Neglect Leading to Bodily Injury and Death of 300 LTC Residents

Painting by Charles Garetz

Jeff Garetz son of Charles has given permission to use the image

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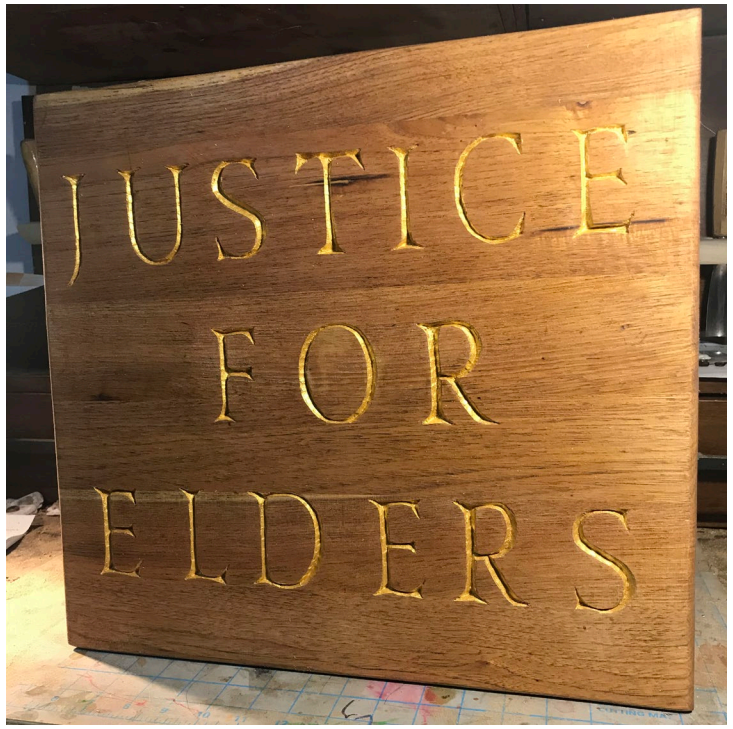
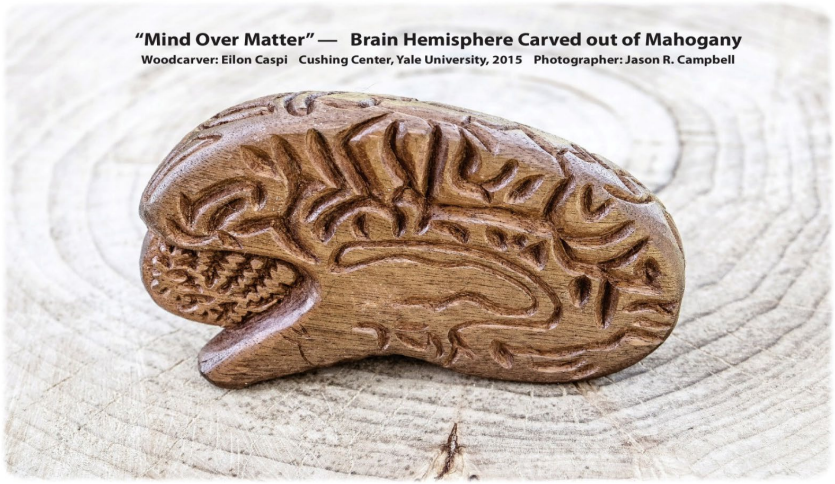
Long Term Care Community Coalition, March 16, 2021





Gerontologist…and sometimes woodcarver…

Acknowledgments

Elder Voice Family Advocates: Debbie Singer, Anna Ostroushko, Anne Sterner, Kay Bromelkamp, Kris Sundberg, and Jean Peters for assistance with this project

Lindsey Krueger & ***Minnesota Department of Health's*** investigators for their work in investigating allegations of neglect in LTC homes

Chris Serres, The Star Tribune

Jennifer Segal for securing permission for using the image on opening slide

elder voice
FAMILY ADVOCATES

"We feel the gentle hands of our loved ones pushing us forward"

– Jean Peters

"Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has."

— Margaret Mead

Without the Voice of Elders:

https://tinyurl.com/yvmdcccs

Website: https://www.eldervoicefamilyadvocates.org/

The majority of direct care staff are dedicated, hard working, compassionate, and caring people

Definition of “Neglect” in Minnesota

(a) Failure or omission by a caregiver **to supply** a vulnerable adult (VA) with **care or services**, including but not limited to, food, clothing, shelter, **health care**, or **supervision** which is:

(1) Reasonable and **necessary to obtain or maintain** physical or mental **health or safety**, considering the physical and mental capacity or dysfunction of the VA;

&

(2) **Not** the result of **an accident** or therapeutic conduct.

(b) **…which a reasonable person would deem essential to** obtain or maintain the VA's **health, safety**, or comfort considering the physical or mental capacity or dysfunction of the VA.

Source: Minnesota Statutes, section 626.5572, subdivision 17

Physical Neglect

"**Failure to provide** the goods or **services necessary** for optimal functioning or **to avoid harm**."

– Lindbloom et al. (2007)

To "Neglect"

"To give little attention or respect to"

"To leave undone or unattended to especially through carelessness"

Disregard: "To treat as <u>unworthy</u> of regard or notice"

– Webster dictionary

“*I want to know that someone will be there for me when something happens to me*.”

– An older woman living with Alzheimer’s disease in assisted living

Common Types of Neglect in LTC Homes

- **Dehydration / Malnutrition**
- **Pressure Sores / Wound infections**
- Lack of monitoring or treatment of **complex health conditions**
- **Delays** in **emergency medical care**
- Inadequate **pain management**
- **Burns**
- Left **soiled in urine and B.M.** for extended periods
- **Call lights** not answered for extended periods
- Unsafe **transfers**
- Inappropriate **use** of **medical equipment**
- **Medication Errors**

- **Lack of Supervision**

Neglect is Prevalent

Nursing Homes

- General Accounting Office, 1998
- Hawes, 2003
- Thompson, 2001
- Page et al. 2009
- Zhang et al. 2011

Assisted Living

- Hawes, 2003
- Page et al. 2009
- Magruder et al. 2019
- Phillips & Gau, 2011
- Philips & Ziminsky, 2012
- Breslow, 2013
- Schoch et al. 2013

"Missed Care" studies

- White et al. (2019) – U.S.
- Knopp-Shiota et al. (2015) – Canada
- Henderson et al. (2017) – Australia

Some incidents are **human errors**…

Major Contributing Factor
Inhumane and Unsafe **People-to-People Ratios**

"**Half** of nursing homes in U.S. have **low staffing levels** and at least a **quarter** have **dangerously low staffing levels**." – Harrington at al. (2016)

It's likely lower because in 2018 CMS shifted from self-report to more reliable Payroll-Based Journal System, which showed:

"Most nursing homes overstated staffing for years"

"It's almost like a ghost town" (NY Times, 2018): https://tinyurl.com/y8c9dhf9

"Even with the new system, many homes still appear to exaggerate how much time nurses spend with patients." (inc. administrators not providing care; employees on vacation)

– NY Times, 3.13.21

Staffing levels generally lower during the pandemic…

Devastating Consequences

NHs

- Thompson, 2001
- Lindbloom et al. 2007
- OIG, 2014, 2019

ALRs

Breslow, 2013. PBS Frontline film: *Life & Death in Assisted Living*

Schoch et al. 2013 – “Deadly Neglect“ (San Diego County)

NY Times: Rau, 2018; Anand, 2019; Span, 2019

“Inhumane and Deadly Neglect“ (Elder Voice Family Advocates, 2019)

Barriers / Disincentives for Reporting

- **Lack of awareness of the problem**
- Lack of knowledge of **reporting processes**
- Concern that it will **reflect negatively on job performance**
- Concern about **disciplinary action**
- Concern about **regulatory issues** (e.g. citations)
- **Adverse publicity**
- **Fear of lawsuits**
- **Lack of internal protocols** for detecting neglect / Poor recognition
- **Lack of training** in nursing and medical schools

Source: Friedman et al. (2017)

The mute nature of Neglect

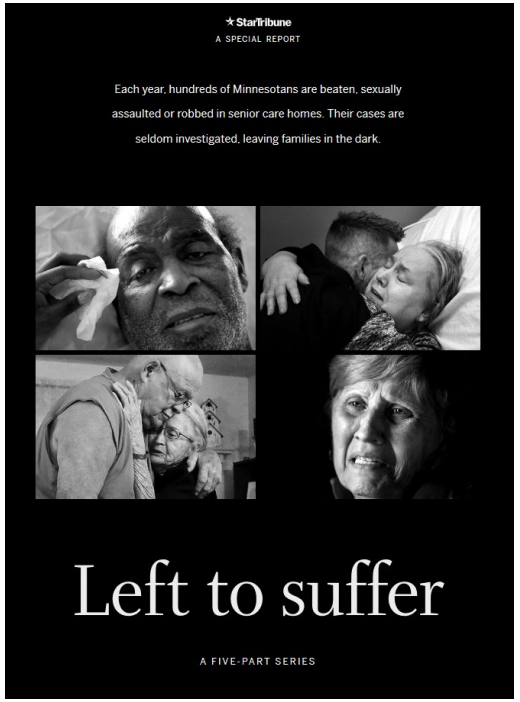
- Advanced **cognitive impairment**
- **Fear of retaliation**

Conditions that may Mimic Neglect in Elders

- **Constipation** from medications or hypercalcemia
- **Fecal impaction** (e.g. Chronic constipation)
- **Dehydration** secondary to medications
- **Diabetes**
- **Poor wound healing**
- **Urinary tract infection** (in women)
- **Vaginitis**

Source: Collins (2006)

Background on Neglect in Minnesota



To access the series:

https://tinyurl.com/y3x9r3rk

November 12-15, 2017

Governor Dayton

"Although the Department of Health is partially to blame, **the real responsibility falls on each and every one of the care providers** in the state's facilities."

"They need to **fix the problems**, **stop breaking state laws**, and **follow moral codes**"

– Channel 5 ABC Eyewitness News, February 22, 2018

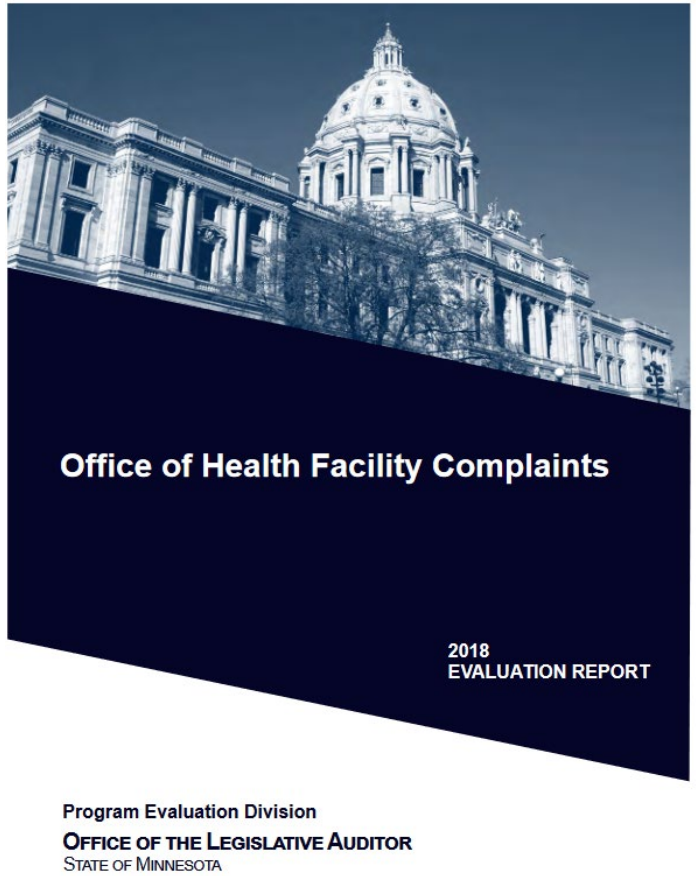
Need to Analyze Investigative Data

Recommendation in OLA 2018 report:

“OHFC should collect data that will allow for rigorous trend analyses. MDH should analyze the data OHFC collects to identify trends and share findings with providers and other stakeholders.”

New Commissioner of Health:

"We strongly agree with the evaluation's findings regarding **better use of complaint and investigation data for prevention”**



“We spend **98% of our efforts responding** to issues **rather than prevention**…and I mean it literally”

– Commissioner of Health, February 18, 2019

Historians of Bad Care

"What are we accomplishing if we find the same deficiencies every year?

We should not be the ***historians of bad things*** *that happen in nursing homes.*

We need to be preventive of bad things from happening…. We need more analysis*. We need to make sure that everything we do is effective and efficient*."

– David Wright, Director, Quality & Safety Oversight Group, CMS, 2016

MN Historical Society

Our Goal: "Preventing future deaths in similar circumstances"

– Dr. Roger Skinner, Office of Chief Coroner, Ontario

“Nested” Neglect

Old F-Tag System

F224: “Prohibit mistreatment/Neglect/Misappropriation”

New F-Tag System

F600: “Free from Abuse and Neglect”

Can CMS track and learn from thousands of Neglect violations each year?

Study Aims

Identification of:

1. **Sequence of events (“Trajectories”) leading to neglect & harm**

2. **Patterns** underlying neglect

3. Preliminary **directions for prevention**

Methods

The Key: Data Practices requests to MDH (under MN Government Data Practices Act)

Initial Dataset: 429 MDH investigation reports substantiated as Neglect; De-identified public records

Excluded 129 not reaching threshold of Serious Bodily Injury (SBI)

Final Dataset
300 MDH investigation reports resulting in SBI or death in NHs and ALRs in Minnesota

Time period: 2013 – early 2020 (Prior to pandemic)

Equivalent of nearly 4 years of investigators' work (2,080 work hours per year)

(7,950 hours of MDH OHFC investigators' time; average 26.5 hours per investigation)

Serious Bodily Injury (SBI) – Definition

Defined in section 2011(19)(A) of the Affordable Care Act:

- An injury involving **extreme physical pain**;
- involving **substantial risk of death**;
- involving protracted **loss or impairment of the function of** a bodily member, **organ**, or mental faculty;

or

- **requiring medical intervention** e.g. **surgery**, **hospitalization**, or physical rehab

+ Criminal Sexual Abuse

* Preliminary Analysis

Step 1. **Qualitative reviews** of 300 MDH investigation reports

Step 2. **Abstraction** of narratives **into Trajectories**

Step 3. **Identification of patterns**

* Work in progress…

Investigation Reports Substantiated as Neglect Resulting in SBI and Death

	Subtotal	SBI	Death
Assisted Living	138	72	66
Nursing Homes	162	89	73
Subtotal	**300**	**161**	**139**
Total		**300 MDH investigation reports**	

Note: 129 MDH investigation reports substantiated as neglect (92 in assisted living and 37 in nursing homes) were excluded from the initial sample of 429 reports because the harm did not meet the definition of serious bodily injury (SBI)

Suffering even when not SBI… Example I

Resident with severe cognitive impairment requiring complete assistance with ADLs

Staff not using standard practice for transfer → Fall

Crawling on floor without underwear on hands and knees with BM… **CAUGHT ON CAMERA**

Staff walk past resident w/o acknowledgment, watch TV, read magazine, leave area several times…

No attempt to assist resident off floor and with change of adult depends…

Another employee assisted resident off the floor after **3 hours and 49 minutes!**

Perpetrator falsely documented the incident and the care provided

Suffering even when not SBI… Example II

- Resident with history of stroke, diabetes, depression & obesity
- Staff assigned to assist resident with toileting during the night shift
- Resident **goes to the bathroom** at **2am**
- Over-the-toilet commode too small; commode legs gave out
- Resident became **wedged on toilet**; could not get up
- Pushed her **call pendant** and **screamed for help**
- Another resident went to find staff
- Staff member asleep
- Fire department arrived around **5am** to assist the resident off the toilet

Suffering even when not SBI… Example III

Resident with cognitive impairment on “memory care” unit

Required hourly checks and assistance with ADLs → not provided

Repeatedly found soaked in urine and sometimes feces

“So bad that the mattress had to be replaced”; Developed UTI; Hospitalized

Example IV:
Adult depend soaked for 19.5 hours and piles of fecal material on bathroom floor

Neglect Allegation “Unsubstantiated”

77-year-old resident attacked by roommate → Brain injury

MDH:

"Based on a preponderance of evidence, the allegation of neglect is not substantiated. Two residents had been roommates for over one month with no history of altercations... Staff could not have anticipated the unexpected and sudden altercation.”

But there *were* warning signs prior to attack:

“I told them that if I have to spend one more night with this man, then I would kill myself. They still ignored me.”

Daughter (begged for a different roommate)**:** “How many times were we supposed to warn them?”

Daughter sued the nursing home for neglect and won…

“Understatement”

Citations issued by SSA at a severity level lower than it should be…

GAO (2008); GAO (2009); OIG (2019)

LTCCC’s Elder Justice “No Harm” Newsletter:
https://nursinghome411.org/news-reports/elder-justice/

Alleged Neglect – Not investigated

90-year-old woman with Alzheimer's in assisted living "memory care" unit

One evening, while in bed she **called for staff help 99 times** over 39 min

Nobody came to assist her

She fell off the bed. While on the floor, she continued to call and **cry out for help for 143 times.** At some point she cried, **"Please help me Lord."**

Nobody came to assist her

In total, she called and cried for help **242 times** over **1 hour & 38 minutes**

Daughter saw it in real time on a **hidden camera and** alerted staff…

Gloria Throndrud

Paid $6,810 each month

Permission to use the image was received from Gloria's daughter

Daughter's voice was heard…

She met with **Senator Scott Dibble** who wrote her: "Thank you for your visit to my office to share your concerns about elder abuse and assisted living facility inspections. I appreciate that you took the time to share your personal story.

The problem you raise is a serious one, and so **I have requested** that the Legislative Audit Commission recommend that **the Legislative Auditor investigate the OHFC's** handling of elder abuse allegations.

Hearing from constituents is crucial to informing my decisions as a legislator…"

Daughter wrote: "**My goal** is to obtain the **basic dignity, safety** and care **my Mom deserves**"

FOX 9 TV segment (January 3, 2021): https://tinyurl.com/59rvm7a2

“Something is fundamentally wrong with the system that allows an elderly woman, anyone elderly, to be **disregarded**”

– Daughter

Alleged Neglect during COVID-19

- Resident w Lewy Body Dementia in assisted living "memory care" **($9,000 a month**)
- **March 18**: Family visits not allowed
- Lost a lot of weight; heavily soiled; disheveled; facial hair; toenails ingrown & painful
- Six falls in less than 2 weeks; unable to walk on his own; required two-staff transfer
- **June 10:** Daughter decided to take him home

WHAT SHE SAW WHEN SHE CAME TO TAKE HER FATHER:

- Shaking uncontrollably; saturated in sweat; bruised head to toe; moaning in pain
- "His genitalia was bright red and the skin was sloughing off"
- Healthcare worker described his treatment as "severe neglect."
- **June 12:** Died at home with family at his side

Daughter's Reflections

"I think it comes down to the **isolation**, the **loneliness**, and ultimately…the **neglect**."

"**Our loved ones are dying** not due to COVID-19 but **due to isolation and neglect** that is going on behind the scenes."

"This was **one of the most painful and excruciating experiences of our lives** that will forever have a lasting impact on us."

KARE 11 (Sep 22, 2020): https://tinyurl.com/y3c2s5pt You Tube: https://tinyurl.com/y54a6bco

Nine months since the resident died… Still waiting for MDH to complete its investigation…

102 Residents Dead in a Single Nursing Home

Special report: “Death was everywhere.” How a Minnesota nursing home fell into a COVID-19 black hole. *Star Tribune*, 12.13.20:

https://tinyurl.com/3p76cvn8

Shall we just disregard it and grant this nursing home legal immunity?

A Perfect Storm (ChangingAging): https://tinyurl.com/53j96r8x

PRELIMINARY FINDINGS

Vulnerable and Frail Population

Nearly half (48%) of the 300 residents had some level of **cognitive impairment**

Dozens of others had conditions such as **stroke, Parkinson's** disease, & **TBI**

Many…
Medically dependent due to various **complex healthcare conditions**

Physically dependent on staff for **extensive assistance with ADLs**

Primary Consequences

- **TREMENDOUS EMOTIONAL / PSYCHOLOGICAL SUFFERING**
- **E.R. VISITS & HOSPITALIZATIONS** (substantial healthcare costs)
- **DECLINE IN PHYSICAL CONDITION**
- **MOVE TO HIGHER LEVEL OF CARE** (such as ALR to nursing homes and/or hospice)
- **TRAUMATIC PHYSICAL INJURIES**
- **DEATHS**

Cost of replacing a single care employee

The **employment** of many care staff members was **terminated**…others **resigned**…

Estimated cost:

Between $2,200 and $4,000

Unknown cost of perpetrator “crossing the street” to work in a different care home…

MDH's Responsibility Determination
(*n*=300)

- LTC Home: 77%
- Both LTC home & Individual: 8%
- Individual: 14%
- Unknown: 1%

Some of these neglectful events should be considered **criminal** and/or **fraud**…

Trajectories

Sequence of neglectful events resulting in harm

Two most prevalent forms of Neglect:

1. Neglect of Healthcare

1. Neglect of Supervision

NEGLECT OF HEALTH CARE – Assisted Living

- **Wellness Checks** required → Not done → Several residents found injured and dead many hours / two or more days later

- Resident with dementia → Falls at night → Arm fracture → Calls for help using **pendant** at 1:55am → **Left unanswered for six hours** → Found on floor at 8am

- **Lack** of **fall-risk assessment/prevention** → Injurious falls (hip fracture) → **No post-fall assessment**

- **Unsafe manual & mechanical lift transfers** against Service Plan → Several injurious falls & deaths

- Resident with TBI & stroke → **Repositioning not done** → 10 cm x 10am pressure sore → No intervention → **25cm x 25cm pressure sore** → Septic shock → Died

NEGLECT OF HEALTH CARE – Assisted Living

- Resident in "memory care" home → **Catheter not draining** → E. Coli → Septic shock → Hospital → Nursing home → Died
- Residents with diabetes → High **blood sugar levels** (540 & 765 mg/dL) → Deaths
- Resident with large bulge on stomach → Moaning in pain → Delays in recognition → **Strangulated hernia** → Death of small intestine → Died
- Resident cognitively impaired → In pain → **Metal object found in heel** → Infection → Foot amputated → Died
- **Medication errors** (e.g. fentanyl patches; blood thinner; antibiotics; antipsychotic meds) → Several deaths

NEGLECT OF SUPERVISION – Assisted Living

- Resident with dementia using wheelchair on "secure" unit → **Left via unsecured door** by the dining room → Fell off a flight of stairs → Severe injuries → Died
- Resident w dementia → **Exits via 2nd floor door** → Fell on stairs → Subdural hematoma → Died 15 days later
- Resident with dementia → **Wellness checks not done** → Left → Found dead in a pond
- Staff **unaware** resident with dementia **moved into "Memory Care" unit for 18 hours** → Found with head wedged b/w toilet & wall → Died
- Resident with Alzheimer's → Neck **entrapped** b/w bed & transfer pole → Died

NEGLECT OF SUPERVISION – Assisted Living

- Three residents with dementia → **Cleaning detergent**/supply **left unattended/ unlocked** → Ingested → Severe burns → Died
- Resident requiring **monitoring for suicide attempts** → No staff supervision at night → Broke into locked meds cabinet → Ingested 85 dosages in an attempted suicide
- Resident with Alzheimer's "up most nights" → Walks at night in common area → **Staff asleep on sofa** (caught on camera) → Fell → Femur fracture → Died
- Resident with dementia and heart failure → Failed to plug **heart pump** at bedtime → Batteries depleted → Died
- Residents with dementia engaged in repeated **altercations** → Lack of supervision and intervention → Several physical injuries (e.g. hip fracture, head injury)

NEGLECT OF SUPERVISION – Assisted Living

Resident with borderline personality disorder & intellectual disability

→ Must be ”visible to staff at all times” due to long history of self-injurious behavior

→ Hammers two nails into her skull with a shoe

→ Ongoing complaints of headaches & swelling on forehead → Not addressed

→ Nearly a month later.....CAT scan: 2 nails (4.8 cm & 6.2 cm) in her frontal lobe

→ Surgical removal, 3 days in ICU, and six weeks of IV antibiotics…

Report

April 22, 2019

Inhumane and Deadly Neglect Revealed in State Assisted Living Facilities

Funded by:
Stevens Square Foundation

Link: https://tinyurl.com/y6zorqzu

STATE + LOCAL

Report highlights abuses, preventable deaths in Minnesota's assisted-living facilities

Report of state data shows a surge in accusations of neglect, poor conditions.

By Chris Serres Star Tribune | APRIL 11, 2019 — 3:58PM

GLEN STUBBE – STAR TRIBUNE

Kristine Sundberg, president of Elder Voice Family Advocates, second from left, led a group to meet with legislators. Also there are Jane Overby, Kristine Sundberg, Kay Bromelkamp, Brenda Roth and Bonnie Wenker.

How many legislators will read long investigation reports?

Example:

6-page MDH Investigation report:

https://tinyurl.com/tuv889r

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Report #: HL21006024

Date Concluded: January 7, 2019
Date of Visit: November 6, 7, 8, 19, 20, and 21, 2018

Name, Address, and County of Facility Investigated:
Chappy's Golden Shores
540 Park Avenue
Hill City, MN 55748
Aitkin County

Name, Address, and County of Housing with Services Registration:
Chappy's Golden Shores
540 Park Avenue
Hill City, MN 55748
Aitkin County

Facility Type: Home Care Provider

Investigator's Name:
Darin Hatch, Special Investigator Senior
Amy Hyers, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An unannounced visit was conducted to investigate an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged that a client was neglected by the facility when the facility failed to provide proper pressure sore care. The client was admitted to the hospital with respiratory failure, sepsis, and several open wounds, including a necrotic stage four ulcer on his coccyx.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility did not provide the necessary care to reduce the risk and treat the client's pressure ulcers. The lack of care and response to the client's change of condition lead to an increase in the size of the wound on the client's coccyx, and caused increased pain and suffering for the client. The lack of early intervention contributed to the client's death.

The investigation included interviews with facility staff, former facility staff, hospital personnel, hospice personnel, family, and case managers. Client facility records, hospital records, hospice

Instead, consider:

15-second "Trajectory" →

1-page "Summary of Conclusion"

15. NEGLECT OF HEALTHCARE

Death following 6 days of hospitalization and transfer to comprehensive care provider where client died after absence of wound care on buttocks by home care provider.

Client with cognitive impairment ➔develops open bleeding wound on buttocks ➔no assessment, documentation, & staff failed to follow physician's orders regarding wound care ➔hospitalization 6 days ➔transferred to a long-term care facility ➔wound did not heal ➔ client died.

Summary of Conclusion

A client with cognitive impairment, stress incontinence, hearing loss and osteoarthritis received services for toileting assistance every two hours as needed and required use of incontinence products. On initial exam by a nurse practitioner (NP) the client had no skin lesions or rashes. Over the course of several weeks, the client developed a rash, then an open bleeding wound as seen by a NP despite previous orders for turning and repositioning. A request for a wound consultation was made but no wound care services were initiated by the home care provider over the course of 7 days. The home health agency assessed the wound two days after receiving the request for consult, found the wound had dark/dead tissue and the physician ordered the client sent to the hospital. The nurse noted the client was wearing a double padded incontinence brief soiled with stool and urine. There was no communication between the home care provider staff or the home care provider and the physician.

The client was hospitalized for 6 days, and then transferred to a long-term care facility. The wound did not heal, and the client subsequently died.

Additional Notes: The home care provider terminated 6 care staff in relation to double padding of incontinence products. Multiple staff were aware of the wound and failed to document an assessment of the skin "breakdown" and failed to ensure the physician's orders for wound care were implemented within 24 hours per policy.

Report #	HL29078012, HL29078013
Date of Visit	December 8, 9, 2016
Date Concluded	December 22, 2017
Facility Name	**Waterford Manor**
City	**Brooklyn Park**
Zip Code	55428
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

NEGLECT OF HEALTH CARE – Nursing Homes

- Resident with heart failure & diabetes → **Change in condition since 4pm** → *"Help me God."* → **Delays in calling 911 (8:48pm)** → Septic shock → Died next day

- Resident with COPD on low flow oxygen (retains CO2) → Nurse turns up oxygen flow due to low oxygen saturation levels → **CO2 poisoning** → Unrecognized →Continued to titrate oxygen flow up despite critical CO2 levels → Unresponsive → Died

- **Unsafe transfers** (against Care Plan) → 16 injuries and 16 deaths

- Resident **requiring foot pedals on wheelchair** during transfers → Foot pedal not used on way to dining room → Fell forward → Fractured vertebrate & neck → Died

NEGLECT OF HEALTH CARE– Nursing Home

- Resident with stroke → Mechanical ceiling lift transfer to commode → **Left unsupervised while attached to ceiling lift** (against manufacturer's guidelines) → **Wheels unlocked** → Commode rolls away → Fell → Legs fractured → Severe pain → ER → Died days later

- Resident with memory loss → **Shower chair wheel defective** → Didn't notify maintenance → Two weeks later → Wheel broke → Fell → Subdural hematoma (brain bleed)

- Resident with dementia → Fell → Hip fracture → **Unrecognized for 18 hours** (despite pain & 5cm x 5cm bruise) → Physician not notified → Family visit → Hospital → Died 5 days later

- Resident with cancer and chronic pain → **Prescribed 30 mg pain med** (for pain 10 out of 10) → **Administered 600 mg (20x higher dose)** → Found dead

NEGLECT OF HEALTH CARE– Nursing Homes

- Resident with "difficulty expressing needs" → Requiring gastric tube feeding → **Tube positioned incorrectly** → Vomited formula → **No emergency medical treatment** → Found unresponsive 3 hours later → Died

- Resident with severe cognitive impairment → **Failed to assess skin under post-surgical immobility boot** → Routine provider visit → Discovers 3 unstageable pressure sores → Hospital → Sepsis → Died

- Resident w severe cognitive impairment → **Enters unlocked laundry room** → **Enters cement basin** (155-degree water) → 2nd degree **burns** → Died

NEGLECT OF SUPERVISION – Nursing Homes

- Cognitively impaired resident→ **On pureed diet** due to risk of aspiration → **Frequently tries to take food from other residents** → **Tray with sandwich left 3 feet away for 90 min** → Eats it → **Chokes** → Died

- Cognitively impaired → Found with "heavy, labored breathing" (**Oxygen 78%)** → Suppl oxygen → **Never above 89%** → Physician not notified → Prepared for unrelated appointment → Didn't recheck vital signs & respiratory status → Van driver asks if should be on oxygen during ride → "No" & "Will be alright" → Arrives 2.5 hours later with "No pulse" → ER → Died

NEGLECT OF SUPERVISION – Nursing Homes

- Resident with Alzheimer's on hospice unable to communicate needs → **Air mattress overlay added** → 4 days later, 1st fall off bed → No assessment to determine safety for use of side rails → 2nd fall off bed (1 month prior to death) → 3rd fall → **Entrapment** → Found dead sitting on floor with **head & neck b/w mattress and side rail**

- Resident with dementia → Found with **foot on top of heat register** by bed → 1st, 2nd, & 3rd degree **foot burns** (5cm x 4cm) → Change in condition → Septic shock → Died

- Resident with Alzheimer's → **History of spilling liquids "at risk of burns"** → **Served hot soup** → Spilled → 1st, 2nd, & 3rd degree burns on thigh (20cm x 20 cm)

- Several residents with dementia → **Left unattended on toilet (against Care Plan)** → Injurious falls

Ventilator-related Deaths
Nursing Homes

- Resident with ALS dependent on ventilator for breathing (oriented but unable to reattach ventilator tubing) → Unable to speak due to tracheostomy and ventilator → **Ventilator disconnected for 11 minutes** → 2 alarms sounded. **Nurse assistant works alone** on unit (nurse on break) → No response → Found dead

~~~

- 2015: Resident with quadriplegia & respiratory failure → **Removed from ventilator 2 hours too early** (not following physician's orders for ventilator weaning process) → Unresponsive → Died next day

- 2017: Resident ventilator dependent 24/7 in vegetative state → **Ventilator tubing detached & alarmed** → Not discovered until one hour later → Died

- 2018: Resident with respiratory failure / ventilator dependent → **Ventilator alarm activated for 39 min** → Understaffed & Nurse assisting on another wing → No response → Returned → Died

THE LAST 3 DEATHS AT THE SAME NURSING HOME…
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Overarching Theme

The vast majority of the emotional and physical traumas and deaths…

could have been prevented

Had…

Safe staffing levels, adequate staff training, policies and procedures, early and skilled nursing assessment, detection, documentation, effective communication/notification, monitoring, nurse manager supervision, and timely and skilled intervention or treatment were implemented…

Quotes – Care Professionals

”*The trauma & hospitalization could have been prevented with earlier intervention*” – Primary medical provider

“*When in doubt, call*” & “*Why didn’t they call the ambulance sooner?*” – Nurse

“*Somebody should have said something. It would have prolonged his life*“ – Physician

Contributing Factors

- **Lack of or Inadequate Nursing Assessment**
- **Omissions of or Inadequate / Unskilled / Unsafe Actions**
- **Communication Problems / Breakdowns**
- **Dangerous Delays**
- **Organizational Factors** (e.g. Unsafe staffing levels; Lack of nurse manager supervision)

Preliminary Patterns

- LACK OF **BASIC NURSING and RISK ASSESSMENT**
- LACK OF **THOROUGH & TIMELY INTERNAL INVESTIGATION** (ROOT CAUSE ANALYSIS)
- FAILURE TO **RECOGNIZE WARNING SIGNS** & SIGNIFICANT **CHANGE IN CONDITION**
- DELAYS IN SEEKING **EMERGENCY MEDICAL CARE**
- LACK OF **BASIC CARE ASSISTANCE & TIMELY INTERVENTIONS**
- LACK OF, INADEQUATE, OR NOT FOLLOWING **CARE PLANS**

Preliminary Patterns

- LACK OF ADEQUATE **SUPERVISION**
- **“SECURED” CARE UNIT** FOR ELDERS WITH **DEMENTIA**…NOT SECURE
- LACK OF OR INADQUATE **NURSING / MANAGERS’ SUPERVISON OF DIRECT CARE STAFF**
- **COMMUNICATION BREAKDOWNS** (e.g. Not notifying supervising nurse or physician)
- **FAMILIES LEFT IN THE DARK**
- **DISCOVERIES BY FAMILY AND PROVIDERS’ VISITS OR DURING OUTSIDE APPOINTMENTS**
- NOT HAVING OR FOLLOWING **INTERNAL POLICIES AND PROCEDURES**

Conclusion

Disregard to the fate and suffering of vulnerable and frail elders in a *subgroup* of LTC homes in Minnesota

- Need to go back to the **fundamental principles of the nursing profession**
- **Shift** from reactive care mode **to proactive ("anticipatory") nursing assessment-based care**
- **Require & fund safe people-to-people ratios**…at all times...of **well-trained staff**
- Commit to **culture of learning** (e.g. Create mechanisms for sharing lessons across care homes)

Conclusion

Break the silence and **dangerous normalization** of elder neglect

Would we accept these horrific incidents in childcare settings?

Hold owners and **administrators** of neglectful LTC homes **accountable**

Conclusion

“Our protections in law are only as good as the <u>enforcement</u> capabilities.”

– Commissioner of Health, November 5, 2018

Ensure Agencies Investigate Alleged Neglect

- State Survey Agency
- Ombudsman for LTC
- Law enforcement
- Medicaid Fraud Control Units
- Medical Examiner / Coroner

Establish

1. **Elder Death Review Teams**
2. **Elder Abuse Forensic Center**

- APS (in states where it has jurisdiction to investigate mistreatment in LTC homes)

Detection & Reporting

- Hospitals
- EMS
- Fire Department
- Funeral home directors

Physicians / N.P.
(often practically “outside agency”)

Report “Reasonable Suspicion of a Crime”

Affordable Care Act & CMS F608

“If the events that cause the reasonable **suspicion result in serious bodily injury**, the **report must be made [to State Survey Agency & Law Enforcement agency] immediately after** forming the suspicion (but **not later than two hours** after forming the suspicion). **Otherwise**, the report must be made **not later than 24 hours after** forming the suspicion”

“**Facility may not retaliate** against an individual who lawfully reports a reasonable suspicion of a crime...”

CMS 2011 Memo: https://tinyurl.com/y6a923z8

Abuse, Neglect and Crime Reporting Center

https://nursinghome411.org/learning-center/abuse-neglect-crime/

Long Term Care Community Coalition

Why Screen for Neglect?

- **A complex constellation of clinical signs** that varies in severity across time within a given person – Bond & Butler (2013)

- **To ensure that signs are not missed** and "to allow health professionals **to promptly intercept** signs of danger" – Gallione et al. (2017)

- **Without adequate screening**, "it is **unlikely that reporting will improve**." – Friedman et al. (2017)

Train Staff in Recognizing Signs of Neglect

- **Elder Assessment Instrument** – E.R. (Fulmer et al. 2000)

Try This (Hartford Institute for Geriatric Nursing): https://tinyurl.com/y5q9rqbw

Abstract: https://www.ncbi.nlm.nih.gov/pubmed/11015061

- The **Clinical Signs of Neglect Scale** (SCNS) – Hospital – Pre-screener (Friedman et al. 2017)

Abstract: https://www.ncbi.nlm.nih.gov/pubmed/28829244

Gaps

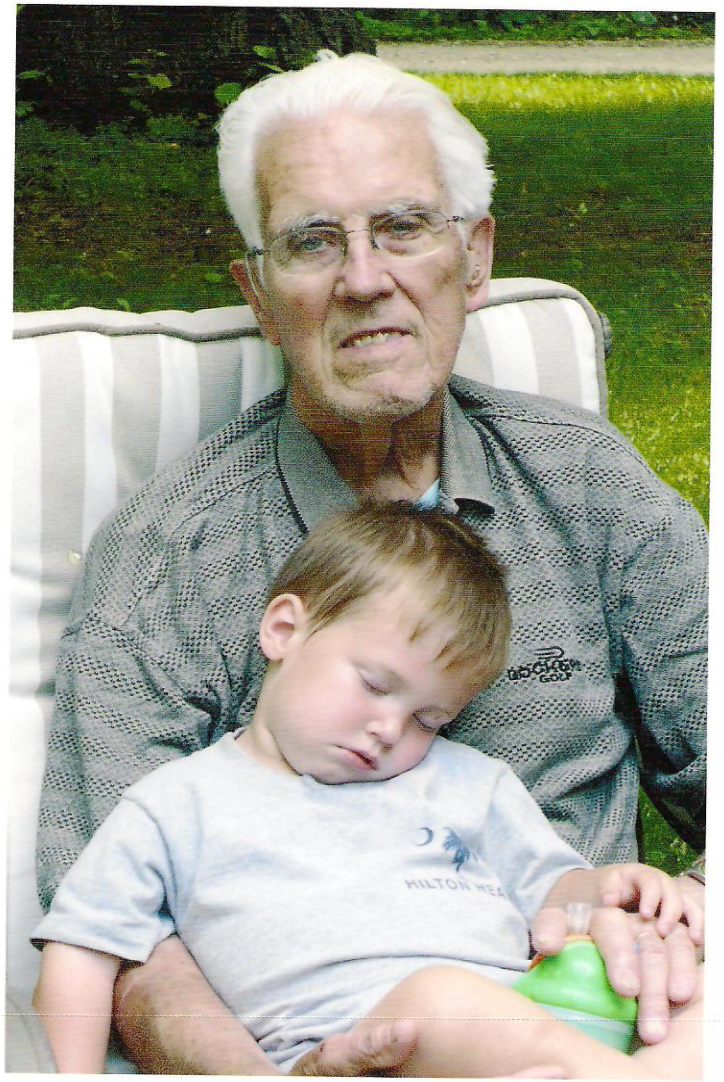
- Screening instruments mostly address manifestations of Neglect; less warning signs / red flags

- Insufficient guidelines and neglect screening tools used in nursing homes and assisted living

Poem – The Promise

ChangingAging:

https://tinyurl.com/8xrhwjvj



Permission to use the image received from Werner's daughter

86-year-old Werner Allen

84-year-old Jacqueline Hourigan

Questions & Discussion

It is the human right of elders to live in safe LTC homes

"We speak for the dead to protect the living"
– Thomas D'Arcy McGee (1825-1868)

Permission to use the image received from Jacqueline's daughters