our nursing expert consultant's opinion, TSVH-Humboldt nursing staff should have immediately called the physician and pharmacist to have a clinical conference concerning the misuse and overuse of the psychotropic drugs and to care plan for ways to address Mr. X.'s needs without resorting to the heavy use of drugs. Unfortunately, staff did not conduct any assessments or interventions or make any clinical decisions to protect this vulnerable resident. Without this basic care, Mr. X. quickly deteriorated and died.

S.S., a TSVH-Murfreesboro resident who, in the opinion of our expert consultant physician, was clearly suffering from Tardive Dyskinesia,[15] is another example of the harmful effects of the TSVHs' dangerous medication practices. Mr. S. was being prescribed a newer, risky psychotropic medication. An abnormal involuntary movement scale evaluation completed by the nursing home rated Mr. S. as having no abnormal involuntary movements. This clearly was inaccurate. More fundamentally, Mr. S. did not have symptoms that necessitated the use of an anti-psychotic drug. Because of the nursing staff's failure to accurately assess Mr. S. for involuntary movements, Mr. S. was exposed to, and indeed harmed, by the side-effects of an anti-psychotic drug that he did not need to be taking. This is a gross departure from generally accepted professional standards.

In addition to these dangers, and as will be further explained later in this letter, TSVHs' deficient medication practices place TSVH residents at increased risk of harm from falling and from the harm associated with falls. Psychiatric medications can often cause dizziness, greatly increasing the risk of residents' falling.

The TSVH-Humboldt consultant pharmacist and Medical Director both acknowledged that many TSVH-Humboldt residents are admitted to the nursing home from residential psychiatric facilities, already taking high doses of psychoactive medications, often without diagnoses. They acknowledge that there is a reluctance on TSVH-Humboldt's part to question these medications when

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[15] Tardive Dyskinesia is a syndrome of involuntary movement of the lips and tongue and is a common side-effect of prolonged anti-psychotic drug use.

newly-admitted residents have difficult-to-control behaviors. Consultations are frequently requested, but from our chart review, it was clear that the consultations also failed to ensure that psychoactive medications are being prescribed and administered in conformance with generally accepted professional standards. Despite these facts, ultimately, it remains the responsibility of the TSVHs to ensure that medication practices for TSVH residents comply with generally accepted professional standards.

We were pleased to learn that a Doctor of Pharmacy has been employed as a consultant by TSVH-Humboldt since March 2006 and has been able to reduce the psychiatric medication use at the facility. However, he visits TSVH-Humboldt only once a month for two days. Also, although the consultant pharmacist did present an in-service on medication practice to physicians in February 2007, nursing staff did not attend. Nursing staff should be in-serviced on psychiatric medication use as well, as it falls primarily to the nursing staff to monitor residents on a day-to-day and shift-by-shift basis to observe residents for signs and symptoms of over-medication.

A monthly Medication Management Committee meeting has also been helpful to identify residents who are receiving unnecessary drugs. However, as of the date of our TSVH-Humboldt tour, key clinical staff were not attending these meetings. This is problematic for the facility due to the dangerous medication practices at the nursing homes, where staff prescribing the medications appear to lack familiarity with the requirements of federal law.

A further reason for the over-use of psychiatric medication at the TSVHs is that the nursing homes lack adequate dementia care programs that could work to lessen the facilities' reliance on medication to address residents' behavior. For example, at TSVH-Humboldt, facility data showed that over half of the residents received psychotropic medication without a psychiatric or other related mental health condition. This indicates that staff's reaction to residents with dementia is all-too-often to medicate the resident for the convenience of staff, a gross departure from generally accepted professional standards. An adequate, structured program of exercise and activities for persons with short attention spans would greatly assist in reducing the nursing home's unnecessary psychotropic medication use.

4. Inadequate Pressure Sore Treatment and Skin Care

Experts in the field of elder care agree that the vast majority of pressure sores acquired in healthcare settings are preventable. Most sores can be successfully treated and progression to advanced stages is preventable.[16] The standard of care for prevention and treatment of pressure sores is set forth in federal regulations and other sources, notably by the National Pressure Sore Advisory Panel and the Agency for Healthcare Research and Quality. Federal law and generally accepted professional standards require nursing homes to conduct comprehensive assessments and ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. Federal law and generally accepted professional standards also require a resident with pressure sores to receive necessary treatment and services to promote healing, to prevent infection, and to prevent new sores from developing. See 42 C.F.R. §483.25.

We found patterns of egregious failures of care regarding pressure sore care at the TSVHs. Both facilities failed to prevent and treat pressure sores. Indeed, in June 2006, CMS issued an Immediate Jeopardy at TSVH-Murfreesboro when surveyors confirmed that maggots had been found in a resident's pressure sore. We were told that, as a result of the CMS finding, TSVH-Murfreesboro had made prevention and treatment of pressure sores a priority. Regrettably, our review found continuing deficiencies in pressure sore treatment and care at the TSVHs.

In the opinion of our expert consultants, the type of pressure wounds we observed at the TSVHs could and should have been prevented with adequate skin care, including regular turning, repositioning, and frequent skin inspections to detect pressure injury before the sores became severe. Examples of inadequate pressure sore treatment at the TSVHs include:

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[16] Pressure sores are staged I-IV according to severity as follows: stage I - intact skin but reddened, non-blanching; stage II - partial thickness injury like an abrasion or blister; stage III - full-thickness pressure damage extending into subcutaneous tissue; stage IV - full-thickness tissue destruction to muscle, tendon or bone. It is critical that pressure sores be "staged" accurately, as the type and frequency of treatment depends on the wound being accurately assessed.

- TSVH-Humboldt resident X.C. returned from a local hospital stay in February 2007 with skin breakdowns. TSVH nursing staff failed to develop a care plan to address his skin breakdowns. Two weeks later, Mr. C. was sent to a local hospital for treatment of hyperglycemia. Hospital staff noted skin breakdowns on Mr. C.'s hips, including a stage IV sore that was so deep that part of his femur bone was exposed. Thus, in the absence of a care plan to direct staff to properly treat Mr. C.'s skin care needs, Mr. C. developed the most serious of pressure sores. Mr. C. died in March 2007, a victim of gross neglect, according to our nursing expert consultant.

- I.N., a current 82-year-old TSVH-Murfreesboro resident, was assessed for skin care on March 28, 2007. The nursing assessment showed no skin breakdown. However, a separate pressure ulcer record in Mr. N.'s chart indicated that Mr. N. had four different stage II pressure ulcers on his buttocks on March 28th. Treatment for the pressure sores was not ordered for several days, until April 3rd. These conflicting assessments call into question the accuracy and reliability of the facility's assessment and documentation practices; the delayed care raises the issue of inadequate treatment.

- According to her admission nursing assessment, G.Q., a TSVH-Murfreesboro resident, had no skin breakdown on her heels when she was admitted in May 2007. However, only four days later, the facility's wound care nurse noted "deep tissue trauma" on Ms. Q.'s heel. Thus, for nearly four days, she did not receive any treatment for this serious wound. It is most likely that the wound must have been present, in some stage, as of the initial assessment, again calling into question the adequacy and accuracy of the facility's skin assessment practices.

- We also reviewed the care of TSVH-Humboldt resident, N.Q., who had a facility-acquired pressure sore on his heel. When we met Mr. Q., he stated that he was in pain from the left heel. The treatment nurse was preparing to treat Mr. Q.'s pressure sore, but was not going to pre-medicate Mr. Q. for pain. When we pointed this out, the nurse said she would administer pain medication, and we could return to observe the treatment. When we returned, Mr. Q. still complained

of pain. The only pain medication that the nurse had given Mr. Q. was Tylenol, an inadequate pain management medication given Mr. Q.'s level of pain. Mr. Q.'s sore was first discovered in August 2006. At that time, a doctor described the pressure sore as a "huge blister ... occupying the whole heel." Numerous surgeries had been performed to remove dead and damaged tissue. Nursing staff continued to classify the wound as a stage II pressure sore, which clearly was inaccurate. Further, during our tour, we observed Mr. Q.'s heel resting directly on the bed. Generally accepted professional standards require that a heel with a pressure sore like Mr. Q.'s be "floated" (a practice where the calf rests on a pillow with no weight on the heel).

- TSVH-Humboldt resident S.E. had a facility-acquired pressure sore above his buttocks. The facility assessed the pressure sore as a Stage II sore. However, when we saw him, the sore was clearly a more serious stage IV wound. In addition, when we observed Mr. E., the underpad beneath him was stained with urine and dried feces. Mr. E.'s buttocks were also soiled. It was obvious that he had not received care for his incontinence for many hours prior to our seeing him.

The TSVHs fail to develop and implement skin care plans that meet generally accepted professional standards. For example:

- TSVH-Humboldt resident K.N. was admitted to the nursing home with a stage III pressure sore on his coccyx and sores on his left and right heels. Mr. N.'s care plan failed to state how, and by when, the sores should be healed, how he should be positioned in bed, what type of mattress should be used for him, or how frequently he should be monitored.

- The care plan of 93-year-old TSVH-Humboldt resident, X.Q., stated only that he was to "maintain skin integrity to the next review." His care plan failed to address several critical skin care issues, including the type, methods, time, and bathing precautions with this elderly resident. Nothing was mentioned about how often or specifically how he was to be turned or repositioned in his wheelchair. As a likely result, Mr. Q. suffered two skin tears.

> Despite these injuries, his care plan did not change. There were no interventions for prevention of further damage to Mr. Q.'s skin.

The TSVHs also use outdated and discredited techniques for caring for residents' skin problems. For example, a TSVH-Humboldt resident, I.G., was identified as at risk of skin breakdown. She had an order in place to cover her heels with bandages. This is an archaic treatment, as heels should be protected from pressure and not bandaged. Another TSVH-Humboldt resident, K.S., returned from a hospital stay with ulcers on both shins. Orders were given to clean his legs with a topical antiseptic. This is another example of an out-dated and ineffective nursing practice because the antiseptic used can damage normal skin. Using this antiseptic was even more problematic for Mr. S. because he has diabetes, which increases the risk of skin damage.

The TSVHs have a history of being cited by CMS for inadequate pressure sore care. In August 2006, CMS cited the TSVHs for not taking appropriate pain management measures when doing pressure sore treatment. A CMS survey several weeks following our tour cited TSVH-Humboldt for deficient pressure sore care. Surveyors found a resident with a stage III pressure sore on the resident's ankle. "The resident's right outer ankle was observed to have a large open area. The wound was dark red with yellow slough (dead or dying skin that indicates deep tissue wounding) noted." Surveyors cited the facility for not identifying the wound before it had advanced to a stage III wound. In another pressure sore case, the CMS survey found that staff had failed to carry out certain physician's orders for a resident with a serious heel wound. Further, the orders that staff did carry out were not performed according to professional standards.

5. Inadequate Pain and End-of-Life Care

The diagnosis and treatment of pain is integral to the practice of medicine. Generally accepted professional standards mandate that residents with pain, acute or chronic, be treated through aggressive and appropriate means. Treatment of pain is especially urgent for residents who experience pain as a result of a terminal illness, and treatment of pain is an especially important issue in the medical treatment of the elderly. Federal regulations require nursing homes to assess residents for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d).

In our review of the TSVHs, we came across numerous examples where the nursing homes failed to adequately manage residents' pain. Examples of inadequate pain management, all of which substantially depart from acceptable professional standards, include:

- In March 2007, a hospice nurse at TSVH-Humboldt wrote that resident X.C. was:

  > moaning and groaning during visit. SW [social worker] reported that it may be pain and the VA nurse stated that [Mr. C.] had not had any pain meds today. [The VA nurse] stated that she would get his meds after she finished with other pts. Pt.'s mouth was bloody and it appeared that pt. had been chewing on mouth.

  Review of Mr. C.'s chart showed that he had been given morphine for "moaning" at 3:00 a.m. that day but none thereafter. There were no nursing notes for the resident between 3:00 a.m. and 10:00 p.m. that day. In the opinion of our medical expert consultant, allowing this resident to suffer through needless pain represents a despicable level of neglect as it was possible that the resident was chewing on his mouth due to uncontrolled pain.

- K.S. was admitted to TSVH-Humboldt in March 2007 with pressure sores above his buttocks and stasis sores[17] on his legs, causing him significant pain. He was prescribed a pain medication patch and, later, morphine. However, during this time, nursing staff failed to do an adequate assessment of Mr. S.'s pain to determine if he was receiving pain relief. Through late March and early April, Mr. S. continued to complain of pain, that, at times, was almost unbearable. In the opinion of our nursing expert consultant, allowing Mr. S. to continue to be in pain amounts to neglect that resulted in his undue suffering.

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[17] Stasis sores are caused when the veins in the legs do not return blood properly to the heart; stasis sores are more commonly found in the elderly than in the non-elderly.

- In early February 2007, K.E. complained of leg pain. The nursing staff failed to treat his leg or to give him any pain medication. Three days later, Mr. E. developed a swollen scrotal sac. The next day, he complained of pain in his penis and scrotum. His scrotum was swollen and red, and he was diagnosed with hydrocele.[18] Notwithstanding his complaints of pain and his urine being dark and pus colored, he was not given any pain medication or any nursing care for several days. The combination of TSVH-Murfreesboro's failure to accurately assess Mr. E.'s condition and to properly manage his pain resulted in his unnecessary suffering.

- In April 2007, TSVH-Murfreesboro resident E.E. threatened to commit suicide because of the pain he was suffering. Mr. E. was given Tylenol. Nursing staff performed no follow-up assessment or care to determine if the Tylenol was effective in relieving his pain or if his psychological state had stabilized. Mr. E. continued to complain of pain in the following weeks, before he eventually died in June 2007. He spent his last few days in unnecessary pain.

- Shortly after his admission to TSVH-Murfreesboro in March 2007, an 84-year-old resident, Q.M., began to suffer from pain, severe and avoidable weight loss, and dehydration. Despite the fact that Mr. M. was suffering from pain and anxiety, the physician did not order any pain medication to relieve his suffering as his health deteriorated. On the day of his death in May 2007, Mr. M. continued to suffer, experiencing pain whenever the staff changed him. He was inadequately treated for his pain and therefore he was forced to endure unnecessary pain before he finally passed away.

CMS surveyors also recently found deficiencies in TSVH-Murfreesboro's pain management practices. For example, they found a resident suffering from back pain. The resident was prescribed pain medication, but the resident continued to suffer pain. Surveyors then reviewed the resident's Medication Administration Record and found that the resident did not consistently receive pain medications that were ordered and, on

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[18] Hydrocele is a condition in which watery fluid accumulates in the scrotum.

two separate days, did not receive any medication. The failure to ensure that the resident was actually administered the medication he was prescribed resulted in this resident's enduring unnecessary pain.

The TSVHs also fail to provide appropriate end-of-life care. End-of-life care should focus on symptom management, not disease-directed therapy as is often the case at the TSVHs (e.g., antibiotic treatment for residents who are near death). For example, we noted that the TSVHs use intravenous fluids on residents when death was imminent. Generally accepted professional standards recognize that, during end-of-life care, IV fluids do not enhance comfort but rather inflict more discomfort through painful intravenous line insertion and fluid overload, which worsens particular respiratory symptoms. In our expert consultant's opinion, this TSVH practice actually increases the suffering of dying residents and constitutes a violation of generally accepted professional standards. Other examples of deficient end-of-life care include:

- G.M., who had lived at the nursing home since 2004, suffered for weeks before his death in August 2006 with uncontrolled symptoms of pain, anxiety, and respiratory distress.

- For another resident, X.D., there were no narrative entries by licensed nurses during the 48 hours before his death. According to generally accepted professional standards, at a minimum, licensed nursing staff should have been monitoring and documenting the resident's condition on a shift-by-shift basis. Rather, staff appeared to neglect the resident at the end of his life.

- TSVH-Murfreesboro resident M.G. died in April 2007. Prior to his death, Mr. G. was referred for hospice services. However, five days passed before he received hospice care. During this five day delay, Mr. G. was unable to eat or drink, and suffered from air hunger,[19] anxiety, and pain. The physician did not prescribe Mr. G. any pain medication. Once hospice intervened, morphine and anti-anxiety medications were ordered, and he finally received relief. For the five days before

[19] Air hunger is an uncomfortable awareness associated with shortness of breath that has been reported in 50 to 70 percent of dying patients.

hospice intervened, however, Mr. G.'s pain was not assessed or treated adequately, resulting in his last days being spent in needless suffering.

6. Inadequate Rehabilitative and Restorative Care

Rehabilitative and restorative nursing care is designed to promote resident independence in areas such as feeding, bathing, toileting, continence, and moving and positioning. Restorative nursing is essential in order for nursing home residents to attain and maintain their highest practicable physical, mental, and psychological well-being, as required by federal regulations. See 42 C.F.R. § 483.25.

We saw numerous problems with restorative care at the nursing homes, including: failure to ensure the proper positioning of residents in wheelchairs; failure to remove residents from wheelchairs on a timely basis; failure to ensure that residents receive adequate range-of-motion services and similar exercises; failure to use appropriate positioning and feeding techniques for residents who need assistance with dining; and failure to ensure that residents who can ambulate with assistance are provided that assistance and not subjected to being restrained because of an absence of staff to assist them with ambulation. The following examples illustrate the problems with the restorative care at the TSVHs:

- TSVH-Murfreesboro resident P.U. is at risk of falling. Even though Mr. U. has a restorative care plan for range-of-motion and other exercises to lessen his fall risk, this plan is not being implemented. Mr. U. continues to fall.

- Another TSVH-Murfreesboro resident, S.C., has behavioral issues, including repeatedly taking off his clothes. Such behaviors are possibly side-effects of his psychotropic medications. However, staff simply walk behind him, pick up his clothes, and put them in his closet. Staff fail to attempt to try other ways of replacing his inappropriate behavior with more appropriate behaviors or activities. Staff simply do not meet Mr. C.'s needs.

- TSVH-Humboldt resident M.M. died in September 2006. Prior to his death, staff conducted a wandering assessment for Mr. M. but failed to implement an adequate program to allow him to wander safely or to decrease his wandering. Although Mr. M. could ambulate

> with staff assistance, he was restrained with a pelvic restraint in his wheelchair, suggesting that this restraint might have been for the convenience of staff. Generally accepted professional standards forbid the use of restraints for the convenience of staff. Mr. M. should have been allowed to ambulate with assistance.

The TSVHs also lack adequate continence programs. For example, at TSVH-Humboldt, more than a third of the residents were dependent on staff for their toileting needs and nine other residents had catheters. Despite the obvious need for a continence program, and in contravention of generally accepted professional standards, there was no adequate program in place. Further, the catheters were used on residents without a clearly defined need for them, and there were no efforts or plans in place to help the residents so that the catheters might be removed.

B. INADEQUATE PROTECTION FROM HARM

Residents of nursing homes such as the TSVHs have the constitutional right to live in reasonably safe conditions and to be provided the essentials of basic care. See Youngberg, 457 U.S. at 315. Federal statutes governing the operation of nursing homes create similar rights. See, e.g., Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1351i-3; and their implementing regulations, 42 U.S.C. § 483 Subpart B. The TSVHs are failing to ensure that residents are reasonably free from harm or unnecessary risk of harm. Specifically, the facilities are failing to ensure that residents are protected adequately from the risk of falling and that residents are protected from harm at the hands of other residents.

1. Inadequate Fall Prevention Programs

The injuries that can result from falls pose a serious risk of harm to elderly persons. Federal regulations and generally accepted professional standards require nursing homes such as the TSVHs 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)(1-2); 483.20(a-k). The TSVHs are failing to protect residents adequately from the risk of falling.

The number of resident falls at the TSVHs is unacceptably high. At TSVH-Humboldt, we reviewed the pattern and trend of resident falls from August 2006 through March 2007. There were 154 resident falls during this period. Based on our review, it is clear that TSVH-Humboldt's fall prevention measures are not working. In fact, falls were becoming more frequent, as March had the highest number of falls (29) of any month during that period. Data for TSVH-Murfreesboro, where there were 217 falls from May 2006 through May 2007, revealed a similar pattern. A review of the TSVHs' incident reports showed a dearth of information, and what information there was, was not very helpful. The incidents are poorly described. Falls are not appropriately investigated nor are adequate prevention programs initiated for residents who fall.

The following are some of the examples we found of the TSVHs' failure to provide adequate fall protection for specific residents:

- A 91-year-old TSVH-Humboldt resident, N.L., was found "sitting on floor at foot of bed with a knot on forehead." Staff did nothing more than apply an ice pack to the resident's head. No neurological assessment was done, which is standard practice following a fall including an injury to the head. Nothing was done to analyze the cause of the fall or to change Mr. L.'s care plan to prevent future falls, leaving him at risk of future harm.

- An 86-year-old TSVH-Humboldt resident, B.Q., was found "lying on floor next to wheelchair. He lost his balance while ambulating with chair on way to the BR (bathroom)." During our tour, we noted numerous instances of residents using wheelchairs as walkers. This is a dangerous practice and most likely resulted in this man's fall. However, nursing home staff are doing nothing to stop this practice.

- H.H., an 82-year-old TSVH-Humboldt resident, fell four times during a 10-day period in March 2007. Despite the repeated falls in a short period of time, staff failed to adequately address the cause of her falls or to plan to prevent future falls. Nursing home staff appeared to accept the resident's falls as a matter of normal routine, and that is a substantial departure from accepted professional standards and practice.

- TSVH-Murfreesboro resident, P.U., has fallen multiple times. Despite being a known fall risk, the staff did not implement a plan of intervention to prevent repeat falls. Mr. U. fell seven times in four months trying to get out of his wheelchair. Once, he slid out of his wheelchair and under the "soft belt" at his waist. This is a very dangerous event because it poses a strangulation hazard to the resident. On another occasion, Mr. U. slipped out of his wheelchair, lacerating his scalp. He had also suffered lacerations to his forehead and elbow from other falls. Nursing staff simply failed to supervise Mr. U., paid little attention to his injuries, and failed to make efforts to protect him against future harm.

- TSVH-Murfreesboro resident E.M. has dementia, Alzheimer's Disease, and diabetes. Because of his diabetic condition, this resident has increased urinary output and increased fluid intake, which necessitates frequent evening toileting. The staff failed to develop and implement an adequate care plan that addressed his urinary frequency and his liquid intake. Because of this, the resident has had frequent falls as he was trying to get to the bathroom. In the opinion of our expert consultant nurse, most of Mr. M.'s falls could have been avoided if staff had developed and implemented an adequate care plan in light of his need for assistance and protection.

The TSVHs were also failing to explore the possible relationship between residents who fell and their psychotropic medication regimens. Many psychotropic medications can cause drowsiness or dizziness, making a person, particularly elderly persons, susceptible to falling. For example, TSVH-Humboldt resident X.Q., who has a history of falls, was prescribed a medication used for Alzheimers' Disease that can actually contribute to falls, by causing a resident to lean forward. Yet, this was not considered adequately, keeping him at risk of further falls. At TSVH-Murfreesboro, two residents who suffered from frequent falls, P.U. and S.C., were both taking medications that exposed them to increased fall risks, yet neither was adequately evaluated or monitored for the effect that these medications might have been having on their falls.

2. Resident-on-Resident Assaults

We uncovered significant evidence that TSVH residents are the victims of assaults and abuse at the hands of other

residents. Many of the assaultive residents have serious mental health and behavioral issues that the TSVHs are not adequately addressing. Thus, vulnerable residents are suffering harm as the result of the behaviors and acts of other residents, without adequate interventions from staff to prevent the harm. Often, the TSVHs' only response to such behaviors is to physically or chemically restrain assaultive residents.

For example, we reviewed the record of a TSVH-Humboldt resident, S.G., who was often assaultive towards TSVH residents and staff. Staff failed to provide adequate behavioral interventions despite repeated episodes of assaults. The following is a summary of some of the incidents involving Mr. G., from January 2007, when Mr. G. was admitted to the nursing home, until the time of our tour of TSVH-Humboldt:

- January 23 - resident kicks a nursing assistant in the stomach, wanders in and out of other residents' rooms. The resident falls, suffering an abrasion to the back. Haldol (a powerful, mind-altering medication) is given for agitation.

- January 24 - resident is hitting, kicking, and spitting at a nurse and is disrobing and removing his pants. Haldol and another powerful psychotropic medication are given. There are inadequate nursing notes about the resident's condition to justify these medications. The resident falls and suffers a laceration under his right eye and is transported to a hospital.

- January 25 - after returning from the hospital, the resident is described as combative, "extremely unmanageable," climbing on furniture, pulling television stands, disrobing, and spitting. The resident is then hospitalized for almost a month.

- February 27 - upon returning from the hospital, the resident is combative with staff and is taking clothes off.

- March 5 - resident is described as "very combative" with staff and is again transferred to a local hospital.

- March 14 - resident is taking off his clothes.

- March 16 - resident is violent when given care, head butting, kneeing, and hitting nursing assistants. Haldol is given.

- March 19 - resident is transferred to the psychiatric unit of a local hospital.

- March 23 - upon return from the hospital, resident is aggressive, using foul language, wandering, going in and out of other residents' rooms, and being aggressive.

- March 30 and April 2 - increased aggression, combativeness, use of foul language is noted.

- April 3 - after entering another resident's room, resident hits staff member and chases staff member with a closed fist.

- April 5 - resident wanders into another resident's room and later falls after trying to grab a laundry cart.

- April 7 - resident is wandering in and out of other residents' rooms.

- April 10 - resident is grabbing other residents and wandering in and out of other residents' rooms. An increase of psychotropic medication is ordered.

- April 11 - resident in another resident's room, placing a pillow over the resident's face. Mr. G. is again transported to a hospital for evaluation.

The care provided to Mr. G. reflects a repeated pattern of the nursing home's failure to provide adequate behavioral interventions to protect the other residents of TSVH-Humboldt from the escalating behaviors of Mr. G. In our expert consultant's opinion, the care provided to S.G. also violates numerous areas of generally accepted professional standards and federal law regarding nursing homes, including: the failure to be free from neglect; the failure to be provided with appropriate levels of care with dignity; failures of adequate health care services; the failure to protect residents from accidents and injuries; the improper use of psychotropic medications; inadequate care planning; and the failure to ensure that the nursing home only admits residents whose needs it can meet.

Consider also the case of TSVH-Humboldt resident G.X., who has a history of psychosis and depression and who was admitted to the nursing home in December 2006. On the day of admission, Mr. X. was twice noted beating on the top of a laundry barrel and also "grabbed a hold of another resident's wheelchair and attempted to tilt both ... backwards." In February, he was described as very agitated and repeatedly attempting to hit staff. He was sedated with a psychotropic medication.

Throughout March 2007, Mr. X. was agitated and aggressive towards staff and other residents. He was once found in another resident's room "tearing the resident's room apart." He was also noted to be going after other residents "with hands in a choking manner." He was ultimately transferred twice to a local hospital for mental health problems and behaviors. Again in April, Mr. F. was "grabbing and pulling at people; pulls another resident down ... and hits the other resident;" "grabbed a nursing assistant by the breast;" and was "striking at a resident and other staff with a fist."

Q.T., a TSVH-Murfreesboro resident, repeatedly became combative with other residents or staff without adequate intervention from staff to eliminate the harm or risk of harm. The following is a summary of Mr. T.'s behavior from November 2006 through January 2007.

- November 25 - resident became "aggressive" with another resident.
- December 5 - staff alerted to stay aware of resident.
- December 7 - resident combative with staff.
- December 9 - resident threatening other residents and accosted a resident. The resident then became verbally abusive and started swinging an artificial flower pot at another resident.
- December 11 - altercation with another resident.
- December 19 - threatening other residents.
- December 22 - yelling and throwing items at the nursing station, threatening and abusing other residents, and picking up a television and threatening to throw it at others.

- January 21 - intentionally hitting and injuring another resident, then pulling a television from the wall and trying to throw it into the hallway.

Again, Mr. T.'s behavior demonstrates the nursing home's failure to develop and implement measures, including behavioral measures, to protect residents from the acts of other residents and to ensure that their homes are reasonably safe.

The unmanaged dangerous behaviors of residents is resulting in harm to the residents' peers. For example, TSVH-Murfreesboro resident P.U. was beaten by fellow residents in January 2007, sustaining facial bruises and a hematoma under his left eye. Just one hour later, he was again involved in another altercation with another resident, where he sustained multiple bruises and a hematoma to his face. A female TSVH-Murfreesboro resident, M.O., has been "pushed" on at least one, and possibly more, occasions by resident Q.T., who has a diagnosis of dementia with psychosis. Ms. O. also found Mr. T. naked in her room in May, 2007. As noted above, a TSVH-Humboldt resident was attacked by a fellow resident who, by the time staff intervened, had forced a pillow over his face in an apparent attempt to suffocate him.

Since our tour, CMS has also cited TSVH-Murfreesboro for failure to keep residents safe from the actions of other residents. CMS found that TSVH-Murfreesboro is failing to intervene to prevent residents' injuries, and also is failing to report and follow-up on the incidents. For example, a resident with a history of aggressive behavior hit another resident while they were outside smoking, and, in a separate incident, another resident, also known to be violent, slapped another resident in the face. Therefore, CMS cited TSVH-Murfreesboro for failure to investigate the attack and to intervene adequately, especially because the aggressor had a known history of dangerous behaviors.

Following that, in October 2007, CMS issued an Immediate Jeopardy regarding TSVH-Murfreesboro because a resident was threatening to harm other residents with razors he was carrying in his pocket. CMS issued the Immediate Jeopardy, in part, because of the nursing home's failure to ensure residents' safety that, as noted above, had been cited in previous surveys during the year.

C. INADEQUATE ACTIVITIES AND PSYCHO-SOCIAL SERVICES

In recognition of the critical importance that activities and mental stimulation play in maintaining good psychological health among nursing home residents, federal regulations and

generally accepted professional standards require nursing homes like the TSVHs to "provide for an ongoing program of activities designed to meet . . . the interests and the physical, mental, and psychosocial well-being of each resident." See, e.g., 42 C.F.R. § 483.15(f)(a).

Adequate resident activity programs are necessary to reduce levels of residents' agitation, combativeness, hopelessness, withdrawal, and resistence to care. Frustrated residents become aggressive toward one another and staff, so that, as discussed above, resident-on-resident and resident-on-staff assaults occur.

The nursing homes' activity calendars were filled with "activities" that were not activities at all, that were only of very short duration, or that were actually nursing staff duties. Residents have very little to occupy their time. Resident activity flow sheets often indicated that for many days in each month, residents would not be involved in any activities at all aside from being offered fluids. In our expert consultants' opinions, the TSVHs' failures to provide adequate activity programs pose an immediate threat to the physical, mental, and psychosocial well-being of the resident population on a wide-spread basis.

At TSVH-Humboldt, we looked at the attendance records for three different activities on a unit of 55 residents on one Monday in April 2007. Six residents attended one of the scheduled activities, while only three residents attended each of the other two planned activities. At TSVH-Murfreesboro, we also found that activities were poorly attended. Our expert consultant reviewed the quality of activity programs at both facilities and found them to be grossly substandard. In many instances, tasks such as "getting ready for breakfast," "breakfast," and "toileting" were designated on the activity calendar. These activities are not recreational activities for residents. Rather, they are nursing and dietary staff tasks. The evening and weekend recreational activity programs were equally minimal.

As a matter of technical assistance, we suggest that the TSVHs consider enhancing their volunteer services. Volunteers can be of great assistance to increase the activity level and psycho-social health of nursing home residents. A Director of Volunteer Services or some similar position dedicated to increasing the volunteer presence at the nursing homes would assist the nursing homes in providing increased activities for residents.

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

The State is failing to serve TSVH residents in the most integrated setting appropriate to their needs. Failure to serve residents in the most integrated setting appropriate to their needs is a 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, 600 (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 that 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, 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. As set forth below, the State

is failing to comply with the ADA with regard to placing persons now living at the TSVHs in the most integrated setting appropriate to their individualized needs.

A significant number of residents are admitted to the TSVHs for only short-term rehabilitation services. Short-term rehabilitation services are usually provided by nursing homes after a patient is discharged from a hospital to help the nursing home resident regain physical or speech functioning after, for example, a stroke, a fall, or after certain types of surgery. It is reasonable to expect that many residents admitted on a short-term basis would be discharged from the facility. This does not seem to be happening at the TSVHs. According to the nursing homes' own data, there have been few TSVH residents discharged into the community. From July 2006 through June 2007, there were only 15 persons discharged to the community.

Based on our tours of the facilities, review of residents' records, and discussions with TSVH and State representatives, it is clear that there are residents at the TSVHs[20] who could be receiving services in the community. There are residents at the TSVHs who have very few nursing care needs or needs for assistance with their activities of daily living. These residents could have their personal care needs met in a community setting. There are also residents who have more complex daily living needs based on dementia who may nevertheless be able to have their needs met in an assisted care living facility ("ACLF") with secure units.

The integration mandate of the ADA also requires that nursing home residents be assessed for discharge potential and that discharge plans be put into place, where appropriate. Discharge planning at the TSVHs also runs afoul of the ADA. A more aggressive approach to discharge planning that does not quickly relegate residents into a "no discharge potential" category must be undertaken. Our expert consultants found that residents' initial assessments often indicate that there is no discharge potential for residents, notwithstanding the fact that

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[20] In an attempt to conserve both State and federal resources, our ADA expert consultant visited only TSVH-Murfreesboro. We specifically asked State representatives to inform us if any substantive distinctions existed between TSVH-Murfreesboro and TSVH-Humboldt. We were informed that, for the purposes of examining the State's compliance with the ADA, there were no such distinctions. Thus, our findings about TSVH-Murfreesboro apply to TSVH-Humboldt as well.

many residents were functioning well in the community prior to being admitted to a TSVH. The following examples illustrate the nursing homes' failures to comply with the integration mandate of the ADA:

- F.S. is a 66-year-old veteran who was living alone in the community before being admitted to TSVH-Murfreesboro following a two week stay at an acute care hospital. Mr. S. was admitted to the nursing home in April 2007 for the purpose of receiving skilled rehabilitation services. He was initially assessed as having no discharge potential. For the next 30 days, he received rehabilitation services and improved substantially. In fact, a TSVH-Murfreesboro psychologist evaluated Mr. S. in early May 2007 and found that he could function at a lower level of care and could be discharged. Thus, the initial assessment, as we believe many were, was inaccurate in assessing that the resident had no discharge potential. The failure to assess adequately and plan for discharge of residents, like Mr. S., is a violation of the ADA.

- X.C., an 80-year-old resident, has been at TSVH-Murfreesboro since August 2006 and lives on the secure wing for residents with dementia who are ambulatory. Physically, he is very independent, personable, and outgoing. He told us his memory comes and goes. His need for assistance with activities of daily living can be met relatively easily. He has no ongoing or intermittent nursing needs. Mr. C. could live in an ACLF as long as the ACLF could provide a secure environment and adequate supervision, given his propensity to wander and memory deficits. In the opinion of our expert consultant, the State is not pursuing Mr. C.'s discharge potential adequately and not exploring possible options with this resident and others like him.

- An 81-year-old resident, K.X., was admitted to the nursing home in February 2007 for skilled nursing care. Since being in the nursing home, her health and condition have improved and she no longer needs the same intensity of skilled nursing care. When we saw her, she still appeared frail but is quite independent and told us she gets around fine. Ms. X. is a candidate for community placement, particularly in an ACLF, as she appears capable of managing her needs, but would benefit from the supervision of ACLF staff.

Despite Ms. X.'s abilities, there was no indication that any discharge planning was occurring for her.

- We reviewed the circumstances of F.I., an 87-year-old resident admitted to TSVH-Murfreesboro in December 2006. His right leg has been amputated, and he is in a wheelchair. He needs assistance with his activities of daily living. Records indicate that he would like to return to the community. He has family support in the community. Mr. I. is an example of a person who often accepts nursing home placement as inevitable without alternative placements being explored adequately. TSVH-Murfreesboro and State social services should re-evaluate the possibility of community placement with this resident, including taking him to visit possible placement sites.

The TSVHs need to assess all of their residents for discharge potential, with a particular focus on residents who have been in the facility for more than six months who have little or no significant needs for assistance with activities of daily living. Particular focus should be placed on educating residents as to potential community alternatives, both at time of admission and on an on-going basis. Potential alternatives to nursing home care should be identified early. If there appears to be potential for discharge but there are no resources available, the facility should keep formal documentation of the reasons why there are no resources available.

TSVH-Murfreesboro staff informed us that there is not a shortage of community-based services for residents of the TSVHs. We were told that there are slots available in assisted living facilities and homes for the aged for persons who are Medicaid eligible. However, staff told us that there are not enough services in the community that can provide medication monitoring and extensive supervision of individuals if the person wanted to remain in their own home. Staff felt that more residents could go back to the community if these needs could be met in the resident's own home.

It appears that the State and the TSVHs are still operating from an out-dated mindset that facility-based nursing care for the elderly is the standard operating model. The low number of discharges into the community also indicates that discharges are the exception and that, if a person enters a TSVH, they will most likely stay there for a long period of time.

This becomes a very real possibility if the State and the individual entering a TSVH sees the nursing home as inevitable simply because they are old and this is where old people go.

IV. MINIMAL REMEDIAL MEASURES

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

A. HEALTH CARE SERVICES

1. Provide each resident with adequate nutrition and hydration services, including:

a. Conducting adequate nutritional and hydration assessments, especially calculation of calories, protein, carbohydrates and fluids, of individual residents' specific nutritional and hydration needs;

b. Ensuring that adequate, individualized care plans, including plans for nutritional needs, are developed that address the individual needs of residents;

c. Ensuring that residents receive appropriate diets, as medically necessary;

d. Monitoring residents' nutritional status, weight, and food intake;

e. Ensuring that any change in residents' nutrition and hydration status is identified and responded to adequately;

f. Ensuring that residents who need assistance in eating are assisted by adequately trained staff;

g. Ensuring that residents are not fed in manners that expose them to risks to their health and safety from issues such as aspiration pneumonia;

h. Conducting peer reviews of any death where weight or hydration is an issue as well as reviewing any residents who suffer unexpected weight loss as

defined by CMS regulations, with particular emphasis on the cause of weight or hydration concerns;

i. Ensuring that there is adequate professional oversight of nutrition and hydration services by a dietician adequately educated and experienced in the needs of the elderly and that the dietician participates in education of TSVH staff regarding nutrition needs of residents; and

j. Ensuring that appropriate policies, procedures, protocols, and clinical guidelines are developed to ensure that nutrition and hydration services comport with generally accepted professional standards.

2. Provide each resident with adequate medical and nursing care, including appropriate and on-going assessments, individualized care plans, and health care interventions to protect the resident's health and safety. To accomplish this, TSVH should:

a. Ensure that each resident's health status is adequately monitored and reviewed, and that changes in a resident's health status are addressed in a timely manner;

b. Ensure that all TSVH medical and nursing staff members are adequately trained in generally accepted professional standards for their respective areas of responsibility, that policies are updated and reflect generally accepted professional standards, and that the staff members are trained on those policies;

c. Ensure that medical and nursing staff address with particular attention residents' conditions such as diabetes and pain management;

d. Develop policies and protocols that ensure that nursing staff identify and respond adequately to abnormal laboratory findings that indicate a change in a resident's condition;

e. Ensure that residents receive restorative care services in order to allow residents to attain and maintain their highest practicable level of functioning; and

f. Employ and deploy a sufficient number of adequately educated nursing staff, including Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants to provide adequate supervision, routine care, preventative care, and restorative care and treatment to each TSVH resident.

3. Implement adequate quality assurance mechanisms that are capable of identifying and remedying resident quality of care deficiencies.

4. Psychopharmacological practices must comport with generally accepted professional standards, particularly as defined by federal regulations. All use of psychoactive drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Medications should be prescribed based on clinical need. Medications should not be used in manners that expose residents to undue risks to their health and safety. Specific attention should be paid to the use of those medications that pose increased risks to the elderly and that may contribute to falls.

5. Provide effective preventive systems for pressure sores and provide adequate care for residents with pressure sores, including ensuring the nursing staff are adequately educated in the proper prevention, “staging,” and treatment of pressure sores.

6. Ensure that residents receive adequate assessment and treatment for pain, particularly at the end-of-life, and that end-of-life care comports with generally accepted professional standards.

7. Ensure that residents receive adequate rehabilitative and restorative nursing care in areas such as feeding, bathing, toileting and continence care, and moving and positioning.

B. PROTECTION FROM HARM

1. Design and implement appropriate interventions to assess and develop care plans for residents at risk of falling. Ensure that when a resident does fall, ensure that staff investigate adequately the reason for the fall and implement measures designed to ameliorate future falls to the extent possible. Particular attention should be paid to the effect psychotropic medication may have on residents' falling. TSVHs must ensure that residents who need assistive devices to ambulate receive them. TSVHs must discourage residents from using wheelchairs as walkers.

2. Institute policies, procedures, and practices to investigate adequately, and implement corrective measures regarding instances of potential resident abuse, including instances of resident-on-resident assaults, and neglect, and/or mistreatment. As an element of these practices, the TSVHs' Medical Directors should also review all incident reports and ensure that appropriate administrative or clinical action is being taken.

3. Ensure, to the extent possible, that the TSVHs do not admit residents who have needs the nursing homes are not able to meet, particularly those residents with behavioral issues that make them a possible threat to other residents.

C. ACTIVITIES AND PSYCHO-SOCIAL SERVICES

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

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

D. MOST INTEGRATED SETTING

1. The State of Tennessee should ensure that residents admitted to the TSVHs for long term care have needs that make them appropriate for such care.

2. Ensure that discharge planning meets professional standards of care and that discharge plans accurately reflect residents' true discharge potential.

3. If there appears to be potential for discharge but there are no resources available, the TSVHs should keep formal documentation of the reasons why there are no resources available.

4. The State of Tennessee must ensure that TSVH residents who do not oppose placement in the community are being served in the most integrated settings appropriate for their needs.

* * *

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 hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with regard to the TSVHs. Provided that our cooperative relationship continues, 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.[21] We hope that you will give this information careful 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 a 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

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

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, please 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 Robert E. Cooper, Jr
Attorney General and Reporter
State of Tennessee

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Commissioner
Tennessee Department of Veterans's Affairs

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