U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
Washington, DC 20530

May 1, 2006

The Honorable Bill Richardson
Governor of New Mexico
Office of the Governor
State Capitol
Room 400
Santa Fe, NM 87501

Re: CRIPA Investigation of Fort Bayard Medical Center, Bayard, New Mexico

Dear Governor Richardson:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Fort Bayard Medical Center ("Ft. Bayard") in Bayard, New Mexico. On April 18, 2005, we notified you of our intent to conduct an investigation of Ft. Bayard pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern and practice of conduct that violates the constitutional or federal statutory rights of nursing home residents who are served in public institutions.

In July and October 2005, we conducted on-site inspections of Ft. Bayard with expert consultants in various disciplines. Our first tour focused on the general care and treatment of residents, while our second tour examined the facility's discharge planning and community integration practices. Before, during, and after our site visits, we reviewed a wide variety of relevant facility documents, including policies and procedures, and medical and other records relating to the care and treatment of Ft. Bayard residents. During our visits, we also interviewed Ft. Bayard administrators, professionals, staff, and residents. In keeping with our pledge to share information and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to

counsel for the State of New Mexico ("State") and Ft. Bayard administrators during verbal exit presentations at the close of each of our on-site visits. We conveyed our deep concerns about the life-threatening conditions at the facility. Shanetta Y. Cutlar, Chief of the Special Litigation Section, sent a July 25, 2005 letter to counsel for the State of New Mexico memorializing our concerns and documenting the nursing home's inadequate medical care and dangerous psychotropic medication usage and requesting that the State take immediate remedial action to address the most serious deficiencies.[1]

Before outlining our findings, we would like to express our appreciation to the State and to Ft. Bayard staff and administration for the extensive cooperation and assistance provided to us throughout our investigation. We particularly appreciated the assistance of Secretary Michelle Lujan Grisham and Aging and Long-Term Services Secretary Deborah Armstrong. We hope to continue to work with the State and officials at Ft. Bayard in the same cooperative manner going forward.

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at Ft. Bayard violate the constitutional and federal statutory rights of its residents. In particular, we find that residents of Ft. Bayard suffer significant harm and risk of harm from the facility's inadequate medical and nursing care services; improper and dangerous psychotropic medication practices; failure to provide adequate safety; inadequate nutritional and hydration services; and inadequate restorative care and specialized rehabilitation services. Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. §§ 1395, 1396r and implementing regulations, 42 C.F.R. § 483 Subpart B (Medicaid and

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[1] Department of Health Secretary Michelle Lujan Grisham responded to Ms. Cutlar's letter on August 12, 2005. In her letter, Secretary Grisham set forth the actions the State pledged to take on an immediate basis to address the dangerous conditions. We appreciate the State's willingness to address these issues on an expedited basis. During our September 2005 tour of Ft. Bayard, we spoke with Secretaries Grisham and Armstrong about our findings and the State's response. We were pleased to note during this tour that the State had taken several steps to begin to remedy the deficiencies we identified.

Medicare Program Provisions). The deficiencies are evidenced through preventable injuries, illnesses, and deaths. In addition, we find that the State fails to provide services to certain Ft. Bayard residents in the most integrated setting, as required by the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

I. FACILITY DESCRIPTION

Ft. Bayard is a state-owned and -operated nursing home in the southwestern part of the state. The nursing home is a three-story 1920s building located on an old military facility. Although the facility is licensed to provide care for 210 residents, at the time of our tour, the facility was only serving 169 residents. The majority of residents are age 65 or older, but the nursing home admits a significant percentage of younger residents – almost a third – who bring with them an accompanying set of behavioral management issues and a wide diversity of interests. At the time of our tour, about 60 residents had a mental health diagnosis and four residents were diagnosed with developmental disabilities. About 90 residents had dementia and 112 were diagnosed with depression.

The facility is divided into six "neighborhoods." One neighborhood provides nursing services to veterans only. There are few private rooms. Most rooms can house three residents, although there are several rooms housing two residents. The average length of stay at Ft. Bayard is a little more than four years.

II. FINDINGS

A. INADEQUATE MEDICAL AND NURSING CARE

Residents of publicly-operated institutions, such as Ft. Bayard, have a Fourteenth Amendment due process right to adequate health care. Youngberg, 457 U.S. at 315; Yvonne L. v. New Mexico Dep't of Human Services, 959 F.2d 883 (10th Cir. 1992) (persons with developmental disabilities committed to State institutions have a Fourteenth Amendment substantive due process right to reasonable care and safety); see also 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide nursing and medical services to "attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident").

Our investigation revealed a wide range of dangerously deficient medical and nursing care practices. These practices not only failed to comply with federal regulations or meet professional standards, but were in fact aiding and contributing to the needless suffering and untimely deaths of Ft. Bayard's residents. We found numerous situations where residents' last days of life were spent in miserable pain as they died from the effects of what appeared to be reckless and almost willful disregard to their health and safety. In fact, in practically every record we reviewed of deceased or current Ft. Bayard residents, we discovered life-threatening omissions and commissions of treatment. In every medical record we reviewed, our consultants found substantial departures from the generally accepted standards in nursing home care.

The pervasive medical and nursing care deficiencies we identified tend to fall into three areas. First, the nursing home fails to adequately assess, plan for, or care for the residents' healthcare needs. Second, the nursing home's use of psychotropic medications is dangerous. And third, the nursing home subjects its residents to undue and unnecessary pain and suffering.

1. Inadequate Healthcare Plans

Ft. Bayard is required by federal regulations to establish a comprehensive care plan for each resident that specifically addresses individualized needs. 42 C.F.R. § 483.20. Assessments must be conducted upon admission and periodically thereafter to ensure there is a comprehensive, accurate, and standardized record of each resident's functional capacity. 42 C.F.R. § 483.20. These assessments are then used by staff to develop a comprehensive care plan specific to the needs of each resident. 42 C.F.R. § 483.20(a)(1). Adequate assessments include measurable objectives and timetables to assist the clinical and mental health staff in ensuring that all of the resident's needs are met in a timely manner. 42 C.F.R. § 483.20(k)(i). The physician is required by federal regulations to take an active role in the care of each resident by reviewing, at each visit, the resident's total program of care, including medications and treatments. 42 C.F.R. § 483.40(b). This care plan must be periodically reviewed and revised, using the results of the resident's regular assessments, to assure continued accuracy. 42 C.F.R. § 483.20(k)(2)(iii).

In our judgment, Ft. Bayard fails to comply with every one of the above regulations. Ft. Bayard staff fail to assess adequately, plan, and respond to the serious medical and nursing

needs of its residents. We highlight below a few examples where these failings have resulted in needless suffering and untimely, and in some deeply distressing cases, preventable deaths.

- On July 20, 2005, a 71-year-old resident with diabetes died. The resident's medical chart revealed numerous instances of abnormal blood-sugar findings during the six-month period preceding his death. Indeed, on June 25, 2005, the resident's blood-sugar was so low that it was life-threatening. Neither medical nor nursing staff at Ft. Bayard responded. No one at Ft. Bayard developed a healthcare plan to respond to this life-threatening situation. Staff appeared to ignore obvious "red flags," and the resident died. There is a strong possibility that the resident died as a result of Ft. Bayard's improper care planning and failure to implement an adequate response to the resident's diabetes and diabetic emergencies.

- Another startlingly similar example of Ft. Bayard's failure to develop and implement adequate care plans in the face of abnormal test results involves the case of a 56-year-old resident who, on at least two separate occasions, had laboratory tests that revealed the resident was not receiving an adequate amount of his needed anti-convulsant medication. Despite these findings, no plan was developed or implemented to correct the seizure mediation regimen. As a result, the resident subsequently suffered continuous uncontrolled seizures and had to be admitted to an acute-care hospital. The resident died shortly thereafter. Ft. Bayard's failure to develop and implement an adequate seizure management program directly contributed to this resident's death and represents a gross departure from generally accepted professional standards. If Ft. Bayard staff had adequately monitored and responded to the changes in the resident's condition, the resident would not have died at the time and in the manner he did.

- Another Ft. Bayard resident died in April 2005, within a week after being admitted for rehabilitation following hip fracture surgery. Upon admission, this 92-year-old resident was recognized as being at high risk for aspiration due to his Parkinson's disease, and Ft. Bayard staff developed a special diet and a plan for feeding precautions for him. Part of the feeding plan required that he be fed liquids either with a spoon or by being given "very small sips." Two days later, despite these precautions, nursing staff attempted to feed him greater quantities of liquid than they should have. Because the resident was "not swallowing," the

liquid had to be "removed" from his mouth. Two days after that, he was noted to be coughing and choking during meals, became delirious (likely due to the fact that he had developed aspiration pneumonia, an infection or inflammation in the lungs caused by the inhalation of food or fluid), and was "call[ing] out for help." He soon became lethargic, but nursing staff continued their dangerous practice of feeding him the liquid improperly. The resident died two days later of chronic aspiration - one week after being admitted to Ft. Bayard. Ft. Bayard never assessed his respiratory status or adequately followed-up on his choking and coughing episodes. If his feeding plan had been appropriately implemented, the resident would not have died at the time or in the manner that he did. Thus, this resident's care was a substantial departure from generally accepted professional standards.

- Another untimely death occurred in the case of a 94-year-old resident who died of aspiration pneumonia in May 2005 after just over a year's stay at Ft. Bayard. She was admitted due to progressive confusion, Alzheimer's Disease, agitation, and a number of other medical conditions. Her condition declined during her stay at Ft. Bayard, and during the last several months of her life, she had problems swallowing. She was seen on multiple occasions by Ft. Bayard's staff responsible for diagnosing swallowing difficulties.[2] Those staff identified the swallowing difficulty and made specific recommendations to the nurses to address the risk of aspiration pneumonia for this resident. However, nursing staff failed to implement the recommendations, which is a stark departure from generally accepted professional standards. The resident aspirated numerous times, ultimately contributing to her untimely death.

- Yet another untimely death involved a 67-year-old resident admitted to Ft. Bayard in January 2005. He was diagnosed with advanced Alzheimer's Disease, hypertension, coronary artery disease, and peripheral vascular disease. He also had significant behavioral problems and was easily agitated. He died just over three months after being admitted to the nursing home. During his stay at Ft. Bayard, he was described as "consistently agitated," for which he was prescribed psychotropic medications. Staff also noted that he "ate poorly," and "spent most of his day in a wheelchair

[2] Residents with swallowing difficulties are at risk of developing life-threatening aspiration.

attempting to remove the lap buddy."[3] In February 2005, x-rays of bones in one of the resident's feet revealed that, due to a combination of infection and the resulting loss of bone calcium, the bone had developed a "moth eaten appearance." The resident's entire foot remained swollen and painful until his untimely demise. According to Ft. Bayard records, the resident continued to do poorly until April 4, 2005, when he suffered what a Ft. Bayard physician described as a "classic....massive right-sided aspiration." The resident died four days later of aspiration pneumonia. This is another case of multiple failings of medical and nursing care staff to assess and address a resident's declining condition. If this resident had had adequate and professionally acceptable care plans in place and implemented for his various needs, this resident most likely would have lived several additional years.

2. Dangerous Psychotropic Medication Practices

Federal regulations require nursing home residents to be free from unnecessary anti-psychotic medication. 42 C.F.R. § 483.25(l)(1). Federal law defines an unnecessary medication as any medication that is excessive in dose; excessive in duration; without adequate monitoring or indication for use; or without specific target symptoms. Id. Federal law also requires that residents receive gradual dose reductions and unless contraindicated, behavioral interventions aimed at reducing medication use. 42 C.F.R. § 483.25(l)(2)(ii).

Ft. Bayard prescribes psychotropic medications at more than double the rate of nationwide nursing home averages. At the time of our July 2005 visit, 50% of Ft. Bayard's residents were on psychotropic medications, as compared to the national average of 23%. In nearly every record we reviewed where psychotropic medication was prescribed, there were often multiple failings, including: the absence of a diagnosis justifying the use of the medication; the absence of behavioral indications warranting the administration of the medication; the absence of any evidence that non-medication interventions were tried and/or considered and found ineffective; the absence of monitoring of the medication's efficacy; the absence of side-effect monitoring; the

[3] A "lap buddy" is a restraining device which is attached to the armrests of a wheelchair, covering the lap of a resident and preventing a resident from getting up from a wheelchair. When used appropriately, the device can be a useful tool to minimize falls and serious injuries.

absence of appropriate response to medication side-effects; and the absence of informed consent for the use of the medication. Medications are also prescribed in excessive dosages. Each of these failures violate federal law governing psychotropic medication practice in nursing homes and has contributed to significant harm to Ft. Bayard's residents. See 42 C.F.R. § 483.25(l)(1).

Ft. Bayard's use of psychotropic medication deviates so far from the requirements of federal law and generally accepted professional standards of care that it is shocking. So deviant are Ft. Bayard psychotropic medications practices that residents have suffered and died premature deaths that can be attributed, at least in part, to the nursing home's psychiatric medications practices. We reviewed ten current residents' records because the residents were being prescribed psychotropic medication. In nine of those ten cases, the psychotropic drugs were inappropriately prescribed and administered. In 15 of the 20 death charts that we reviewed, we found significant violations with respect to the prescription and administration of psychotropic medications.

Because of the risks that psychotropic medications pose to nursing home residents in particular, their use is highly regulated and scrutinized under federal law. See 42 C.F.R. § 483.25(l)(1). We found many violations of these federal regulations. For example, the interaction of the medications' side-effects and the sedation resulting from psychotropic medication are known to cause swallowing difficulties in elders. Residents with swallowing disorders are particularly at risk for aspiration pneumonia[4], a life-threatening condition in elders, because they are unable to protect their airways adequately while eating or drinking. Our consultant reviewed six records of residents who had died at Ft. Bayard of aspiration pneumonia. In every case, the resident had been given psychoactive or sedating medications without an appropriate justification or diagnosis and without appropriate side-effects monitoring. Care plan interventions were not carried out or were absent. Signs of medication side-effects and/or aspiration were present but were ignored by both nursing and medical staff prior to the development of the final aspiration event leading to death. Consider the following examples:

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[4] Aspiration pneumonia is a condition where food or fluid enters the lungs rather than remaining in the esophagus. Once in the lungs, this food or fluid can lead to the development of pneumonia.

- In June 2005, a 66-year-old resident died of aspiration pneumonia. He had a long history of behavioral disturbances while at Ft. Bayard and had been treated with several different anti-psychotic drugs. Prior to his death, he was on a daily regimen of anti-psychotic medication nearly ten times the maximum recommended dosage under federal guidelines. The resident's medical record showed no systematic evaluation of the side-effects of the various medications, nor did it contain an adequate justification for the combinations of medications. Ft. Bayard's dangerous medication practices contributed to this resident's death from aspiration pneumonia.

- Another untimely death occurred in December 2004, when a 90-year-old resident died less than two months after being admitted to Ft. Bayard. His death was attributed to aspiration pneumonia. During his stay at Ft. Bayard, he was prescribed and administered excessive doses of anti-psychotic drugs without adequate indications for use of the medications, informed consent, side-effects monitoring, or the use of behavioral programming. The anti-psychotic drugs may have been causing the aspiration. The cause and manner of this resident's death was likely preventable.

- In November 2004, a 56-year-old resident died after developing aspiration pneumonia. He was being treated with large amounts of psychotropic medications without clinical indications. Shortly before his death, he had "lost his gag and swallow reflex completely," but nurses gave him two cartons of a nutritional supplement to drink. He was subsequently observed to have been unable to swallow the supplement. Death from aspiration pneumonia occurred two days later. This resident's death was also discussed under the section of this letter addressing Ft. Bayard's dangerous medication practices.

- In June 2005, an 89-year-old resident died of aspiration pneumonia after a nine month stay at Ft. Bayard. The resident was taking a number of psychotropic medications, including at least one known to have severe side effects in elders. Indeed, at one point the resident reported to nurses that he was having trouble walking and talking because he "felt drunk." The nurse's response to this red flag was to restrain the resident in his wheelchair with a lap buddy. This resident was often restrained for his behaviors and suffered another common side effect for elders taking psychotropic medication – constipation. Three months before he died, the resident went for a 22 day period without a bowel movement. Constipation can cause increased

aggression, and this resident became increasingly combative, which led to an increase in his psychotropic medications. He died shortly thereafter, of aspiration pneumonia.

- In May 2005, a 94-year-old resident suffered an untimely aspiration pneumonia death after just over a year's stay at Ft. Bayard. As with many other residents, Ft. Bayard had placed her on multiple psychoactive medications without adequate assessments for the need of such medications or plans to monitor adequately the effects of the medications. According to Ft. Bayard documents, she was prescribed these medications for "irritable mood." She suffered recurrent bouts of aspiration pneumonia during the last months of her life, and was seen by Ft. Bayard's speech therapy staff on multiple occasions. However, nursing staff failed to implement and monitor the recommendations made by the speech therapy staff. This resident's death was also discussed under the section of this letter addressing Ft. Bayard's failure to develop and implement adequate healthcare plans.

3. Undue and Unnecessary Pain and Suffering

The diagnosis and treatment of pain is integral to the practice of medicine. Generally accepted professional standards mandate that patients with pain, acute or chronic, be treated through aggressive and appropriate means. Treatment of pain is especially urgent for patients who experience pain as a result of a terminal illness, and treatment of pain is an especially important issue in the medical treatment of the elderly. It has been estimated that over 50% of elderly persons in the community, and 80% of those in nursing homes, live with persistent or recurring pain that must be treated. Examples of the causes of chronic pain conditions in older people include osteoarthritis[5], various forms of cancer, post-stroke pain, joint pain and peripheral neuropathy[6] in diabetes. Federal regulations require nursing homes to assess residents for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d).

In practically every case we reviewed where pain management was an issue, the facility failed to either assess pain

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[5] Osteoarthritis is a degenerative joint disease that is especially prone to affecting weight-bearing joints and is very common in older persons.

[6] Peripheral neuropathy is damage to the nervous system, particularly in the fingers and feet, and is frequently seen in older people with diabetes.

adequately, prescribe appropriate medication, or monitor the effectiveness of pain medication. The nursing home failed to manage pain adequately in long term residents, post-operative residents, and dying residents alike. Also, agitated residents with dementia were often not adequately assessed for pain, but were medicated with psychotropic drugs instead. As a result, residents of Ft. Bayard suffer undue and unnecessary pain and suffering. Consider the following examples:

- A 66-year-old resident with metastatic breast cancer was admitted to Ft. Bayard in June 2004. She was admitted from an acute care hospital following surgery for a fracture to her thigh bone caused by cancer that had spread to that bone. It was known at the outset that the resident was admitted to receive care until she died from cancer. No further treatment was possible for her cancer, which had spread to many of her bones and elsewhere in her body. In an outrageous departure from accepted professional standards, nurses failed to list pain management in her plan of care. Pain management should have been the first item in her care plan, and nurses should have focused on relief of pain at least once every single shift. During the early part of her stay, she was given pills for pain in an amount equal to 600 mg of morphine per day - a very high dose. The resident's condition deteriorated, and she became unable to swallow the oral medication. In mid-July 2004, she was changed from the oral medication to a liquid form of morphine. In a gross mismanagement of pain, staff at Ft. Bayard prescribed a dose one-tenth the equivalent of the pills she had been taking. The resident died three days later. Allowing a human being to die under such circumstances is unconscionable.

- A 91-year-old resident was admitted to Ft. Bayard in December 2004 for rehabilitation therapy to recover from hip surgery. At the time of her admission, she was screaming in pain due not only to the surgery but to a large bed sore on the posterior of her pelvis. Ft. Bayard's nurse rated her pain at a 10 on a 0-to-10 scale, yet the resident received no pain medication at that time. For the next two weeks, Ft. Bayard prescribed only minimal pain medication. At two weeks, the resident was given morphine and was noted to be "less tearful." In early February 2005, the resident's pain appeared to get worse and she was noted to be "grimacing, moaning and crying in pain." The facility made no changes to her pain regimen. The resident became combative with staff, possibly as a result of delirium brought on by untreated pain. Rather than adequately assessing and alleviating the resident's pain, Ft. Bayard responded by

chemically restraining her with psychotropic medications. The combination of pain and psychotropic medications contributed to her decreased appetite and food intake. At one point, the resident lost almost 20 pounds in one month's time. Again, Ft. Bayard failed to develop a healthcare plan to address this serious weight loss. The resident lived only a few months after admission to Ft. Bayard and died on March 1, 2005. The combination of Ft. Bayard's failures to develop adequate healthcare plans to address the resident's pain, behaviors, or nutritional needs resulted in the resident suffering unnecessarily and contributed to her untimely death.

- Another example of Ft. Bayard's allowing a resident to suffer needless pain is the case of a 94-year-old woman who was admitted to Ft. Bayard in January 2004. Among other conditions, she had a spinal condition and osteoporosis, which caused her chronic back pain. During the last week of her life in May, 2004, after having experienced increasing pain, she was observed as being "confused," "agitated," "paranoid," and "restless." During this time, she made the statement, "I'd rather be dead than let them get me" before falling to the ground while attempting to get in her wheelchair. Among other failings, such as Ft. Bayard's failure to assess and treat her delirium, the resident's pain was not assessed or adequately treated.

- Another resident of Ft. Bayard, at various times over a period of about 18 months, suffered a fractured collar bone; complained of pain in one of his front teeth; had his penis inflamed so badly that he could not retract the foreskin; suffered swollen and contused joints in his hand; had abrasions on his left index and middle fingers; fell off the toilet; fell two other times in the bathroom; suffered a black eye from a fall; and fell on his left hip. Pain was not appropriately assessed, evaluated, managed, or documented in any of these incidents.

- On the day before he died, one resident was murmuring "I hurt. I hurt." Yet, Ft. Bayard failed to respond adequately to his pain, causing unnecessary suffering.

- A resident died at Ft. Bayard after a year's stay. At the end of her life, she was not provided adequate pain or comfort measures and was allowed to suffer needlessly prior to her death.

Furthermore, the nursing home systemically fails to ensure that pain medications (which are controlled substances) are adequately administered or safeguarded. Specifically, unlicensed medication aides are allowed to administer pain medication to residents without direct supervision by nurses. Indeed, we reviewed two instances where staff charted that pain medication had been "refused" by a resident, but the refused medication could not be accounted for. In another case, a bottle of liquid morphine had been "dropped," although the broken bottle was never produced. Opiate medications are stored en masse in the narcotics drawers of the medication carts without individuals' names or prescriptions.

Added to these two unsafe practices is the fact that Ft. Bayard staff are not adequately monitoring residents to determine exactly how much pain medication residents are, in fact, receiving. We found many residents complaining of being in pain even though the facility was prescribing large amounts of narcotic pain killers to these residents. Ft. Bayard was over-relying on residents to report whether or not they had received their medications. Residents with cognitive impairments, such as residents with dementia, are often not be able to remember or state whether they have received pain medication. Thus, this practice further allows for the possibility of opiate medications not being given to residents as prescribed.

Finally, we asked the managers at Ft. Bayard how many of the staff at Ft. Bayard likely take illegal drugs and were told it was a significant percentage. We were also told that staff at Ft. Bayard are not tested for drugs unless they are in special positions that place others at risk.

This combination of deficient practices and evidence has led us to the disquieting possibility that certain Ft. Bayard staff are purloining opiate medications away from residents. Thus, as unconscionable as it may seem, Ft. Bayard staff may very well be allowing residents to suffer needless pain while they themselves take (or sell) medication intended for residents. Obviously, if this is occurring, it is a gross departure from accepted professionals standards of practice and is likely a violation of federal and state criminal law.

B. INADEQUATE PROTECTION FROM HARM

Residents of Ft. Bayard have the constitutional right to live in reasonably safe conditions and to be provided the essentials of basic care. See Youngberg, 457 U.S. at 315. Federal statutes governing the operation of nursing homes create

similar rights. See, e.g., Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1351i-3; and their implementing regulations, 42 U.S.C. § 483 Subpart B. However, Ft. Bayard is failing to ensure that residents are kept free from harm or unnecessary risk of harm. Specifically, the facility is failing to ensure that residents are free from harm at the hands of other residents; that residents are protected adequately from the risk of falling; and that care is provided in an environment that comports with federal regulations.

1. Resident-on-Resident Violence

During our tours of Ft. Bayard, State officials told us that Ft. Bayard acts as a "safety net" for the State of New Mexico. As a result, Ft. Bayard accepts residents that private nursing homes refuse. Consequently, Ft. Bayard admits a significant number of residents, both elderly and not, with serious mental health and behavioral issues. These residents are often aggressive, combative, and prone to physical aggression against other residents, who are often very vulnerable, as well as staff members.

We uncovered significant evidence, in chart after chart, where residents would repeatedly become combative with other residents or staff without adequate interventions from staff to ameliorate the harm or risk of harm. For example, the following is taken from one resident's chart in early 2005:

January 29	Resident struck nursing assistant in the face;
February 11	Resident punched another resident;
February 20	Resident threatened to hit staff member;
March 3	After being punched in the mouth by another resident, resident scratched the aggressor on the chest;
March 4	Resident punched another resident in the mouth;
March 12	Resident was struck by another resident in the mouth;
April 3	Resident struck another resident twice in the face;

April 6	Resident struck another resident in the face, cutting the resident's lip; and
April 18	Resident was hit by another resident in the face.

Another resident's chart told a similar story:

January 6	Resident grabbed another resident on the arm and the other resident possibly hit the resident on the arm and hands;
January 8	Resident attempted to hit staff and other residents;
January 13	Staff noticed bump above resident's right eye;
January 18	Resident aggressive and trying to spit and grab staff;
January 20	Resident aggressive with another resident; scratched resident on head, neck, and back;
January 29	Resident had altercation with another resident resulting in a bruise to right hand;
February 8	Resident aggressive with staff;
February 10	Resident aggressive; grabbed a nurse's arm; hit another resident three times;
February 15	Resident combative with staff;
February 27	Resident aggressive;
March 3	Resident grabbed another resident by the forearm resulting in evident nail imprints;
March 30	Resident hit another resident twice in the face;
April 1	Resident struck another resident;
May through June (multiple dates)	Resident combative with staff;

July 6 Resident kicked by another resident resulting in skin tear; and,

July 12 Resident attempted to grab other residents.

The frequency of repeated acts of aggression without appropriate staff intervention demonstrates the nursing home's inability to adequately treat and manage residents with behavioral disorders and to keep those residents' peers safe from harm.

We also reviewed situations where residents suffered injuries without an adequate investigation into the injury's cause. For example, in one two-month period, a resident was found in one instance with blood on his wheelchair, lap tray, and sleeve and in a later instance was found with a skin tear above his eyebrow and bruising to his cheek. Yet, there is no evidence that either event was investigated for potential abuse of the resident. Our consultant found that Ft. Bayard also failed to have adequate quality assurance mechanisms in place to analyze assaults and implement measures to prevent further assaults.

2. Lack of Adequate Fall Prevention Program

Ft. Bayard staff fails to protect residents adequately from the risk of falling. Falls, and the injuries that can result from falls (particularly fractures), pose a serious risk to elderly persons. Generally accepted standards of practice require nursing homes to assess residents for risk of falls, make appropriate diagnoses related to fall risk, develop appropriate care plans to mitigate risk of falls, and supervise residents adequately to protect then from falling. 42 C.F.R. § 483.25(h)(1-2); 483.20(a-k).

According to the nursing home's data, there were 108 resident falls in the first six months of 2005. Our nursing expert found that the vast majority of these falls were preventable. For example, inappropriate footwear (such as socks, which provide no traction on the slippery nursing home floors); the failure of staff to use a gait belt[7] when helping residents, who are known to be at high risk of falling, ambulate; and the inadequate or improper use of electronic alarms contributed to a high risk of falls for several residents. The nursing home's

[7] A gait belt is a device worn around a resident's waist that staff can hold to assist staff in ambulating the resident and prevent the resident from falling.

policy on falls is focused on reporting and follow-up of falls, but provides no guidance on how to prevent residents from falling in the first place. Further, the fall prevention program that Ft. Bayard offers to residents is limited to ten participants.

Care plans for residents who were known to be at risk of falls (because they had already fallen) failed to contain specific measures for fall prevention and did not address issues such as toileting, ambulation and mobility, dementia care, and monitoring. Addressing each of these issues in a care plan can help prevent falls.

For example, we reviewed the record of a resident who had fallen 15 times during the first half of 2005. When the resident was seated in his wheelchair, staff were instructed to hook an alarm to his clothing. The alarm was supposed to alert staff when the resident got out of his chair to ambulate on his own. However, staff continued to hook the alarm to the resident's clothing in a position enabling the resident to remove the alarm before he attempted to get out of his chair. Thus, staff were not alerted that the resident was ambulating on his own so that they could help protect him from falling as he attempted to meet his needs to go the bathroom, get some water, or get a TV remote. The resident fell seven times in early 2005 trying to get out of his wheelchair unattended. Once his wheelchair tipped over, catching and injuring his finger; once he fell on and scraped his shoulder; once he tore the skin on his left elbow and scraped his right knee; and once he bruised his left hip. Nursing staff failed to implement simple corrective measures (like using an alarm that the resident could not see or placing a water pitcher and a TV remote within easy reach) to break the cycle of falls caused by an ineffective care plan.

The fall prevention plan for another resident who had fractured his collar bone due to a fall at Ft. Bayard in 2003 and who had fallen 10 times in the first six months of 2005 stated only "one-on-one observation to prevent repeat falls." Staff could "observe" this resident constantly, but simply looking at this man cannot prevent him from falling. Staff need a plan to anticipate the resident's needs and specific interventions that staff can take to help prevent the resident from falling. Without that, the resident will continue to be at risk of further falls. And, indeed, this resident suffered again and again from falls. For instance, in May, June, and July 2005, this resident fell seven separate times in the restroom, mostly trying to transfer himself from his wheelchair to the toilet or from the toilet to his wheelchair. Our consultant found these repeated

preventable falls to be evidence of neglect, bordering on abuse, and a total disregard for human dignity.

3. The Ft. Bayard Environment

Ft. Bayard is a very old facility that is not appropriate for the provision of nursing home care. Residents' rooms are dingy and ill-lit, presenting challenges to residents' vision and efforts to prevent falls. Most rooms are multiple-resident rooms where curtains provide some privacy, but auditory privacy is non-existent. Resident beds are antiquated and mattresses are hard, raising the risk of skin breakdown. Clothes cabinets have no doors and are thus not secure from wandering residents. There are only two communal bathrooms, one for men and one for women, per ward. However, access to both the male and female bathrooms is through a larger room that is also used for resident bathing, creating further privacy issues for residents being bathed.

Combined, these environmental conditions violate federal regulations that require nursing homes to provide a "safe, clean, comfortable and homelike environment." 42 C.F.R. 483.15(h)(1). State officials are well aware of these issues. Secretaries Grisham and Armstrong informed us that it is the State's intention to replace the current structure with a newer facility in the near future.

C. INADEQUATE NUTRITIONAL AND HYDRATION SERVICES

Nursing homes such as Ft. Bayard are required by federal law to provide residents with adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 C.F.R. § 483.25(i-j). Ft. Bayard's failure to ensure that residents receive adequate nutritional services and that residents are fed in a safe manner has contributed to the death of residents.

During our visit to Ft. Bayard, we watched several mealtimes on various units, observing the manner in which food was served. We observed numerous instances where residents were improperly positioned and where staff were using inappropriate techniques to feed residents who needed assistance to eat. In addition, residents at risk of choking were left unattended. Further, necessary precautions were not taken for residents at risk of aspiration pneumonia. As noted above, numerous Ft. Bayard residents have died of aspiration pneumonia.

In addition to our observations, the medical charts of Ft. Bayard residents revealed case after case where residents with

known swallowing difficulties were fed in dangerous ways, often in contravention of specific care plans that had been written to protect the residents. We found that even in cases where residents had developed aspiration pneumonia, nursing staff failed to implement detailed instructions for feeding the residents. A primary cause for this failing is that Ft. Bayard staff have not been sufficiently and adequately educated to know how to assist residents with eating and drinking difficulties.

We also observed situations where Ft. Bayard failed to develop care plans to ensure that residents receive adequate fluids. This violates federal regulations. 42 U.S.C. 483.25(j). The facility failed to ensure that residents had access to adequate fluids during the course of the day and evening.

Ft. Bayard's nutritional and hydration services substantially depart from generally accepted professional standards of care, and these departures are not only harming Ft. Bayard residents, they are also contributing, in some cases, to their deaths.

D. INADEQUATE ACTIVITIES

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

The nursing home offers grossly substandard activity programs for its residents. Our consultant rated the quality of Ft. Bayard's activity program as between 0 and 1 on a scale of 0 to 10. Ft. Bayard's activity calendars are sparse and often contain "activities" that are actually duties for the staff, such as "transporting residents to the dining room." When there are scheduled activities, such as a movie off-ward, the majority of residents remain on the ward, where no activities are scheduled. Many other activities are not activities at all, such as "music" activities which amounted to staff playing music on the radio while transporting residents. We observed these patterns throughout the nursing home.

Because of the lack of activities, a cascade of undesirable consequences ensues. Residents experience greater levels of agitation, combativeness, hopelessness, withdrawal, and resistence to care. Frustrated residents become aggressive toward one another and to staff, so that, as discussed above, resident-to-resident and resident-to-staff assaults occur. There is an absence of effective behavior management programs at the facility. Staff, therefore, do not have the skills or guidance to prevent or properly manage this aggressiveness. As noted earlier, Ft. Bayard's primary, and often only, response to residents' behavior issues is to chemically restrain the residents with psychotropic medications, in violation of both federal regulations and generally accepted professional standards of practice, and placing the residents at great risk of harm.

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

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

In construing the anti-discrimination provision contained within the public services portion (Title II) of the ADA, the Supreme Court held that "[u]njustified [institutional] isolation ... is properly regarded as discrimination based on disability." Olmstead v. L.C., 527 U.S. 581, 597, 600 (1999). Specifically, the Court established that States are required to provide community-based treatment for persons with disabilities when the State's treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities. Id. at 602, 607.

Further, with the New Freedom Initiative, President George W. Bush announced that it was a high priority for his Administration to tear down barriers to equality and to expand opportunities available to Americans living with disabilities.

As one step in implementing the New Freedom Initiative, on June 18, 2001, the President signed Executive Order No. 13217, entitled "Community-Based Alternatives for Individuals with Disabilities." Specifically, the President emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities. Exec. Order No. 13217, §§ 1(a)-(c), 66 Fed. Reg. 33155 (June 18, 2001). The President directed the Attorney General to "fully enforce" Title II of the ADA, especially for the victims of unjustified institutionalization. Id. at § 2(c). As set forth below, the State is failing to comply with the ADA with regard to placing persons now living at Ft. Bayard in the most integrated setting appropriate to their individualized needs.

Based on our tours of the facility, review of residents' records, and discussions with Ft. Bayard and State representatives, it is clear that most of the residents of Ft. Bayard are appropriately placed in the nursing facility and reintegration is not appropriate at this time. However, it is also clear that several Ft. Bayard residents could be, and wish to be, served in community-based placements – and their treating professionals concur. At this time, however, New Mexico does not have the capacity to serve these residents in the community. The Olmstead court specifically recognized the need for a state "to maintain a range" of placements to care for persons with disabilities. Olmstead, 527 U.S. at 597.

Further, the State has not sufficiently examined, or responded to, the reasons why Ft. Bayard residents with mental health or behavioral issues have not been reintegrated into the community. This problem is not addressed adequately in the State's Olmstead planning. By failing to develop plan to address these issues, the State is failing to serve certain Ft. Bayard residents in the most integrated setting appropriate to their needs. Olmstead requires the development of plans to address the ADA's integration mandate. See, e.g., Pennsylvania Protection & Advocacy v. Department of Public Welfare, 402 F.3rd 374, 382 (3d Cir. 2005).

As evidence of the ADA violations at Ft. Bayard, consider the following cases:

- A 51-year-old resident of Ft. Bayard was admitted to the nursing home in July 2001. She is diagnosed with schizophrenia, an orofacial disorder, and a urinary tract infection. She is independent in all activities of daily living. She wants to live in the community and her treating professionals agree that she could live in the community. Staff at Ft. Bayard are trying to find an assisted living facility for this resident.

- A 57-year-old resident of Ft. Bayard was admitted to the nursing home in March 2004. She has anemia and hypertensive heart disease. She requires little assistance in performing her activities of daily living. She wants to return to the community and her treating professionals agree that she could live in the community. Ft. Bayard staff are trying to find a place for her to live in the community, but lack of appropriate housing is a major barrier.

- A 43-year-old resident of Ft. Bayard was admitted to the nursing home in May 2004. He has dementia, cerebral degeneration, and renal insufficiency. He wants to return to the community and his treating professionals agree that he could live in the community. Staff at Ft. Bayard are trying to find appropriate housing for this resident.

Our review of the nursing home's efforts to place Ft. Bayard residents into more integrated settings raises several concerns. The single most problematic barrier to community placement is a lack of residential housing adequate to meet the needs of Ft. Bayard residents who wish to, and are appropriate for, return to the community, particularly those with mental health or behavioral issues. In particular, there is a lack of living situations in the community where administration of medications can be supervised and monitored. If a resident cannot be discharged back to his or her home, it his highly unlikely that an alternative residence will be found. For example, between July 2004 and July 2005, 106 residents were discharged from Ft. Bayard. Of these, 103 were discharged back to their own homes; only three were discharged to places other than their own homes.

Another barrier to community placement is the lack of supportive psychiatric services that many Ft. Bayard residents would need in the community. So, even if alternative living arrangements could be found, the necessary supportive services, such as counseling, may not be available.

On a related note, the Pre-Admission Screening and Resident Review (PASRR) is a process required by the federal government to determine if a resident of a nursing home who has mental illness or mental retardation actually needs the level of services provided in a nursing facility. The purpose of PASRR is to ensure that persons who need mental illness or mental retardation services get them in the most appropriate setting and are not placed in a nursing home inappropriately. We are concerned that the intent of the federally required PASRR reviews is not being met at Ft. Bayard. Many PASRR reviews are being completed without the thoroughness required to ensure that residents who need mental health or retardation services are served in the most appropriate setting.

We understand and applaud the fact that the State is taking measures such as developing an Aging and Disability Resource Center and is working to establish a Behavioral Health Collaborative that should help to identify and deliver services to New Mexico's disabled and elderly. The State is also working to create a managed long-term care delivery system that may work to increase the utilization of community-based services.

III. MINIMAL REMEDIAL MEASURES

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

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

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

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

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

d. Design and implement appropriate interventions to assess and develop care plans for residents at risk of falling and re-evaluate those interventions as necessary;

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

f. Employ and deploy a sufficient number of consistent nursing staff to provide adequate supervision, routine care, preventative care, and treatment to each Ft. Bayard resident;

2. Psychopharmacological practices must comport with generally accepted professional standards. All use of psychoactive drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Medications should be prescribed based on clinical need. Medications should not be used in manners that expose residents to undue risks to their health and safety.

3. Implement policies and procedures to ensure that residents actually receive the pain medications that are prescribed for them.

4. Institute policies, procedures, and practices to investigate adequately, and follow-up on, instances of potential resident abuse, neglect, and/or mistreatment, including injuries resulting from resident-on-resident abuse and from unknown causes. As an element of these practices, the Ft. Bayard Medical Director should review all incident reports and initiate appropriate administrative or clinical action.

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

6. Provide adequate nutritional management services, including:

   a. Conducting adequate nutritional assessments of individual residents' specific nutritional needs;

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

   c. Monitoring residents' nutritional status, weight, and food intake, as medically necessary;

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

   e. Ensuring that residents are not exposed to undue risk of aspiration pneumonia; and,

   f. Providing residents with adequate amounts of fluids to ensure proper hydration.

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

8. Provide an environment for residents that adequately provides and protects the residents' health, comfort, and dignity.

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

10. The State of New Mexico must ensure that Ft. Bayard residents who do not oppose placement in the community are being served in the most integrated settings appropriate for their needs.

11. The State of New Mexico must redress the barriers that are preventing Olmstead-eligible Ft. Bayard residents with mental illness from reintegrating into the community.

* * *

We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with regard to Ft. Bayard. Provided that our cooperative relationship

continues, we will forward our expert consultants' reports under separate cover. Although their reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the relevant concerns and offer practical, technical assistance in addressing them. 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 soon contact State officials to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Wan J. Kim

Wan J. Kim
Assistant Attorney General

cc: The Honorable Pat Madrid
Attorney General

Michelle Lujan Grisham
Secretary
New Mexico Department of Health and
Acting Administrator
Fort Bayard Medical Center

Deborah Armstrong
Secretary
New Mexico Department of Aging
and Long-Term Services

David C. Iglesias
United States Attorney
District of New Mexico