



U.S. Department of Justice

Civil Rights Division

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

January 25, 2011

The Honorable Lyndon Bode
Presiding Commissioner
Marion County Courthouse
100 South Main Street
Palmyra, Missouri 63461-1661

Re: Investigation of the Maple Lawn Nursing Home, Palmyra, Missouri

Dear Commissioner Bode:

We write to report the findings of the Civil Rights Division's investigation into the conditions, practices, care, and treatment of individuals at the Maple Lawn Nursing Home ("Maple Lawn") in Palmyra, Missouri. On July 1, 2009, the Department of Justice ("Department") notified you of its intent to investigate Maple Lawn pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999). CRIPA authorizes the Department to seek remedies for any pattern or practice of conduct that violates the constitutional and federal statutory rights (including those under the ADA) of persons who reside in public institutions. The Department also has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C § 12133.

I. SUMMARY OF FINDINGS

We find that Maple Lawn violates the constitutional and federal statutory rights of people in the nursing home. Maple Lawn fails to provide services to persons with disabilities in the most integrated setting appropriate to their needs, as required by the ADA. In addition, Maple Lawn fails to prevent unconstitutional harms, or minimize the risk of such harm, from inadequate medical and nursing care; inadequate nutritional and hydration services; improper and dangerous psychotropic medication practices; inadequate pressure sore treatment and skin care; inadequate pain management and end-of-life care; and, inadequate protection from harm due to falls. Maple Lawn has inadequate quality assurance systems to identify and cure these deficiencies. Examples of these systemic deprivations of individuals' constitutional and federal statutory rights, include:

- Failure to divert individuals who could be served in more integrated settings from being admitted to the nursing home in the first place;
- Failure to have in place an adequate process to identify and plan for the discharge of individuals who could be served in more integrated settings instead of remaining at Maple Lawn;
- Inadequate emergent care for individuals suffering life-threatening, and in some cases, life-ending medical crises;
- Failure to treat known communicable diseases;
- Shockingly inadequate nutrition practices that caused at least one individual to lose as much as 20 pounds in one month, and in other cases to suffer untimely and needless deaths;
- Dangerous psychotropic medication practices, including overmedication, combining contraindicated drugs, and failing to note adverse drug reactions;
- Woefully inadequate pressure sore care and prevention, resulting in painful and needless sores;
- Exceedingly long periods of unaddressed pain, where individuals sometimes wait weeks for proper pain assessment and care; and,
- Inadequate protection from falling that has led to excessively high fall rates, where some at-risk individuals have fallen five or more times.

These system-wide deficiencies not only contribute to individuals remaining at Maple Lawn instead of being served in more integrated settings, but also result in untimely deaths and other preventable illnesses, injuries, risks, and harms.

II. INVESTIGATION

The Department and its expert consultants in relevant disciplines conducted an on-site review at Maple Lawn from October 26 through October 30, 2009. The review focused on the general care and treatment of individuals at Maple Lawn as well as on the facility's discharge planning and community integration practices. Before, during, and after our site visit, we reviewed a wide variety of relevant facility documents, including policies and procedures, medical records, and other records relating to the care and treatment of individuals at Maple Lawn. During our visit, we also interviewed Maple Lawn administrators, professionals, staff, and individuals residing at Maple Lawn. In keeping with our pledge to share information and to provide technical assistance, we conveyed our preliminary findings to Maple Lawn's counsel and to facility administrators and staff during exit briefings at the close of our on-site visit.

Despite that we identified very serious concerns, the Facility Director expressed a genuine interest in reform. Many staff members genuinely care for the well-being of those who reside at the facility. Lastly, the Department appreciates the assistance, support, professionalism, and courtesy that Maple Lawn's administrators and staff showed. We look forward to working with the County and Maple Lawn officials in the same cooperative manner we have thus far enjoyed.

III. BACKGROUND

Maple Lawn nursing home is owned and operated by Marion County, Missouri. Maple Lawn is located in Palmyra, about 120 miles from St. Louis. Maple Lawn has licensures under both Medicare and Medicaid. The facility is certified by the Centers for Medicare and Medicaid Services ("CMS") to serve up to 140 individuals. Maple Lawn is made up of four wings, one of which is the locked Special Care Unit, designed for individuals with dementia. At the time of our tour, there were 101 individuals in the facility.

IV. FINDINGS

A. MAPLE LAWN IS VIOLATING THE ADA BY FAILING TO SERVE INDIVIDUALS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

Many individuals at Maple Lawn are not being served in the most integrated setting appropriate to their needs, as required by the ADA. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

One form of discrimination prohibited by Title II of the ADA is violation of the “integration mandate.” The integration mandate arises out of Congress’s explicit findings in the ADA, the regulations of the Attorney General implementing Title II,¹ and the Supreme Court’s decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607. In so holding, the Court explained that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Id. It also recognized the harm caused by unnecessary institutionalization: “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” Id. at 601.² As the Eighth Circuit Court of Appeals has made clear, there is a “consensus among health care professionals that community access is not only possible, but desirable for individuals with disabilities.” See Lankford v. Sherman, 451 F.3d 496, 512 (8th Cir. 2006) (quoting letter received from the Center for Medicaid and State Operations).

Maple Lawn is a segregated setting where individuals with serious illnesses or disabilities are congregated together with little to no opportunity to interact with their healthy and non-disabled peers. 28 C.F.R. § 35.130(d), App. A. at 571 (stating that an integrated setting “enables individuals with disabilities to interacted with nondisabled persons to the fullest extent possible”). Individuals at Maple Lawn cannot choose with whom they associate and live, have set mealtimes with little to no choice of content, and have limited contact with the community outside the four walls of the facility. Accord Disability Advocates Inc. (DAI) v. Paterson, 653 F. Supp. 2d 184, 200-207 (E.D.N.Y. 2009) (describing characteristics of institutions to include

¹ The regulations provide that “a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities.” 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA “integration regulation” explains that “the most integrated setting” is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.” 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

² Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: having the choice to live independently.”).

regimented daily activities, lack of privacy, and few choices). Yet the County continues to provide services in the segregated setting of Maple Lawn to too many individuals with illnesses and disabilities who could be served in the community.

This failure was made evident when we asked Maple Lawn staff to provide the names of individuals they felt could transition into the community. Staff identified only four out of the 101 individuals at Maple Lawn. In contrast, after speaking to individuals at Maple Lawn, reviewing their charts, and comparing them to similarly situated individuals who are being served in the community, our expert consultant identified additional individuals who could reside in more integrated settings.

While Maple Lawn has developed policies and procedures that could help to ensure that individuals live in more integrated settings, they do not routinely follow these policies and procedures. Maple Lawn is not taking sufficient steps to assess, identify, and prepare individuals for discharge to programs in the community. First, Maple Lawn does not have an adequate process to avoid inappropriate admissions. The Preadmission Screening and Resident Review (“PASRR”) screening process employed by the facility is inadequate. Second, we found that Maple Lawn fails to adequately develop and implement transition and discharge plans for the individuals whom it has identified as ready for discharge. Finally, we found that Maple Lawn fails to engage in discharge planning for individuals who could and wish to live in more integrated settings.

1. Maple Lawn Is Violating the ADA by Failing to Avoid Inappropriate Admissions.

We find that Maple Lawn is violating the ADA by failing to have adequate processes in place to avoid inappropriate admissions. The ADA’s integration mandate not only applies to individuals who are currently institutionalized but also to individuals who are at risk of unnecessary institutionalization. See, e.g., Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same). A nursing home’s admission process must include a determination of whether individuals’ needs could be served in a more integrated setting than the nursing home and of whether the individual is aware of and interested in community-based alternatives to nursing home care. For nursing homes that receive Medicaid funding, implementation of the federally-mandated PASRR is an essential component of an adequate admissions process.

PASRR is designed to ensure that persons with mental or developmental disabilities,³ are not inappropriately placed in nursing facilities and is an important tool for diversion from admission of individuals who could be served in more integrated settings. See 42 U.S.C. §§ 1396r(b)(3)(f)(i) & (ii), 1396r(e)(7)(A) & (B), and 42 C.F.R. § 483.128; see also Letter from the Centers for Medicaid and Medicare Services to State Medicaid Directors (May 20, 2010), available at <https://www.cms.gov/smdl/downloads/smdl10008.pdf>. PASRR requires that individuals with mental or developmental disabilities being considered for admission to a nursing facility are evaluated to determine the most integrated setting to meet their needs. Specifically, PASRR mandates a two-level screening procedure. 42 U.S.C. §1396r(e)(7)(A). Level I screening is designed to identify individuals with mental illnesses or developmental disabilities prior to their admission to a nursing home. Level I screens are done for any person for whom placement in a Medicaid certified bed is being sought, and private pay individuals must be screened as well as those on Medicaid. Level II screening is completed on those persons identified at Level I who are known or suspected to have mental illnesses or developmental disabilities. Level II screens examine whether the identified individuals' needs could be met in a more integrated setting and, if it is determined that admission to the nursing home is necessary, whether specialized services are needed, including services to help the individual gain the skills necessary to move to a more integrated setting.

PASRR is also an important tool for identifying individuals in a nursing home who can be transitioned to more integrated settings. See Letter from the Centers for Medicaid and Medicare Services to State Medicaid Directors (May 20, 2010), available at <https://www.cms.gov/smdl/downloads/smdl10008.pdf>. In that regard, PASRR mandates regular reviews of nursing home individuals' needs, including whether they could be served in a more integrated setting, upon any change in their condition. 42 C.F.R. §§ 482.116(b)(2), 483.130(n).

Our tour of Maple Lawn and review of its clinical files revealed that implementation of PASRR at Maple Lawn is inadequate, causing admission of individuals who could be served in more integrated settings. According to Maple Lawn, few individuals have mental or developmental disabilities. However, we observed instances where Maple Lawn failed to identify individuals with these disabilities prior to their admission or failed to conduct Level II screens when such individuals were identified:

- Medical information in A.A.'s⁴ file states that her medical history is "significant for schizophrenia." However, the PASRR Level I screening checked the box "no" for major mental disorder. Because Maple Lawn failed to identify A.A. as an individual with

³ Developmental disabilities covered by PASRR are broadly defined and include intellectual disabilities as well as conditions such as cerebral palsy, traumatic brain injury, and epilepsy, or any other conditions that result in impairment of general intellectual functioning or adaptive behavior.

⁴ To protect residents' privacy, we identified residents by initials other than their own. We will separately transmit to the County a schedule that cross references the initials used in this letter with the residents' actual names.

mental illness on a Level I screen, a Level II screen was never completed. Thus, no determination was ever made whether A.A. could be served with community-based mental health services.

- B.B.'s file indicates she has schizophrenia and a mild intellectual disability. A Level I screening was completed, but there was no evidence in her file that a Level II screening was completed, including an assessment of whether B.B.'s needs could be met with community-based services. Moreover, there is no evidence that Maple Lawn has contacted either the State or local developmental disability office to arrange for an assessment of B.B.'s capabilities and needs.

Maple Lawn's failure to have an adequate admissions process in place, including its failure to adequately conduct PASRR screens, is leading to individuals being served in more restrictive settings than appropriate to their needs, in violation of the ADA.

2. Maple Lawn is Violating the ADA by Failing to Provide Adequate Transition and Discharge Planning for Individuals It Identifies As Ready for Discharge

Maple Lawn is violating the ADA by failing to have an adequate process to identify and plan for the discharge of individuals who could be served in more integrated settings instead of remaining at Maple Lawn. Maple Lawn's discharge planning process is causing individuals who could be served in the community to remain inappropriately and needlessly institutionalized in violation of the ADA. Olmstead, 527 U.S. at 607. Effective discharge planning must focus on the individual's specific capacities to function in a more integrated setting and identify and address any barriers to discharge. It should identify the supports and services necessary for the individual's successful community living. Planning for discharge must begin upon admission.

Our review of Maple Lawn's discharge plans shows that they are deficient. They do not describe, identify, or secure the community resources necessary to serve individuals in the community, despite the fact that the facility has a written discharge planning policy that requires these issues to be addressed. Maple Lawn's written policy requires two essential processes to be completed for each individual: a discharge summary and a post-discharge plan of care.

- Maple Lawn's discharge policy requires a summary of the individual's status, including medical information, physical and mental functional status, sensory and physical impairments, mental and psychosocial status, discharge potential, activities potential, rehabilitation potential, cognitive status, and drug therapy. According to the policy, this information is to be filed in the individual's medical record.
- Maple Lawn's post-discharge plan requires a description of how the individual and family will access and pay for needed services, a description of how the care should be coordinated if continuing treatment involves multiple caregivers, and the identification of specific needs after discharge including personal care, Activities of Daily Living ("ADLs"), self-administration of medications, diet,

sterile dressings, and physical therapy. Appropriate referrals, when necessary, are to be made by social services and documented in the medical record. The policy also requires the institution to: discuss preferences for care with the individual and his or her family; discuss how the individual and family need to prepare for discharge; and review the post-discharge plan with the individual and family.

The documentation in the files of individuals at Maple Lawn, however, routinely revealed a failure to complete both a discharge summary and a post-discharge plan. Essential components of adequate discharge planning are not developed or shared with the individuals and their families. This failure occurred in both files of persons recently discharged and in individuals who were identified by staff as persons who could return to the community. There was no documentation of an individual's preferences for care, how such care is to be paid for, how care is to be coordinated, what specific care needs have to be addressed after discharge, and what preparation has to be done before discharge. In almost all instances, the documentation on the summary concerning discharge planning simply states that the individual requires 24-hour care and supervision.

Examples of deficient discharge planning for individuals whom Maple Lawn staff identified as ready for community placement include:

- C.C. is at Maple Lawn to recuperate from complications following surgery. C.C. stated that he plans to return home soon and have his ex-wife care for him, as he is starting to feel better from the hospitalization, attending rehab, and working on getting his strength back. However, a review of C.C.'s file provided no indication that Maple Lawn staff had discussed with C.C. the capacity of his ex-wife to provide care or explored the services and supports necessary to meet his needs in the community.
- D.D. was admitted to Maple Lawn as a result of a hip fracture that required rehabilitation. D.D. ambulates with a wheelchair and a walker, and needs limited assistance in bed mobility, transferring, and toileting. Yet, we were unable to find any documentation regarding discharge planning even though D.D. had multiple admissions to Maple Lawn for rehabilitation. This is particularly troubling, as a lack of discharge planning that addresses an individual's specific needs increases the likelihood that the individual will be readmitted to Maple Lawn in the future. It is possible that adequate discharge planning on previous admissions would have prevented D.D.'s subsequent readmission.

Moreover, in order for discharge planning to be adequate, Maple Lawn staff involved in discharge planning should be knowledgeable about community-based services and supports. During our tour of Maple Lawn and review of clinical files, it became clear that staff responsible for discharge planning were not aware of and were not sufficiently utilizing these potential resources to place individuals in more integrated, appropriate settings, in violation of the ADA.

Missouri has a range of community services that could support individuals discharged from Maple Lawn to the community. For example, the Aged and Disabled Waiver and the Independent Living Waiver (“ILW”) are two sources that may be utilized by individuals at Maple Lawn to move to a more integrated, community-based setting, including into their own home. The Aged and Disabled Waiver provides community-based services to Medicaid-eligible elderly individuals who meet a nursing home level of care, including homemaker services, chore services, respite care, advanced respite care, nurse respite care, institutional respite care, and adult day healthcare. The Missouri ILW provides community-based services to Medicaid-eligible persons between the ages of 18 and 64 who meet a nursing home level of care, including personal care services, case management, specialized medical equipment and supplies, and environmental accessibility adaptations. Missouri also provides for an array of services in the community through their Medicaid State Plan, including the Consumer-Directed Services (“CDS”) program which provides personal care assistance services for Medicaid-eligible consumers with physical disabilities who need assistance with activities of daily living to live independently. Finally, according to staff at the Marion County Division of Senior and Disability Services Office, persons needing more complex assistance in their home can receive Advanced Personal Care. These services can include catheter care, bowel and bladder assistance, and assistance that requires the use of lift equipment.

In sum, even the individuals that Maple Lawn believes are ready for community placement remain improperly institutionalized in the nursing home in violation of their rights under the ADA because of Maple Lawn’s inadequate discharge planning process.

3. Maple Lawn’s Discharge Planning Process Violates the ADA Because It Fails to Identify Many Individuals Who Could Be Served in More Integrated Settings

Maple Lawn’s discharge planning process also violates the ADA because it fails to identify and plan for many individuals who could be discharged to a more integrated setting. Maple Lawn does not meaningfully engage in the discharge planning process until its treating professionals have recommended community placement. Instead of using the discharge planning process as a means to identify and address barriers to discharge, we found that Maple Lawn keeps many individuals (including those who have expressed a desire for community placement) from even reaching the point where Maple Lawn staff will explore discharge options with them. As a result, individuals who could live in integrated community settings remain at Maple Lawn because they have not received adequate assessments of the supports and services necessary to allow them to succeed in the community. Accord Frederick L. v. Dept. of Public Welfare, 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001) (“Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with disabilities.”); DAI, 653 F. Supp. 2d at 259 (same).

For example, our consultant’s review of individual’s files revealed that Maple Lawn engaged in no meaningful discharge planning for numerous individuals who had expressed a strong desire to be discharged and who, in our expert’s opinion, likely could be served in more integrated settings. The fact that these individuals have indicated they wish to return to the

community should trigger a detailed analysis of how this can be accomplished or why it is not appropriate and what needs to occur so that goal can be met. For example:

- A.A. is a 75-year-old woman who came to the facility in April 2009 as a result of a motor vehicle accident that caused head and leg injuries. Her diagnoses included organic brain damage and schizophrenia. A.A.'s husband, who was also in the accident, visits regularly and stated that he has prepared their home to accommodate her physical needs when she returns home. There is no assessment in her file, however, that documents his efforts or identifies what services and supports A.A. would need to return to the community.
- E.E., a 79-year-old retired school teacher who lives in Quincy, Illinois, plans on returning there when she is ready for discharge. She came to the facility in September 2009. E.E. requires limited assistance in transferring, mobility, toileting and bathing, but is independent in dressing, eating, and personal hygiene. Despite the fact that E.E.'s needs are relatively light, there has been no determination of what services are available to meet her needs in the community once her medical condition is stabilized, and there have been no arrangements made to see that these services are delivered.

We also found examples where Maple Lawn staff failed to examine all options for community-based supports and services for individuals who had expressed a clear preference to live in the community but whose family members or other significant persons indicated that they could not themselves handle some of the individuals' needs. Instead, Maple Lawn simply determined that these individuals were not able to be discharged. However, our expert consultant identified a variety of supports that Maple Lawn failed to explore, including Advanced Personal Care through the Medicaid program, that might be able to meet these individuals' needs. For example:

- F.F., a 77-year-old, was admitted in February 2009 with chronic renal failure and advanced peripheral vascular disease. F.F. uses a wheelchair and needs assistance with his ADLs. The social service notes indicate that F.F. wants to go home, but his wife and son cannot provide 24-hour care and supervision. F.F. told us that he would rather be "someplace else" other than the nursing facility. There is no evidence in F.F.'s file that Maple Lawn staff have examined what services are available, including those through Medicaid that could meet his care needs in the community.
- G.G., a 71-year-old, was admitted in June 2009 with diabetes, hypertension, and difficulty moving muscles on one side of his body. G.G. does not require significant help with his ADLs, although he needs tube feeding and supervision with bathing, walks with the assistance of a cane, and is occasionally incontinent. G.G. is adamant that he wants to return home, and told us that he has spoken to the social service staff about this desire, but says he cannot return to the community until the feeding tube is removed. G.G. told us that he has a girlfriend who can help him with his needs. However, his file contained a doctor's note that states his girlfriend had concerns

regarding taking G.G. home because of the tube feeding and the blood testing required for his diabetes. There is no evidence in G.G.'s file indicating whether or not Maple Lawn's staff have followed-up with G.G.'s girlfriend to discuss her concerns, or indicating whether staff have examined whether other services, such as intensive personal care through Medicaid, would be able to address his needs.

Finally, we found that Maple Lawn's discharge planning process fails to provide the information individuals need to make an informed choice regarding moving to a more integrated setting. Maple Lawn should provide information to individuals in order to enable them to make an informed choice, as ambivalence among individuals about their ability to reside in the community is frequently based on a lack of information and counseling concerning alternatives. Cf. DAI, 653 F. Supp. 2d at 267 (“[W]ith accurate information and a meaningful choice, many . . . residents would choose to live and receive services in a more integrated setting”); Letter from the Center for Medicaid and State Operations Health Care Financing Administration to State Medicaid Directors (Jan. 14, 2000), available at <https://www.cms.gov/smdl/downloads/smd011400c.pdf> (advising states that their Olmstead plans must “address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices”).

We found the following examples where Maple Lawn's failure to inform individuals about community-based alternatives to nursing home care is leading to individuals for whom discharge may be appropriate remaining at Maple Lawn:

- H.H. is 87 years old and was most recently admitted to the facility in April 2009. H.H. states that he would rather be home with his nearby family but is resigned to being in the facility. However, H.H.'s file contains no documentation of discussions with H.H. regarding the possibility of moving to the community or discussions to ascertain the reason for his resignation, and no indication of what, if any, barriers prevent his return to the community.
- I.I. is 60 years old and was admitted to the facility in April 2009. She has Parkinson's disease and coronary artery disease, needs the assistance of one person to transfer her from her bed to her wheelchair, and needs limited assistance in dressing, toileting, and bathing. In July 2009, I.I. indicated a preference to return to the community. Her daughter lives in the community and supports the discharge. When we spoke to I.I. during our visit, however, she was ambivalent about moving to the community. There is no evidence in I.I.'s file, however, that Maple Lawn staff have addressed I.I.'s ambivalence towards a return to the community through counseling or through the provision of information on what services are available to address her needs in the community.

Thus, Maple Lawn's deficient discharge planning process is leading to individuals who could be served in more integrated settings unnecessarily remaining at Maple Lawn in violation of the ADA.

B. MAPLE LAWN DEPRIVES INDIVIDUALS OF THEIR CONSTITUTIONALLY PROTECTED RIGHTS TO RECEIVE ADEQUATE HEALTHCARE SERVICES

Unnecessary segregation of individuals at Maple Lawn not only violates the ADA, but subjects them to a high risk of harm from unconstitutional conditions. Individuals residing in a county-owned nursing home such as Maple Lawn have a Fourteenth Amendment Due Process right to adequate healthcare. See Youngberg v. Romeo, 457 U.S. 307, 315 (1982); Goodman v. Parwatar, 570 F.2d 801, 804 (8th Cir. 1978) (holding that once admitted, an individual with mental illness “had a constitutional right to a basically safe and humane living environment”). A governmental entity that holds people in confinement for care and treatment violates the Due Process Clause when it provides medical care that substantially departs from professional standards. See Morgan v. Rabun, 128 F.3d 694, 697-98 (8th Cir. 1997).

We find a number of conditions and practices at Maple Lawn that violate individuals’ constitutional right to adequate healthcare services. In particular, individuals at Maple Lawn suffer significant harm and risk of harm due to Maple Lawn’s: (1) failure to provide adequate medical care; (2) failure to provide adequate nutritional and hydration care; (3) allowing dangerous psychotropic medication practices; (4) failure to provide adequate pressure sore treatment and skin care; and (5) failure to provide adequate pain management and end-of-life care. These failures not only result in unconstitutional harms, they also contribute to a regression in individuals’ skills, leading to their prolonged institutionalization at Maple Lawn.

1. Maple Lawn’s Inadequate Medical Care Practices Are Resulting in Unconstitutional Harm.

Maple Lawn fails to provide adequate healthcare. We consistently found examples where Maple Lawn failed to properly treat the healthcare needs of individuals. As a result, individuals unnecessarily suffered falls, declined in functional abilities, and lost excessive amounts of weight without proper intervention. These failures resulted in unconstitutional harm.

At Maple Lawn, we found assessments that were inaccurate, inadequate, and inconsistent. We found care plans that were boiler-plate, did not contain measurable outcomes, and failed to address individuals’ needs. As a result, care plans appeared useless as a guide to address individual care. In our nursing consultant’s opinion, the major cause of the inadequate delivery of healthcare was inadequate nursing training, with staff unable to recognize and react to changes in individuals’ conditions. Moreover, Maple Lawn does not have an adequate quality assurance or quality improvement mechanism that would identify the deficient medical care.

The inadequate medical care of the following individuals illustrates these problems:

- J.J., who had a history of diabetes, died in November 2008. According to J.J.’s medical records, she experienced unstable blood sugars on November 11, 2008. Yet, nursing staff failed to notify her physician, failed to assess her change of condition, failed to update her care plan, and failed to timely intervene. When

J.J.'s blood sugar rose to 502 mg/dl⁵ and she began foaming out the mouth, it appears that nursing staff left J.J. in her room unattended as she was gasping for breath. When nursing staff finally returned to her room, J.J. was not breathing and did not have a pulse. Nursing staff failed to initiate life saving efforts despite clear indications to do so. According to our nursing expert, the nurse who was assigned to J.J.'s unit on the evening when J.J. died was neither properly trained to handle J.J.'s declining condition nor properly supervised while J.J.'s condition declined. Ms. J. needlessly suffered before she died. Staff's utter failure to act to treat Ms. J. can only be seen as deliberate indifference to her serious medical condition and is therefore a violation of her constitutional right to adequate medical care.

- In May 2009, K.K., who had been fairly independent and able to walk without assistance, exhibited symptoms of a stroke (left side limp and unable to ambulate). Despite this change in K.K.'s condition, nursing staff waited over five hours before they finally contacted her physician. Even then, her physician failed to evaluate her condition and K.K. continued to decline. In reviewing K.K.'s records, it also appears that nursing staff failed to reassess and document her declining condition as she worsened. Further, nursing staff continued to administer medication that increased K.K.'s risk for bleeding even though she was already at risk for bleeding. Less than seven days after her change of condition, K.K. had to be rushed to the emergency room where she was treated for a large ventricular hemorrhage and was placed in the Intensive Care Unit. When K.K. was returned to Maple Lawn on June 9, her condition had drastically deteriorated. She was unresponsive and totally dependent on nursing staff to assist with her daily needs. The facility's failure to treat Ms. K's worsening condition likely contributed to her hospitalization and decline, and again, bespoke of deliberate indifference to her serious medical needs.
- Even though L.L. had a condition identifying him as a high risk for falls, his care plan did not include specific interventions designed to reduce the risk of falls. Nursing staff thus failed to provide adequate supervision and assistance. In January 2009, L.L. fell and fractured his hip. It appears that a Maple Lawn employee witnessed the fall but did not intervene. Maple Lawn's failure to identify specific interventions given his medical history and his known proclivity for falls likely contributed to Mr. L.'s fracture that required surgery to repair.
- M.M. had a history of falls. In reviewing M.M.'s records, we found that he had a medical condition that likely contributed to several falls at the facility, but nursing staff failed to address this risk. In fact, his care was so deficient that it failed to address his known previous falls as well as his risk for future falls. As a result, he continued to fall without any intervention.

⁵ The normal blood sugar level is 70-100 mg/dl.

- N.N., whom Maple Lawn identified as a fall risk, fell 11 times between August and October 2009. Despite its knowledge, the facility made no attempt to monitor, evaluate, or revise her care plan even though she continued to fall. The misadministration of medication contributed to the increased falls during the period of August to October 2009. Nursing notes revealed that Ms. N.'s psychotropic medication was incorrectly increased during this time, and she exhibited poor balance, unsteady gait, and was lethargic; despite this, staff failed to reassess her care. Further, it appears that during this time, N.N.'s physician did not evaluate her after multiple falls and failed to detect the medication error that likely increased her fall risk.
- O.O. was prescribed a potent pain medication that could cause sedation and respiratory depression and required close monitoring. In reviewing Mr. O.'s record, it appears that he had an adverse reaction to the medication, yet nursing staff failed to monitor him closely and failed to treat him despite his negative reaction to his medication. Again, Maple Lawn failed to act to treat known risks of harm.

Maple Lawn's nursing staff did not appear to monitor individuals for any of the known side effects of drugs. For example, none of the nursing notes that our consultants reviewed suggested that staff rule out, or even consider, the role of an individual's drug protocol in contributing to falls. It is likely that a substantial number of fall-related incidents occur from polypharmacy, or the use of multiple and often unnecessary medications.

Maple Lawn also fails to adequately assess, manage, and treat communicable diseases. We learned during our on-site visit that Maple Lawn did not have a dedicated Infection Control Nurse, which likely contributed to inadequate staff training and poor facility practices. Even more alarming, Maple Lawn lacked adequate policies and procedures regarding infection control and infection surveillance and tracking. Notably, nursing staff admitted that, even though infections were a current and past problem, in-service training on infection control was never provided. The following examples illustrate the facility's failure to adequately treat communicable diseases:

- Even though P.P. complained of rectal pain and diarrhea, nursing staff failed to test for a bacterial infection. Nursing staff waited nearly five weeks before they finally ordered a lab test that confirmed a potentially life-threatening and highly contagious bacterial infection. In our nursing consultant's opinion, Maple Lawn's failure to timely treat P.P.'s condition unnecessarily exposed individuals and staff to an unreasonable risk from infectious disease.

- Q.Q. was diagnosed with Methicillin Resistant Staph Aureus (“MRSA”)⁶ in her urine in September 2009. In reviewing Q.Q.’s records, we found that nursing staff failed to maintain proper contact isolation to prevent the spread of MRSA to other individuals.
- R.R. was diagnosed with MRSA in his respiratory tract yet staff did not isolate him. In fact, we learned that R.R. was placed in a semi-private room where there were no isolation carts or supplies readily available for the staff.
- Another individual, S.S., was diagnosed with MRSA in his respiratory tract and nursing staff failed to use isolation carts and failed to have supplies readily available for the staff to prevent the spread of MRSA.

A major contributing factor to the nursing home’s inability to prevent the spread of infectious diseases stems from the fact that the Maple Lawn does not have policies or procedures that address isolation to prevent the spread of these prevalent and serious infections, and the facility staff have not been properly trained to address these issues. In any event, the facility’s failure to adequately treat highly contagious and potentially life threatening communicable diseases exposes individuals to unconstitutional harm.

2. Maple Lawn’s Inadequate Nutrition and Hydration Practices Expose Individuals to Unlawful Harm.

Individuals at Maple Lawn have a constitutional right to adequate food. Youngberg, 457 U.S. at 315. Nursing facilities, such as Maple Lawn, are also obligated by federal regulation to provide individuals with adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 C.F.R. § 483.25 (i-j).⁷ Maple Lawn’s inadequate nutrition and hydration practices have resulted in unlawful harm. In particular, we found that staff and physicians fail to adequately treat individuals with significant weight loss or poor oral intake. As a result, individuals have suffered, and sometimes, have died untimely and needless deaths. In cases where there was clear evidence that individuals had inadequate oral intake, we noted that licensed nurses did not determine the reasons why intake was poor.

We reviewed weight records for the month of September 2009 and were alarmed to find that staff did not weigh any individuals during this period. This is an egregious departure from generally acceptable professional standards of care. In our discussion with the facility dietitian,

⁶ Methicillin Resistant Staph Aureus (“MRSA”) are drug-resistant bacteria that can cause different kinds of illness, including skin infections, bone infections, pneumonia, and severe life-threatening bloodstream infections. MRSA is particularly prevalent and virulent in institutions where many people are housed in close proximity and basic hygiene may be lacking.

⁷ Federal nursing home regulations require a high quality of care and establish generally accepted professional standards.

she confirmed that weights likely were not taken in September and emphasized the importance of having members of the nursing department participate in monitoring and tracking individuals' nutritional status. Yet, we learned during our site visit that the nursing department had abdicated its responsibility for monitoring individuals' weights to the restorative department. When we reviewed weight loss records, we were unable to find any evidence that restorative staff were involved in tracking weight changes, nutritional intake, or overall nutritional status. The failure to weigh individuals for the entire month of September calls into question Maple Lawn's avowed practice of accurately monitoring individuals' weights, and undermines data concerning nutritional and hydration status as well.

The following are examples of dangerously inadequate nutritional and hydration care for individuals at Maple Lawn. Many of these examples, again, demonstrate staff's utter failure to treat serious, and in some cases, life threatening conditions.

- T.T. is 105 years old and was admitted to the nursing home in May 2008. She had a history of diabetes, glaucoma, depression, and dementia. In reviewing her weight logs, we noted that Ms. T. lost nearly 20 pounds in one month. Nursing staff did not report this significant loss to her physician or evaluate her condition to determine the cause of the weight loss. As a result, this potentially life-threatening weight loss went unaddressed by the facility.
- J.J. was 75 years old and died in November 2008. Ms. J. had an extensive medical history; most notably, she had brittle diabetes⁸ and required strict monitoring. Despite her medical history, it appears that Maple Lawn staff failed to adequately monitor her condition. As J.J.'s condition declined and she apparently stopped eating, nursing staff failed to contact her physician, failed to assess her changing condition, failed to monitor her blood sugar levels, failed to follow physician's orders for insulin, and failed to intervene in any way. Even though Ms. J. consumed no food on the day that she died, nursing staff continued to administer long-acting and fast-acting insulin until she had irregular breathing and was foaming at the mouth. When Ms. J.'s heart and respiration ceased, nursing staff failed to initiate life saving efforts to resuscitate her despite clear direction in her chart to do so. In our medical consultant's opinion, Ms. J. likely died from hypoglycemic shock -- excessive insulin administration leading to severely low blood sugar and death.
- In another example, U.U., a 91-year-old, was admitted from Maple Lawn to the hospital in July 2009 after she lost a great deal of weight and became severely anemic. While at the hospital, Ms. U. received a blood transfusion, which significantly improved her condition. Thereafter, she returned to the nursing home and again, lost a significant amount of weight -- nearly 11 pounds in one

⁸ Brittle diabetes is a term used to describe a type of diabetes when a person's blood glucose (sugar) level often swings quickly from high to low and from low to high.

month. This significant weight loss was not reported to her physician for several weeks. When the doctor finally evaluated her, he noted a “rapid deterioration,” yet he did not make any changes to her medications. One week later Ms. U. died. The lack of medical and nursing interventions and monitoring likely contributed to her death.

- In October 2009, I.I. lost 18 pounds, yet Maple Lawn staff failed to adequately assess and monitor his condition. The failure to assess and respond to Mr. I.’s declining nutritional status and weight loss is emblematic of the unlawful actions of Maple Lawn staff.

In summary, due to Maple Lawn’s failure to consistently weigh, monitor, assess, and evaluate individuals’ nutritional needs, many individuals have unnecessarily suffered avoidable weight loss, compromising their individual conditions, and in some cases these failures have hastened these deaths. In all cases, the resulting harm was unconstitutional.

3. Maple Lawn’s Psychotropic Medication Practices are Causing Unconstitutional Harm

Maple Lawn is providing unnecessary psychotropic medications in violation of the law. Both federal law and generally accepted professional standards require that nursing home individuals be free from unnecessary anti-psychotropic medication. 42 C.F.R. § 483.25(1)(1). Psychotropic medications are widely prescribed at Maple Lawn. Over half of those who live at Maple Lawn receive multiple psychotropic medications, many without clinical justification. Even more alarming, we found in almost every case that we reviewed, the treating physician did not monitor the effectiveness of the prescribed medication and nursing staff failed to monitor changes in individuals’ condition. When we asked about the shockingly high numbers of psychotropic medications administered to individuals, the facility’s consultant pharmacist told us that he is “trying to reduce the number of prescriptions,” but his efforts have been ineffective because his recommendations for medication reduction are rarely accepted by the treating physicians. Problems with psychotropic medication practices may stem from Maple Lawn’s failure to appropriately divert individuals with mental illnesses from admission to the nursing home in the first place, as discussed in Part IV(A)(1) above.

We found numerous examples of unnecessary medication use at Maple Lawn, where little or no apparent effort had been made to reduce dosage and little or no monitoring had been undertaken of the appropriateness of the dose or drug interactions. For example:

- N.N., discussed above, was prescribed a psychotropic medication. Her records revealed that in July 2009, nursing staff took a verbal order to decrease her dosage, but instead, increased the dosage by 25 mg. For nearly three months, nursing staff failed to recognize the medication error and failed to monitor the side effects that the medication was causing. During this period, N.N. fell 11 times, a potential side-effect from the medication, yet nursing staff failed to complete an evaluation.

- V.V. has a history of Alzheimer's disease and was prescribed antipsychotic medications since at least May 2009. Although he was prescribed medications for agitation, there was no documentation in his record of any recent symptoms that required the medication. Further, we noted that his physician refused to reduce his medication dosage despite clear indications that Mr. V. exhibited no signs of agitation or restlessness for several months.
- Q.Q. was admitted to Maple Lawn in November 2008. Q.Q. was prescribed four antipsychotic medications, two anti-anxiety medications, two pain medication drugs, and one drug for Parkinson's symptoms. In September 2009, nursing staff notified the physician that Q.Q.'s hands were shaking, a potentially adverse reaction to the antipsychotic medication, yet the physician neither reduced nor changed her medication for nearly one month. Her medical records indicate that, during this period, nursing staff failed to properly assess her changing condition or to monitor the side effects that her medication caused.
- W.W., an 89-year-old resident who died prior to our visit, was prescribed 29 different drugs up until his death. It appears that his physician failed to consistently review the list of drugs that W.W. was taking. According to our expert consultant, the excessive numbers of drugs likely contributed to W.W.'s decline in condition.
- X.X. had been taking psychotropic medication without adequate monitoring and assessment. It was not until his family intervened that Maple Lawn staff finally assessed and reduced his medication.

Finally, we found a concerning pattern of prescribing a medication used to treat urinary urge incontinence without records that could explain the rationale for prescribing this medication. Even more troubling, we learned that despite the facility pharmacist's request to discontinue this medication because of possible adverse effects, Maple Lawn's physicians continued to prescribe the medication without addressing the pharmacist's concern.

In summary, the nurses' and physicians' failures with regard to psychotropic medication practices are unlawful and are causing unconstitutional harm.

4. Maple Lawn Fails to Adequately Treat Individuals with Pressure Sore and Skin Care Needs

We find that individuals at Maple Lawn are suffering painful and preventable pressure sores due to unlawfully inadequate services. Federal law and generally accepted professional standards require that nursing homes ensure that individuals with pressure sores receive necessary treatment. See 42 C.F.R. § 483.25(c)(1). Maple Lawn's unacceptable pressure sore care and skin care place individuals at risk of harm. We found several instances where staff failed to take basic steps necessary to adequately care for pressure sores. Staff failed to turn and reposition individuals, failed to assess and report changes in individuals' condition, and failed to

accurately document individuals' records. In our expert consultant's opinion, these failures likely occurred because nursing staff are not adequately trained in pressure sore prevention and treatment.

In reviewing the in-service training records for the six months prior to our on-site investigation, we noted minimal training sessions devoted to identifying and treating pressure sores and skin care. Even more troubling, Maple Lawn did not have a clearly defined set of policies and procedures guiding pressure sore prevention and treatment. In addition, Maple Lawn's pressure sore treatment and prevention program lacks multidisciplinary involvement. Adequate nutritional care is critical in the prevention and treatment of pressure sores. Unfortunately, there is no evidence that the dietitian participates in any team effort on prevention or treatment of pressure sores. Similarly, medical staff and therapy staff are not involved in a group effort to address pressure sore prevention and treatment.

The combined deficiencies in nurse training and lack of multidisciplinary involvement in pressure sore treatment and prevention is causing grievous harm. The following are examples of the harm suffered because of inadequate pressure sore treatment:

- L.L. fell and fractured his hip at the facility in January 2009, and staff noted that he was at high risk of skin breakdown. Because of the fracture, L.L. had limited mobility and was dependent on nursing staff for repositioning in his bed and wheelchair and for removing his stockings and boots every evening. However, nursing staff failed to adequately provide this care. As a result, Mr. L. developed a Stage II pressure sore⁹ on his heel and Stage I pressure sore on his coccyx. Even after staff noted the facility-acquired sores, they waited two days before they finally notified his physician or the wound care nurse. When the wound care nurse finally saw him, she noted his Stage II pressure sore and recommended treatment. Nursing staff, however, waited four days before they finally attempted to treat the sores on Mr. L.'s heel and coccyx.
- Y.Y. was at risk of skin breakdown and required daily skin inspections. In reviewing Y.Y.'s records, we found that in May 2009 nursing staff noted a skin breakdown on Y.Y.'s heel but failed to document it in the weekly skin report. For two months, staff failed to conduct daily skin inspections of Mr. Y. As a result of Maple Lawn's absence of care, Mr. Y.'s wounds were not identified until July 2009 when they were advanced (Stage III or IV) and had become infected.

⁹ 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.

Discolored drainage from his heel indicated that his wound was infected and painful.

- P.P. was known to be at risk for skin breakdown and was totally dependent on staff for her care. In reviewing P.P.'s records, we found that she developed a facility-acquired pressure sore that nursing staff neither identified nor treated. In fact, it was not until P.P. was admitted to a local hospital that the pressure sore on her buttocks was identified and treated. It is most likely that the wound was present in some stage prior to her hospital admission, yet Maple Lawn nursing staff failed to assess, develop a care plan, or treat P.P.'s condition.
- Z.Z., another totally dependent individual who was known to be at risk for skin breakdown and required repositioning in her bed, developed a facility-acquired pressure sore. In reviewing Z.Z.'s records, we found that nursing staff failed to turn and reposition her, failed to conduct daily inspections, and failed to update and individualize her care plan. As a result, Z.Z. developed a pressure sore on her coccyx that became infected. In our expert consultant's opinion, the staff's failures to provide care likely caused the development of her skin breakdown.

5. Maple Lawn's Inadequate Pain Management and End-Of-Life Care is Causing Unlawful Harm

Maple Lawn does not provide adequate pain management and end-of-life care practices to those in residence. Federal regulations require nursing homes to assess individuals for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d). Diagnosing and treating pain is essential to the practice of medicine and is especially urgent in caring for elderly individuals and those with terminal illnesses. During our review, we found several examples where the nursing home failed to adequately manage or assess individuals' pain. Examples of inadequate pain management that are causing grave harm include:

- A.B. was admitted to Maple Lawn in July 2009 after suffering a fractured spine. Although she was admitted for short-term rehabilitation, she died less than three weeks after admission. From the outset, Ms. B. complained of pain yet staff waited nearly two weeks before they finally contacted her physician to address her continued complaints of pain. During this period, Ms. B. refused to eat, threatened to "let self go," and stated that she was "tired of the pain." Even then, Ms. B.'s physician did not come to the facility to assess her condition; rather, he simply increased her medications and quadrupled the strength of her fentanyl patch¹⁰. Thereafter, Ms. B. became unable to eat or drink and increasingly nonresponsive and died within a week.

¹⁰ A fentanyl patch is a narcotic (opiod) pain medicine applied to the skin for treating persistent moderate to severe pain.

- A.C. was admitted to Maple Lawn in April 2009 after suffering from breast cancer complications. Despite clear indications that A.C. required pain management, it appears that nursing staff failed to adequately address her pain. Nursing staff mistakenly administered a short-acting form of morphine rather than a long-acting form to address her pain. According to our medical expert, this medication error likely contributed to an escalation of pain that went untreated. In reviewing the nurse's notes, it appears that Ms. C. suffered laboring breathing, twitching, shaking, and moaning when staff attempted to reposition her in her bed, yet we were unable to find any indication that Ms. C.'s drug regime was adjusted to address her pain.
- A.D. was admitted to Maple Lawn in June 2009 after suffering from obstructive pulmonary disease and a prior stroke. Mr. D. steadily declined in the three months before his death. In reviewing Mr. D.'s records, we found that A.D.'s care plan lacked specific direction for comfort measures, symptom management during this terminal illness, and any social services assessment and plan for his needs. Further, his physician ordered a series of painful and futile interventions that likely exacerbated his discomfort. The nurses notes state that Mr. D. "was rubbing his stomach and grimacing," "restless," "gaggy," "drawing up legs," and "whispered 'ow,'" yet his physician did not increase his medication dosage. In our expert consultant's opinion, Maple Lawn's treatment of Mr. D. is a gross deviation from lawful practices.

C. MAPLE LAWN SUBJECTS INDIVIDUALS TO HARM IN VIOLATION OF THEIR CONSTITUTIONAL RIGHTS AND FEDERAL LAW

Through Maple Lawn's acts or omissions, individuals suffer harm, or are at risk of harm from preventable deaths, preventable falls, fractures, unexplained injuries, skin tears, and bruises. The Due Process Clause of the Fourteenth Amendment requires a county-run facility to protect individuals from harm when it affirmatively places those individuals in danger. Tinder v. Lewis County Nursing Home District, 207 F. Supp. 2d 951, 955-57 (E.D. Mo. 2001) (holding that the nursing home violated plaintiffs' substantive due process rights because it had a duty to protect or care for an individual when it affirmatively placed that individual "in a position of danger the individual would not have otherwise faced"). The facility must deliver services with "reasonable care and safety." Youngberg, 457 U.S. at 324. It must also take all reasonable steps to protect those who live at the facility from harm. Id. at 315-16. Maple Lawn violates the constitutional rights of those who reside at the facility when it affirmatively places them in dangerous positions they otherwise would not have otherwise faced. Tinder, 207 F. Supp. 2d at 955-56.

1. Fall Risk

Individuals at Maple Lawn suffer serious injuries from preventable falls, where staff fail to reasonably mitigate known fall risks. More than 50 individuals at Maple Lawn suffered 166 documented falls between January and September 2009. Almost 20% of these individuals fell

more than five times, many resulting in serious injuries. The following 12 individuals suffered a total of 108 documented falls during this period; in each case, staff response was so cursory or delayed, it amounted to a deliberate indifference to their needs for care and resulted in unnecessary pain. See Estelle v. Gamble, 429 U.S. 97, 104 (1976) (concluding that deliberate indifference to medical needs constitutes an unnecessary infliction of pain (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976) (joint opinion))).

- A.E. fell six times between January and September 2009. Following one fall, Maple Lawn staff described A.E.'s left hand as "purple." Over the next five days, A.E. fell twice more. Staff noted her falls, but provided her with no medical care. After complaining of pain in her right leg and being unable to bear weight, it was discovered that A.E. had fractured her left wrist and right foot.
- A.F. had seven falls and three injuries over three months, including from tripping over another individual, and walking with closed eyes. Staff did not change the care provided to A.F. after any of the seven events.
- A.G. fell nine times over a six month period, with no record of follow-up or care.
- A.H. fell, first, from a sitting position, and later, after attempting to stand. There is no indication that staff changed his mobility protocol as a result.
- A.G. had 22 falls in six months, including eight in one month, yet there is no documented follow-up or care.
- A.I. had 13 falls while walking in socks, trying to sit, or trying to "fly," and in no case did staff note preventive intervention.
- N.N. had 11 falls in 12 weeks, where staff failed to take measures to prevent additional falls.
- I.I. had ten falls over four months, yet again, there is no documented response of a change in his care plan to prevent further harm.
- A.J. had had nine falls, with no appropriate staff intervention or follow-up documented.
- A.K. had six falls, with no appropriate staff intervention or follow-up documented.
- A.L. had six falls in 90 days, with no appropriate staff intervention or follow-up documented.
- A.M. had five falls, with no appropriate staff intervention or follow-up documented.

By failing to take action to prevent falls when falls risks are not just known but obvious, Maple Lawn acted with deliberate indifference to individuals' needs. See, e.g., Snow v. City of Citonelle, et al., 420 F.3d 1262, 1270 (11th Cir. 2005) (finding sufficient evidence of deliberate indifference where custodian failed to act in response to known risk of serious harm).

2. Risk of Preventable Injury

Individuals at Maple Lawn also suffer from harm from fractures, bruises, and skin tears. In many of these situations, staff creates a danger by failing to provide adequate nursing assistance and supervision. Further, Maple Lawn creates a serious risk of harm from hazardous environmental conditions. For example, Maple Lawn nursing and facility staff exposed people in the facility to harmful, and even potentially fatal, toxins on at least four occasions during our review. Facility staff left the cleaning utility room unlocked and unobserved, even though staff left a large bucket containing cleaning solution on the counter. Staff left the storage room unlocked, where cabinets contained hazardous solutions.

Maple Lawn also fails to investigate unknown injuries, even when they continue. In a particularly disturbing example, U.U., discussed above, had a number of unexplained injuries that Maple Lawn staff failed to investigate. Staff discovered U.U. with a large bruise under her right eye. Within days of that discovery, U.U.'s nurse found both of her eyes "blackened," and U.U. crying and "very tearful." Thereafter, staff regularly found skin breaches and "muscle knots" on U.U.'s back, and she was crying almost daily. U.U.'s charts also showed that blood was seeping from her right ear canal. U.U. slowed, and then stopped eating altogether, and soon died. Maple Lawn's failure to investigate these injuries likely contributed to their continuation.

3. Risk of Harm Created by Improper Drug Storage and Inadequate Care

Maple Lawn also creates a serious risk of harm by failing to properly monitor and secure dangerous drugs. Maple Lawn has no system to safely monitor, store, and control dangerous drugs. For example, nurses neither count nor record the number of Demerol or Morphine Sulfate on their units. Both Demerol and Morphine Sulfate are highly addictive and severely restricted narcotics. We also learned that nurses pre-sign blank or partially completed control sheets, which deviates so substantially from accepted professional standard of having two nurses count and sign a control log together that it evidence a deliberate indifference to care. Maple Lawn's failure to track controlled medications increases the likelihood for medication to become lost, misappropriated, or misused.

Maple Lawn also creates a serious risk of harm to its individuals from inadequate repositioning and continence care, which increases an individual's risk of harm from pressure sores and infections. Maple Lawn's own nurses and nursing assistants report that weekend unit staffing is particularly inadequate. As a direct result, staff do not deliver incontinence care, and individuals sit in feces and urine for long periods of time. Aides do not routinely turn or reposition individuals as required. These lapses deprive individuals of their constitutional right to adequate care. Youngberg, 457 U.S. at 315.

4. Inadequate Nursing Policies

Maple Lawn creates a serious risk of harm because it had no nursing services policy and procedure manual. When our nursing consultant requested Maple Lawn's manual, the Director of Nursing ("DON") provided internet print-outs of policies that staff had included in generic guidelines written by Maple Lawn within the past day. Maple Lawn's Assistant Director of Nursing ("ADON") assembled a smaller, unit-based policy and procedure manual that contained some of the same policies as the DON's manual but that also had completely different policies. Maple Lawn's manual was inadequate in both scope and implementation. For example, it failed to address infection control. It contained procedures on hand washing, but no isolation procedures to prevent the spread of highly infectious contagious infections, though they have been found at Maple Lawn. Finally, because the policies did not consistently reflect implementation or review dates, the nursing staff was unable to determine which policies were current.

All of these failures to provide basic care are resulting in serious injuries and violating the constitutional rights of the individuals at Maple Lawn.

V. MINIMAL REMEDIAL MEASURES

To remedy the deficiencies discussed above, and protect the constitutional and statutory rights of individuals at Maple Lawn and those at risk of being institutionalized at Maple Lawn, the County should promptly implement the minimum remedial measures set forth below.

A. MOST INTEGRATED SETTING

In order to remedy its failure to serve its individuals in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulation, it is essential for Maple Lawn to provide transition, discharge, and community placement services to ensure that all individuals residing at Maple Lawn are served in the most integrated setting appropriate to their needs.

Maple Lawn should have an admissions process in place that examines whether individuals could be served in more integrated settings and that provides individuals information about alternatives to nursing home care. As part of this process, and in order to ensure that persons with mental or developmental disabilities are not inappropriately placed in a nursing facility, Maple Lawn should adequately complete PASRR screenings, including regular individual reviews, to examine whether the individual could be served in a more integrated setting.

Maple Lawn should also have in place a discharge planning process that ensures that individuals who could be served in more integrated settings are identified and that appropriate plans are developed and implemented. Maple Lawn should actively pursue, from the time of admission, the appropriate discharge of individuals residing at Maple Lawn and provide them with adequate and appropriate supports and services consistent with each person's individualized

needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object. Maple Lawn should assume that every admission is temporary until there is overwhelming medical and psychosocial evidence that the placement is going to be for a long period of time. It must clearly understand individuals' desires concerning where they would ultimately like to reside after their stay in the facility. While it is important to recognize and document the need for the current level of care, there also needs to be an ongoing conversation about what the individual's plan is for the future.

During the treatment planning process and in implementing individual treatment plans, Maple Lawn should ensure, for all individuals, that barriers to discharge are identified and addressed, and for individuals with a history of re-admission, that factors that led to re-admission are analyzed and addressed. Discharge planning should begin upon admission and should be an on-going process for all individuals, not only for individuals Maple Lawn's staff have deemed imminently ready for discharge. Treatment plans should set forth in reasonable detail a written transition plan specifying the particular supports and services that each individual will or may need in order to safely and successfully transition to and live in the community. The plan should include, at a minimum: the individual's and families' preferences for care; a discussion of how the individual and family will access and pay for such services; the names and positions of those responsible for the individual's care, making appropriate referrals when necessary; a plan on how to coordinate care among multiple caregivers, if applicable; identification of the individual's specific needs after discharge; a discussion of how the individual and family need to prepare for discharge; and corresponding time frames for completion of needed steps to effect transition. In order to Maple Lawn staff to be able to develop and implement adequate discharge plans, they should become knowledgeable with the range of community-based services available to individuals being discharged from Maple Lawn, including the Aged and Disabled Waiver, Independent Living Waiver, Consumer Directed Services program, and Advanced Personal Care.

In order to support individuals in making an informed choice regarding discharge, Maple Lawn should ensure the participation in all aspects of care, treatment and discharge planning by the individual, his or her guardian, family, and friends, as appropriate, and staff who know the individual best. Staff should provide information and counseling to individuals, their guardians, and/or families regarding community supports and services that could support the individual's discharge to a more integrated setting, and information about the transition process. Further, staff should provide counseling and information to address any objections from individuals to being discharged to a more integrated setting, and document those efforts. If an individual opposes placement, Maple Lawn should document the steps taken to ensure that any individual objection is an informed one.

Finally, in order to ensure continuity of care upon discharge, Maple Lawn should require contact with identified community providers prior to discharge, and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. Maple Lawn should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged

individuals to determine if they receive care in the community as set forth in their discharge plan; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

B. HEALTHCARE SERVICES

Medical Care

In order to provide adequate medical care, Maple Lawn should develop and implement comprehensive care plans for each individual that specifically address her or his needs. 42 C.F.R. § 483.20. Each care plan should include: an initial assessment; nursing diagnosis; care planning; interdisciplinary intervention; and an evaluation. The initial assessment is arguably the most important step in developing adequate and appropriate care plans. Care plans should be comprehensive and focused to address specific needs.

Maple Lawn should implement procedures to ensure that nursing staff timely recognize and identify problems and needs. Nursing staff should then devise care plans, evaluate the plans for effectiveness, and update and change the plans when goals and outcomes are not achieved. Maple Lawn should ensure that interdisciplinary teams consisting of nursing, dietary, social services, activities, and rehabilitation staff are established to ensure that all care plans have measureable outcomes, have time-limited goals, and reflect changes in an individual's condition. Generally accepted professional standards require Maple Lawn to provide individuals necessary care and services to attain or maintain highest practical physical, mental, and psychological well-being. 42 C.F.R. § 483.25.

Nutrition and Hydration Care

In order to provide adequate food and basic care, and meet generally accepted professional standards, Maple Lawn should implement procedures that ensure that individuals receive adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 CFR § 483.25(i-j). All individuals should be assessed and care plans should be devised with measureable and time-limited goals. Each assessment should track and calculate calories, proteins, carbohydrates, and specific nutrition and hydration needs. Individuals should be weighed on admission and readmission weekly for four weeks, then monthly unless there is a change in an individual's condition. Any individual who loses five percent of total body weight in one month or 10 percent in six months should be re-evaluated and nursing staff shall contact the attending physician.

Nursing staff, along with assistance from restorative staff, should conduct daily monitoring of each individual's food and fluid intake. Nursing staff should be responsible for ensuring that each individual's daily food and fluid intake is documented and maintained in each individual's medical record.

Finally, Maple Lawn should ensure that the facility's dietitian oversees nutrition and hydration services. The dietitian should be responsible for educating Maple Lawn staff

regarding nutritional needs and developing clinical guidelines to ensure that nutrition and hydration services comport with generally accepted professional standards.

Psychotropic Medications

Maple Lawn should ensure that its psychotropic medication practices comport with generally accepted professional standards. Federal law strictly regulates the prescription of psychotropic medications for people in nursing homes, and generally accepted professional standards require that they be free from unnecessary antipsychotic medication. See 42 C.F.R. § 483.25(l)(1). “Unnecessary medication” is defined by federal law as any medication that is excessive in dose, excessive in duration, without adequate monitoring or indication for use, or without specific target symptoms. Id.

Maple Lawn should ensure that the use of psychotropic drugs is professionally justified, carefully monitored by physicians and nursing staff, documented by nursing staff, and reviewed, as needed, by physicians and nursing staff. Maple Lawn should also ensure that prescribed medications are based on clinical needs and not used in a manner that exposes individuals to undue risks to their health and safety.

Finally, Maple Lawn should document that, prior to using psychotropic medications, other less restrictive techniques have systematically been tried and have been demonstrated to be ineffective.

Pressure Sore Treatment and Skin Care

Maple Lawn should develop and implement procedures that ensure that individuals do not develop pressure sores that are clinically avoidable and ensure that existing pressure sores receive necessary treatment and services to promote healing. See 42 C.F.R. § 483.25. Maple Lawn should ensure that staff conduct risk assessments for skin breakdown for all individuals at least quarterly. Maple Lawn should also ensure that staff develop and follow an individualized plan of care for each individual at risk for skin breakdown and for each individual with existing pressure sores.

Maple Lawn should develop and implement procedures that ensure that individuals with pressure sores are appropriately positioned, turned and repositioned, and monitored on a daily basis. Maple Lawn staff should ensure that physicians are notified within 24 hours of signs of new skin breakdown or deterioration of existing pressure sores. Finally, Maple Lawn should develop and implement a protocol to track all individuals with pressure sores, all outstanding physician orders regarding pressure sores, and all recommended pressure sore treatments.

Pain Management and End-of-Life Care

Maple Lawn should develop and implement procedures that ensure that its pain management and end-of-life care practices comport with generally accepted professional standards of care. Federal regulations and generally accepted professional standards require

nursing homes to assess individuals for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d). Maple Lawn should ensure that nursing staff are conducting pain assessments, implementing appropriate interventions, and monitoring individual pain to ensure that medications are administered as needed. Maple Lawn should also ensure that changes in each individual's condition are documented and placed in the comprehensive care plan. Finally, Maple Lawn should ensure that physicians review medication usage and analyze pain data consistent with generally accepted professional standards.

C. PROTECTION FROM HARM

Investigation Process

In order to identify threats to safety and care, Maple Lawn should conduct thorough investigations of individual incidents. 42 C.F.R. § 483.13(B)(3); Grace Healthcare v. United States HHS, 589 F.3d 926, 927 (8th Cir. 2009). Maple Lawn should thoroughly investigate incidents, and promptly report the results of investigations to the facility's administrator and to other officials in accordance with state law within 5 working days of [an] incident." Grace, 589 F.3d at 930 n.6. Specifically, Maple Lawn investigators should visit the scene of an alleged incident, collect physical evidence, and obtain witness accounts. Investigators should also identify, preserve, and record evidence, and then conduct a reasoned analysis of all evidence received. In addition, Maple Lawn investigators should issue a report of their findings, detailing: (1) interviews conducted; (2) evidence considered; (3) staff compliance with care guidelines and facility policies; (4) the basis for each conclusion; and (5) recommended corrective measures. The facility should promulgate policies or procedures addressing basic investigative principles such as collecting biological, video, or other physical evidence; conducting sensitive staff and individual interviews; and navigating the difficult inquiry into possible peer misconduct.

Maple Lawn should investigate all serious injuries, deaths, and suspected cases of abuse, neglect, and maltreatment. 42 C.F.R. 483.13(B)(3). See also 42 U.S.C. § 1396r(g)(4)(A) ("Each state shall maintain procedures ... to investigate of violations of requirements by nursing facilities."). Maple Lawn may not limit its investigations to a single category of injury falls. Investigators should evaluate possible cases of abuse, neglect, or inadequate care following a questionable individual death, or when an incident resulted in severe individual injury. Maple Lawn should investigate, for example, injuries from staff, self-injurious behaviors, supervisory neglect, treatment neglect, or failure train and supervise care staff.

Lastly, Maple Lawn should use trained investigators to conduct its investigations. Maple Lawn tasked two staff persons with conducting incident investigations, yet neither has had any investigative training.

Fall Prevention Program and Practices

In order to minimize harm from preventable falls, Maple Lawn should actively ensure that each individual receives adequate assistance to prevent accidents and falls. See generally 42 C.F.R. § 483.25(h). First, Maple Lawn should assess physical functioning and structural

problems at least annually. Thereafter, Maple Lawn staff should assess fall risks within 14 calendar days after staff have determined, or should have determined, a change in an individual's condition likely to go unresolved without intervention. 42 C.F.R. § 483.20(b)(1)(viii), (b)(2)(ii)-(iii). Staff should consider the circumstances leading to falls. For many individuals with a high fall risk, staff should do more than a generic assessment, and should adjust intervention plans to decrease their likelihood of falling.

Next, within seven days of completing the comprehensive assessment, Maple Lawn should develop a comprehensive care plan with measurable objectives and timetables for medical, nursing, and mental health needs. 42 C.F.R. 483.20(k). The plan should be developed by an "interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the individual, and other appropriate staff in disciplines as determined by the individual's needs." 42 C.F.R. 483.20(k)(2)(ii). Lastly, Maple Lawn should also maintain all assessments completed within the past 15 months of active treatment and use the results to revise individuals' plan of care. 42 C.F.R. 483.20(d).

Maple Lawn's physicians should monitor drugs used during treatment for their likelihood to increase risk to fall, and review the drug regime of any at-risk individual who ultimately falls. See 42 C.F.R. § 483.40(b)(1) (noting that physicians should review medications when assessing care programs). Maple Lawn should ensure that such assessments occur at each visit, which should take place, at a minimum, once every 30 days for the first 90 days after an individual's admission, and once every 60 days thereafter. 42 C.F.R. § 483.40(c)(1). Physicians should properly monitor and chart drug side effects, especially when using medication known to contribute to falls. In addition, physicians should review drug regimens and eliminate drugs to decrease fall risks.

Finally, Maple Lawn's pharmacist should advise care teams about any medications in an individual's regimen that increase the likelihood of a fall. See 42 C.F.R. § 483.60 ("The pharmacist should report any irregularities to the attending physician and the director of nursing, and these reports should be acted upon."). Maple Lawn has pharmacists on staff, and physicians should incorporate pharmacists' recommendations where medically indicated to eliminate or reduce drugs and drug combinations specifically for their potential to contribute to falls.

Quality Assurance Program

In order to identify and reduce sources of recurrent harm, Maple Lawn should implement a quality assurance program to: (1) make certain its senior staff respond appropriately to issues placing individuals at risk; (2) provide its nursing staff with clear policies and procedures that define adequate direct care; and (3) share findings and recommendations so its various disciplines can avoid recurrent or potentially harmful incidents.

Maple Lawn's senior clinical administrators should ensure that care is appropriate. MO. CODE REGS. ANN. tit. 19, § 30-86.042(42). Maple Lawn should develop and implement written policies and procedures preventing mistreatment, neglect, abuse, and misappropriation. 42 C.F.R. § 483.13(c). To ensure proper individual care, nursing and facility staff should have

ready access to those policies; management should enforce the policies through regular supervision and training; and, staff should be trained on new or revised policies.

Maple Lawn should also develop and “maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.” 42 U.S.C. § 1396r(b)(1)(B); 42 C.F.R. § 483.75(o). This does not exist at Maple Lawn. Instead, Maple Lawn had a number of “stand alone” review teams, comprised primarily of its Quality Assurance, Fall Prevention, Weight, and Safety Committees. Each team narrowly and independently considers the staff, individual, or environmental events relevant to its focus; nothing suggested that individual disciplines either formally or informally shared data, evidence, findings, recommendations, or even their basic understanding of the events themselves. Maple Lawn should employ a collaborative, interdisciplinary analysis to prevent harm or recurrence at any level, thus mitigating risk of individual harm. Finally, Maple Lawn should “ensure that all allegations of abuse or neglect are reported to the facility's administrator and to other officials in accordance with state law.” Grace, 589 F.3d at 930 n.6.

Risk Management Practices

In order to reduce harm from inadequate staffing, substandard care, hazardous environmental conditions, and dangerous narcotics control practices, Maple Lawn should establish a comprehensive risk management system.

Maple Lawn should provide a sufficient number of qualified nurses to meet the total nursing care needs within the facility twenty-four hours per day, seven days a week. 42 C.F.R. § 483.30(a)(1). In keeping with State law, Maple Lawn's staffing pattern should be “one (1) staff person for every fifteen (15) individuals or major fraction of fifteen (15) during the day shift, one (1) person for every fifteen (15) residents or major fraction of fifteen (15) during the evening shift, and one (1) person for every twenty (20) residents or major fraction of twenty (20) during the night shift.” MO. CODE REGS. ANN. tit. 19, § 30-86.045 (4)(A) (2009). There shall be a licensed nurse employed by the facility to work at least eight (8) hours per week at the facility for every thirty (30) residents” or fraction thereof. Id. at § 30-86.047 (61)(E).

Maple Lawn should ensure that its nurses, aides, technicians, and care staff are able to function at the level required by the State. 42 C.F.R. § 483.75(g)(2). Maple Lawn should discontinue its current practice of hiring staff and failing to provide ongoing training and supervision for nurses and aides.

Maple Lawn should provide a safe environment, with appropriate services to maintain a sanitary and orderly interior. 42 C.F.R. 483.15(h). Its rooms should be designed and equipped such that safety is provided for at all times. MO. CODE REGS. ANN. tit. 19, § 30-86.032(22). In addition, generally accepted professional standards require Maple Lawn staff to take affirmative, strategic efforts to protect individuals from environmental harm. Maple Lawn staff

should evaluate hazards, implement interventions, monitor effectiveness, and make needed modifications to minimize preventable risk. See generally 42 C.F.R. § 483.25(h)(1) (“The facility should ensure that the resident environment remain free of accident hazards as is possible.”).

Finally, Federal and State laws require Maple Lawn care staff to tightly control narcotics through facility oversight and management. See MO. CODE REGS. ANN. tit. 19, § 30-86.047(41)(A)-(B) (“All medication . . . shall be kept in a secured location behind at least one (1) locked door or cabinet. . . . Schedule II controlled substances shall be stored in locked compartments separate from non-controlled medications”); 42 C.F.R. § 483.60(e) (requiring that facilities store general in locked, access controlled compartments, and Schedule II substances in separate, locked, permanently affixed compartments). A Maple Lawn pharmacist or registered nurse should review the controlled substance record keeping quarterly, including reconciling the inventories of controlled substances. MO. CODE REGS. ANN. tit. 19, § 30-86.042(57).

* * *

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 County in an amicable and cooperative fashion to resolve our outstanding concerns with regard to Maple Lawn. 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 the work of each expert consultant 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. 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 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 contact County officials shortly to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5401.

Sincerely,

s/ Thomas E. Perez

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The Honorable Richard G. Callahan
United States Attorney
Eastern District of Missouri