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7 DEC 1984

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Honorable Richard D. Lamm #90024
Governor
State of Colorado
Capitol Building
200 East Colfax
Denver, Colorado 80203

Re: Notice of Findings Regarding Wheat Ridge Regional Center, 42 U.S.C. §1997(b)(a)(i)

Dear Governor Lamm:

On December 16, 1983, we notified you that we were commencing an investigation of the Wheat Ridge Regional Center, Wheat Ridge, Colorado, pursuant to the provisions of the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997. This letter is to apprise you of the major findings of our investigaton to date as required by the statute.

In the course of our investigation we conducted two tours of Wheat Ridge with outside consultants and Civil Rights Division personnel. In connection with their tours, the consultants examined resident records and interviewed the administrator, the professional staff, and some of the direct care staff at Wheat Ridge. In addition, we reviewed incident reports provided to us by the state of Colorado and the survey findings of the Department of Health and Human Services.

Throughout our investigation the staff of Wheat Ridge and personnel from the Colorado Department of Developmental Disabilities have provided us with substantial assistance. Both of our consultants expressed appreciation to Colorado officials for their cooperation, and we join our consultants in thanking them.

Below are our findings and recommendations. We will discuss only those particular areas of concern that rise to the level of constitutional deprivations. These are: staffing; neglect of residents; medical care; medication practices; and the level of training afforded to residents. The supporting

facts giving rise to these conditions are derived from the sources listed above. On the basis of our investigation we believe that these conditions have existed for a protracted period of time and at least since 1932.

Staff, Care and Training

Both our consultants and Wheat Ridge authorities themselves agree that the facility is understaffed. The level of direct care staff on the day and evening shifts is grossly inadequate and leads to dangerous situations where residents are not protected from unreasonable risks to their personal safety. Too frequently a single staff person is left on duty to supervise all residents in a living area.

Due to lack of staff, residents suffer neglect and numerous accidents and injuries. Incident reports compiled at Wheat Ridge reveal that numerous residents have sustained injuries where the cause remains unknown. Resident on resident assaults are common; residents engaging in self-abusive behaviors are frequently unsupervised and unattended. Residents have been found with unexplained broken bones and burns to the body. For example, one resident was found with a femur segment protruding through the skin. Another resident was found with a left arm that was swollen and loose and floppy at the shoulder. Both these residents had broken bones but staff were unaware of how the injuries occurred. Similarly, staff were unable to explain how a resident suffered second degree burns on his arm.

On the night shift, it is very common for one staff person to be alone on a living unit with up to 24 residents. Even the locked wards which house non-ambulatory residents are covered by only one staff person at night. Both our consultants believe that this level of staffing is grossly inadequate on a daily basis and that it endangers residents should a fire, medical crisis or other emergency occur.

During a visit to one locked hall, our consultant had to wait over five minutes before the staff person on duty was able to unlock the door. Upon entering, our consultant found approximately 20 adult women being cared for by one person amid great disorder and confusion. Many of these women were partially undressed, one was urinating on the floor of the living area and several were engaging in self-abusive behavior. Under such circumstances, appropriate supervision is impossible, and the physical safety of residents is threatened.

The lack of direct care staff to appropriately care for and supervise residents is aggravated by the lack of an adequate housekeeping staff. Available direct care staff often are required to perform housekeeping duties in addition to their other duties. Because staff are not always able to perform this dual function, many of the living areas are unsanitary and smell of urine and waste.

Professional staffing also is inadequate. Records at Wheat Ridge demonstrate incomplete and outdated evaluations of residents. Residents are failing to receive qualified judgments by institutional professionals as to care necessary to prevent unreasonable risks to personal safety. There is insufficient staff to implement needed behavior modification programs necessary to train residents to reduce and eliminate self-abusive and other destructive behaviors. Those staff who are available are uninformed as to training programs which have been prescribed and are not trained to implement them. While the staff at Wheat Ridge is well intentioned and desires to participate actively in resident treatment, staff and resource shortages prevent them from serving as anything more than inadequate custodians of the facility and its residents.

Medication Practices

There appear to be severe problems in the medication practices at Wheat Ridge. Due to inadequate professional staff to make the necessary professional judgments, medication appears to be used as an alternative to training programs to address injurious behaviors. Our medical consultant found an unusually high number of residents on psychotropic medication and a lack of adequate procedures to review medication levels. Since there is no system in place which assures that psychotropic medications will be used consistent with the exercise of professional judgment by a qualified professional, patients' safety is threatened.

Medical Care

The most notable deficiency in residents' medical care is the lack of physical therapy and occupational therapy services. A large number of Wheat Ridge residents suffer from severe contractures of their limbs and other body deformities due to the absence of necessary physical and occupational therapy. Residents who come to Wheat Ridge with some ambulatory ability

or other mobility often lose those physical capabilities due to atrophy of muscles. This lack of care is directly attributable to the lack of sufficient qualified staff and support personnel to carry out physical and occupational therapy services.

The failure to provide such therapeutic services creates severe medical problems for residents and, in many cases, endangers their physical health. One troublesome secondary effect of these immobilizing contractures due to lack of physical therapy is the dysfunctioning of the digestive system. This dysfunction apparently has caused an abnormally high percentage of Wheat Ridge residents to require pureed diets or gastrostomies for tube feeding. Our medical consultant, in fact, found that the complete lack of orthopedic care represented a "crisis" situation and a direct threat to the physical well-being and safety of many physically handicapped residents.

Remedial Measures

On the basis of our investigation, we have concluded that the residents of Wheat Ridge are subject to flagrant and egregious conditions resulting in violations of their constitutional rights. The following are the minimum measures which, in our view, are necessary to remedy the deficiencies discussed herein:

1. Adequate numbers of qualified professional and direct care staff must be employed. Wheat Ridge particularly needs to hire additional physical therapists, occupational therapists, and adequately trained direct care staff.

2. Wheat Ridge staff should receive training in implementing necessary medical care and those training programs needed to afford residents freedom from undue risks to their personal safety.

3. Wheat Ridge must modify its medication practices to ensure that psychotropic medications are used consistent with the exercise of bona fide professional judgment.

4. Wheat Ridge must ensure, as determined by qualified professional judgment, that residents are provided with the minimal training necessary to ensure their safety and their freedom from undue bodily restraint.

We are are hopeful that, after your review of this letter, meetings can be arranged between ourselves and appropriate Colorado officials to discuss means by which such corrections might be made. Please be advised that we wish to resolve these matters amicably and in a reasonable manner. Again, thank you for the cooperation.

Sincerely,

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Civil Rights Division

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Center