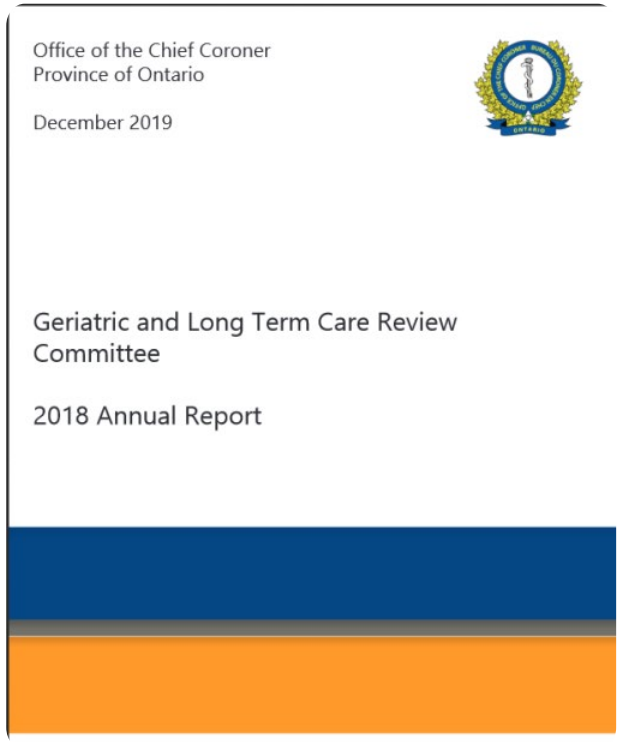
Harmful
Resident-to-Resident Incidents

Eilon Caspi PhD
September 20, 2022
Elder Justice Past, Present, & Future Conference
Long Term Care Community Coalition

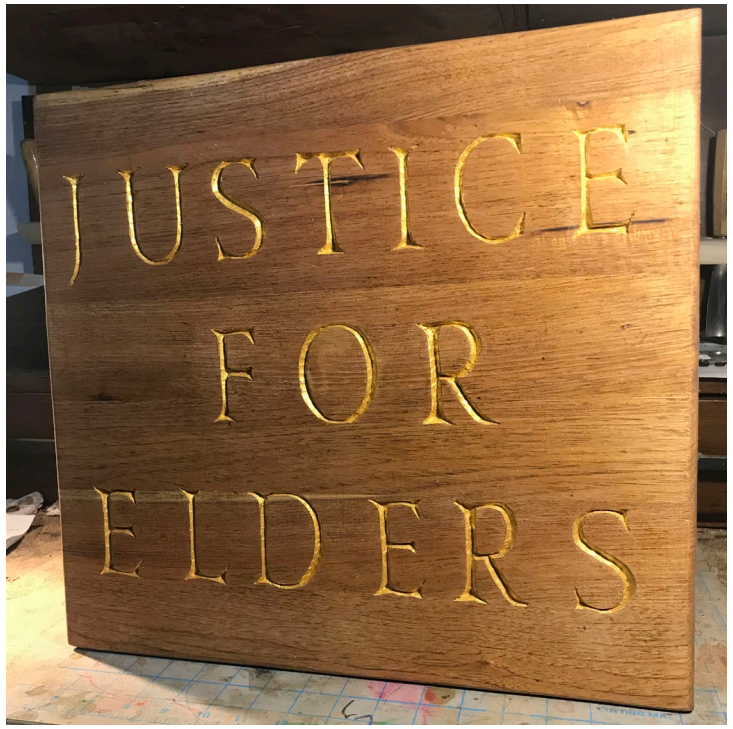
Illustrator: Yuval Caspi

Acknowledgements

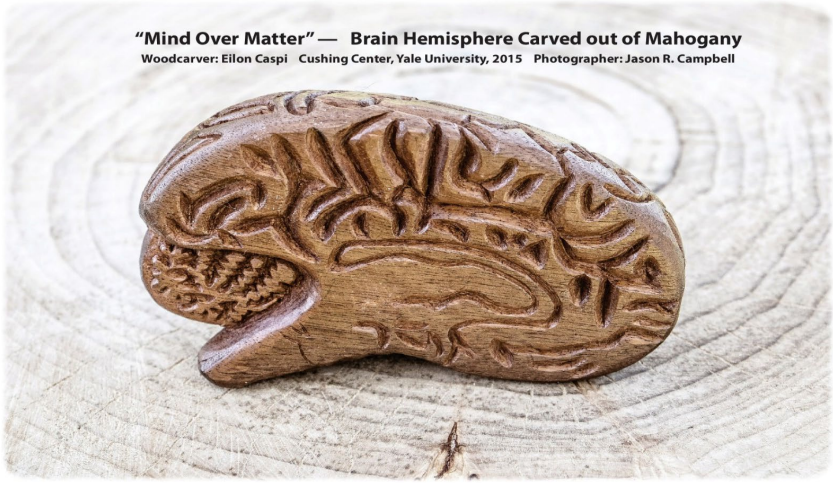
Theresa Piccolo

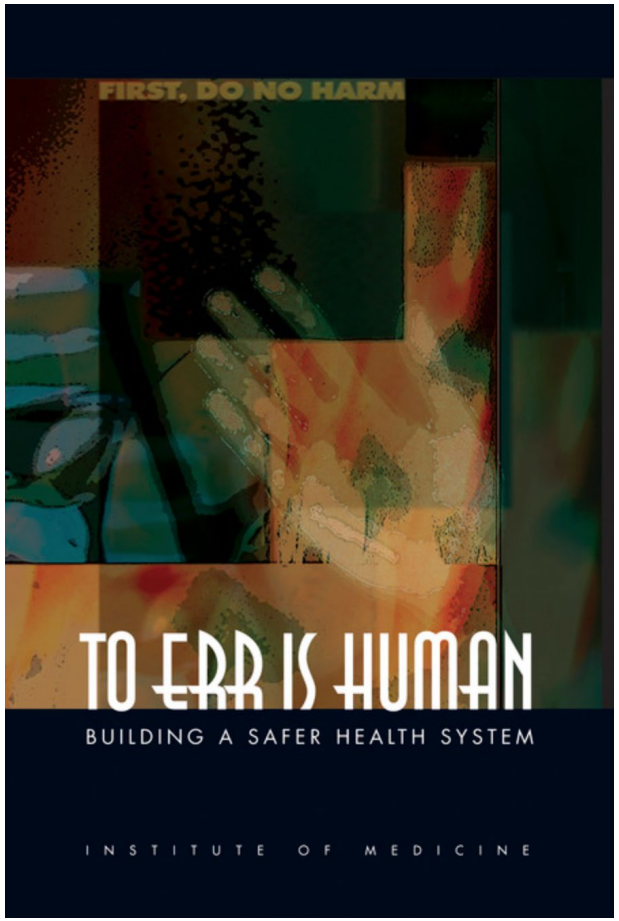


Ontario's
Geriatric Long Term Care Review Committee
(GLTCRC)



Gerontologist & woodcarver…





Institute of Medicine (2000):
https://tinyurl.com/3nx3fdrt

עבודת סיכום בקורס
ניהול בתי אבות

סדנא למניעת
תופעת תוקפנות
בין דיירי בית אבות

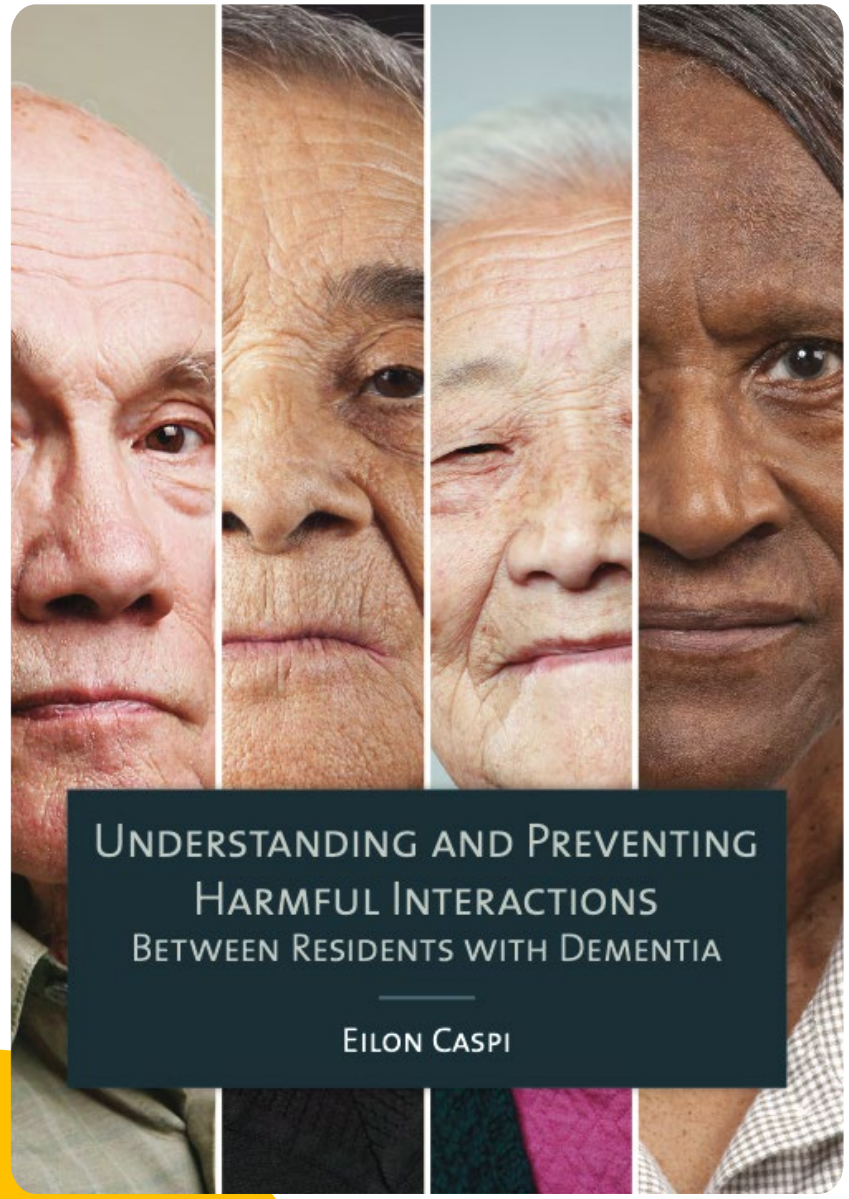
מגיש: אילון כספי

תאריך: 15.12.2000

לידי: גב' אירית פישר

קורס: ניהול בתי אבות

אוניברסיטת בר-אילן



New Book

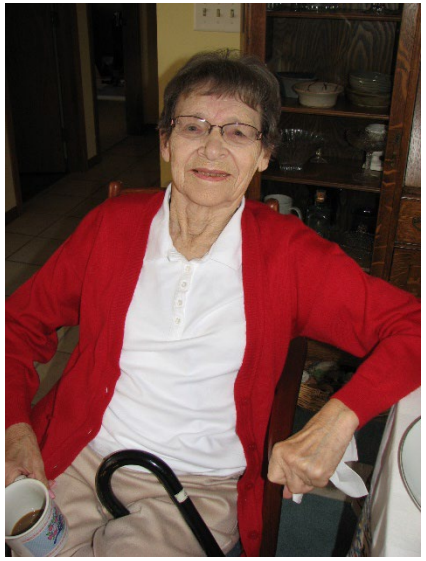
Caspi, E. (2022). Understanding and preventing harmful interactions between residents with dementia

https://tinyurl.com/5yeeevht

Documentary Film

Fighting for Dignity

Injurious and Deadly Resident-to-Resident Incidents in LTC Homes



Co-directors: Eilon Caspi & Judy Berry:

https://tinyurl.com/2s3d47t8 Eligible for 2 CEU hours

Film review in *The Gerontologist:* https://tinyurl.com/2p8cdjw4

If I had only one slide…

Fighting for Dignity

“The quality or state of
being worthy, honored or esteemed”

– Webster Dictionary

If I had two…

Lachs et al. (2016):
https://tinyurl.com/3et7px74

Higher nurse aide "caseload"
=
Higher R-REM

"There is **almost total consensus** that **the most critical factor in improving conditions** of care and work in LTC is **enough staff**."

– Ontario Health Coalition 2019 report

"Pretty much in all cases It comes down to the fact that there's just **not enough staff** on the ground **or** the staff that are there **aren't qualified enough** to provide the care needed."

Jessica Wilson, Consumer New Zealand, 10.12.19

Behavioral Expressions labeled as “Aggressive” in people with dementia are mostly…

- **Expressions of unmet human needs**
- Have **meaning, purpose & function** *to the person…*
- Attempts at **communication** that need be explored with validation – Judy Berry, president, Dementia Specialist Consulting
- Attempts at **gaining control** over unwanted, frustrating, frightening or threatening situations
- Attempts at **preserving identity & dignity**

=> BAROMETERS of resident’s tolerance to stressful stimuli…

A word about words…

Resident-to-resident “Aggression” / “Abuse” / “Violence” / “Mistreatment”

Caspi, E. (1.21.22). Conflicts between nursing home residents are often chalked up to dementia – **the real problem is inadequate care & neglect**. *The Conversation:* https://tinyurl.com/2p8cvhst

“A story of Neglect”: Understanding and preventing resident-to-resident incidents. **Podcast.** Long Term Care Community Coalition: https://nursinghome411.org/podcast/story-of-neglect/

Grigorovich et al. (2019). The **“violent resident”:** A **critical exploration** of the ethics of resident-to-resident aggression. *Journal of Bioethical Inquiry, 16*, 173-183. https://link.springer.com/article/10.1007/s11673-019-09898-1

Herron et al. (2021). Stories of violence and dementia in **mainstream news** media: Applying a citizenship perspective. *Dementia, 20(6*), 2077-2090.

https://journals.sagepub.com/doi/10.1177/1471301220981232

"~~Exhibitor~~" vs. "~~Target~~"

"~~Perpetrator~~" vs. "Victim"

"Exhibitor" – Resident A: 81 y/o newly admitted man with dementia

"Target" – Resident B: 79 y/o resident in advanced Alzheimer's disease

11:30am by elevator – Punched and head-butted resident B in the face

Fell on his face → Subdural hematoma → Died 2 weeks later

~~~

Resident A reported:

Resident B made disparaging **racial remarks** to a female staff

Resident B "**grabbed and pulled**" Resident A

Resident A head-butted Resident B In self-defense

Source: GLTCRC 2020 redacted narrative
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It’s Often a Process

Study

Focus groups with staff (n=36) in 2 dementia-specific LTC homes in Toronto

“Sequential pathways” / **“Highly interactive process”** / “Escalation points”

Reciprocity of sequenced interactions reframed RRA as **a bi-directional process.**

“Furthers RRA conceptualization as a process rather than an aggressive event.”

Burns et al. (2021): https://pubmed.ncbi.nlm.nih.gov/32909492/

Definition

"Negative, aggressive, and intrusive verbal, physical, sexual, and material interactions between LTC residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress in the recipient."

– MacDonald et al. (2015)

Ageism & Dementism but also…

It is a

gender

issue

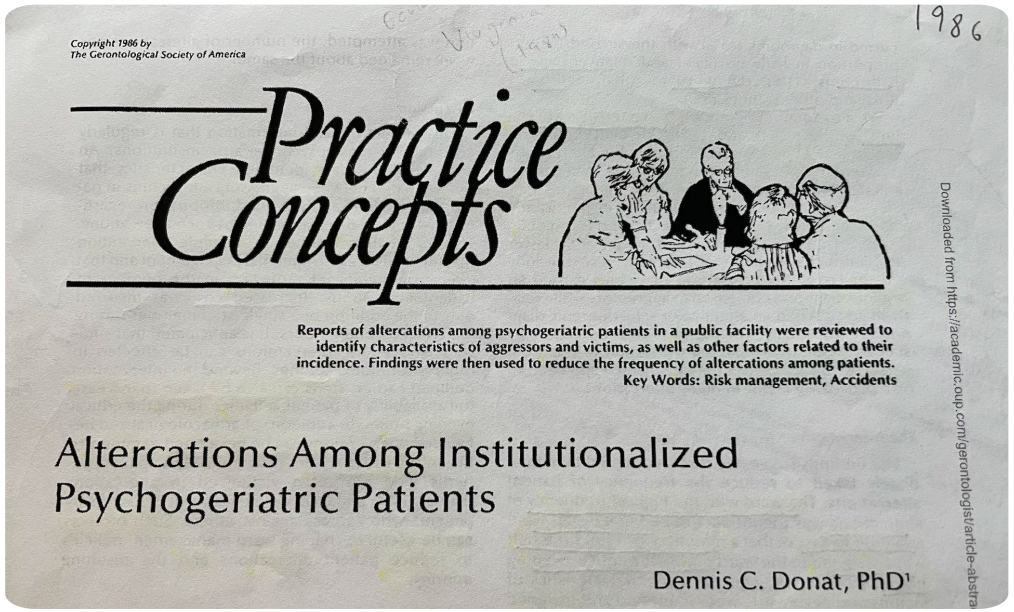
Over a Century-long Problem

"…when walking about **groped the faces** of other patients and was often **struck** by them **in return."**

Auguste D. Year: 1901

Source: Maurer and Maurer (1986). Alzheimer: The life of a physician and the career of a disease. New York: Columbia University Press.

Nothing New



1986

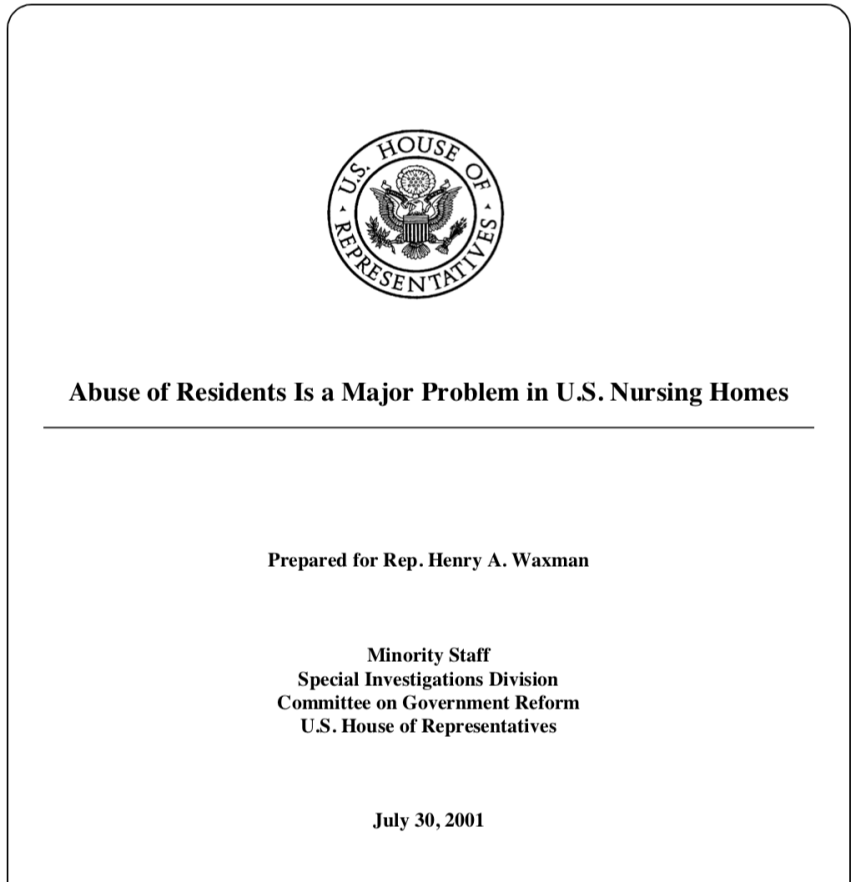
Practice Concepts

Reports of altercations among psychogeriatric patients in a public facility were reviewed to identify characteristics of aggressors and victims, as well as other factors related to their incidence. Findings were then used to reduce the frequency of altercations among patients.
Key Words: Risk management, Accidents

Altercations Among Institutionalized Psychogeriatric Patients

Dennis C. Donat, PhD[1]

Donat (1986): https://tinyurl.com/2p8avfmc



U.S. HOUSE OF REPRESENTATIVES

Abuse of Residents Is a Major Problem in U.S. Nursing Homes

Prepared for Rep. Henry A. Waxman

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

July 30, 2001

Government report (2001): https://tinyurl.com/2arbk6hz

Dangerous Normalization

"Up to now, the issue has been one of **indifference**, that these are old people and they're going to die anyways. Somehow in a collective setting like a nursing home, **the abnormal becomes normalized.**"

– Professor Gloria Gutman, SFU, Canada

Dangerous Normalization

"We tend not to reflect on these deaths in the same way we do a child who dies in a playground, but we really want to get people to think about the fact that **your life is worth something no matter how old you are**." "And **if you die a week before you had to, that week could be a really precious week lost**. Time's more precious the older you get, because you've got less of it."

– Professor Joseph Ibrahim, Monash U, Australia

Dangerous Normalization

Including by some residents:

Lapuk (2007): https://tinyurl.com/bddya3ha

Canadian frontline care workers report SIX times more physical “violence” than their Scandinavian counterparts

Contributing factors: **Poor staffing levels** & less staff training

Banerjee et al. (2012): https://tinyurl.com/5h3a2r8t

Study (University of B.C.):

“Family members’ experiences of RRA occurred in the context where violence perpetrated by residents with dementia was **largely normalized** because it was considered an **inevitable aspect** of the **disease process**.”

Normalization of RRA = Permission for minimal intervention

Baumbusch et al. (2018): https://tinyurl.com/nhafrjxx

Dangerous Normalization

"Violence in LTC homes continues to be normalized."

”Due to limited system resources to provide a safe and effective **environment** for those individuals, health care **providers have become accustomed to violence** in LTC homes and care providers **simply accept it as normal."**

"Managers often do not appreciate the extent of the problems and **manage the cases with a lower level of concern than required. This leads to disastrous outcomes** before a change in Care Plan is made – essentially a **reactionary environment** rather than a proactive one."

Source: GLTCRC 2019 annual report

Warning signs (22 incidents)

82 y/o woman with dementia

- Slapped, kicked, & struck residents & staff over 6 months
- ”High risk incidents occurred frequently”
- “Clearly a danger to the LTCH residents”
- Ran and pushed an 84 y/o man to the ground as he was coming out of the bathroom
- Hip fracture → Two days later found without vital signs → Died

Source: GLTCRC 2019 Annual Report (redacted narrative)

“A Sense of Learned Helplessness”

– GLTCRC (2020)

Resident A: 72 y/o man in severe stage of Alzheimer’s disease

Resident B: 77 y/o man with vascular dementia & severe cognitive impairment

Resident B repeatedly entered other residents’ bedrooms over 3 months

Resident A pushed him b/c “he came into his bedroom and took his cookies”

Multiple rib fractures & subdural hematoma → Died 2 weeks later

“The **GLTCRC** was **struck by the normalization** of violent behaviours and the level of resident-on-resident, and resident-on-staff violence in the Responsive Behavior Unit”

Invisible Neglect

"Victims of RRA in the past 12 months were **4 times more likely** to be **neglected** than those w/o such mistreatment" (reported by families)

Zhang (2011): https://tinyurl.com/y54har96

"There can be little doubt that the **inadequacy of care levels is a central contributing factor**. This is a policy choice. Not a necessity."

– Ontario Health Coalition, 2019

“Care” Staff Encouraging Fights

Two women with dementia in assisted living “memory care” home in NC

Fought each other in a bedroom, “hitting each other as staffers looked on without trying to physically stop the altercation.”

Three care home employees “watched, **encouraged**, and videotaped the 73 y/o woman **fighting** with a 70 y/o woman.”

When one of the women began choking the other, a staffer **told the woman to “punch her in the face”** while another staffer told her co-worker to film the fight and send her the video.

Newspaper article (March 5, 2022): https://tinyurl.com/5cy9csv5

COVID-19 Immunity / A License to Neglect?

- 80 y/o Garland Garrett with dementia in assisted living (AL) secure "memory care" unit in North Carolina
- Another male resident with dementia with 27 incidents against residents, staff, and objects
- 6am on Sunday – Garland was attacked in his bedroom by the resident
- Two neck fractures (inoperable) → "Excruciating pain and suffering" → Died six days later
- **Inspection cited** the AL with highest level of violation for **failing to supervise care**
- The AL claimed exempt from legal liability under NC COVID-19 pandemic immunity law…

Washington Post (8.20.21): https://tinyurl.com/mr3s6mt3

The wrongful death lawsuit was settled out of court (5.10.2022): https://tinyurl.com/w7nfpm28

De facto, Extensive immunity prior to pandemic

A perfect storm:

25 reasons why, de facto, legal immunity has already been granted to nursing homes and assisted living residences across Minnesota

ChangingAging (1.12.21):

https://changingaging.org/covid-resources/a-perfect-storm/

$1.9 Million Settlement in Assisted Living in California

88 y/o Olivia Deloney with dementia in a “memory care” unit

A 67 y/o man with early-onset Alzheimer’s and history of “aggressive” behaviors followed her and **knocked her to the ground** as she tried to get away from him → She broke her hip

Returned, left unattended, broke same hip, declined, died 2 months later

Attorney’s (10.16.17) description of Negligence:
https://tinyurl.com/y9s8qf5x

“We can **try to make such conduct too expensive for corporate owners** to risk it in another instance with other elders.”

NY Times (12.13.18): https://tinyurl.com/yc5s7fmj

$1.2 Million Settlement

“Two residents with dementia engaged in an altercation when the male resident **tried to help** a female resident open the door to her apartment”

“The female resident refused his assistance and he **pushed** her down.”

“Her fall resulted in significant injuries”

“She died two weeks later.”

“The family sued and won”

Consequences of RRI

Resident on receiving end

The other resident

Residents witnessing
Staff
Family members
Visitors
LTC home
Society

+ Substantial cost implications…

Quotes

"This is a matter of serious concern. It happens very often and will be fatal." – Resident

"Some of them really get afraid of him, and when I say get afraid…I mean get afraid…When they see him coming, they don't want to sit in the dining room…" – CNA

"I am afraid that he will hurt someone when we don't see it…especially someone frail whom he can take down with one blow." – CNA

Prevalence / Incidence

National Center on Elder Abuse

“More common than physical abuse by staff”

High Prevalence & Incidence

U.S. Nursing Homes

Castle (2012): 249 nursing homes (NHs) in 10 states;

Mail questionnaire: n = 4,451 nurse aides; past 3 months

The number of resident-to-resident "abuse" cases is high

Lachs et al. (2016): *n*= 2011 residents; 10 NHs in NY;

Resident & staff interviews, chart reviews, direct observation

1-month prevalence of residents "involved" in R-REM = 20% (Verbal = 16%; Physical = 6%; Sexual = 1%; Other = 11%)

Pillemer et al. (2022):

25% of residents were involved in R-REM **during a 1-year period**

Study in MA Nursing Homes

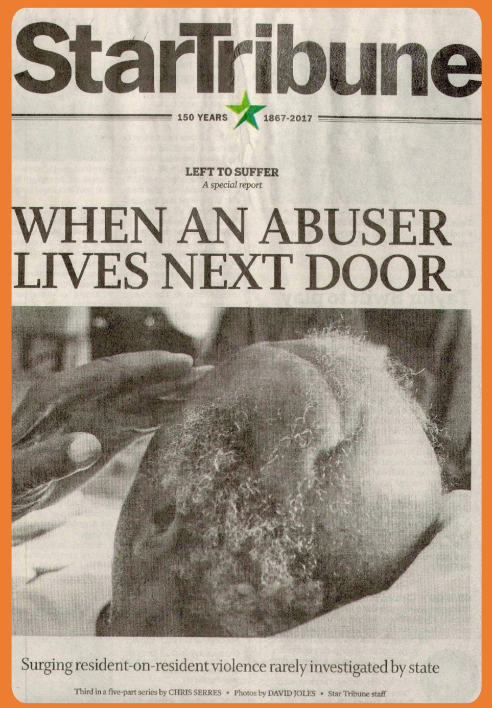
294 residents physically injured in a single year

Shinoda-Tagawa et al. (2004):
https://pubmed.ncbi.nlm.nih.gov/14762038/

#1 Reason police called to nursing homes in CT

Lachs et al. (2007). Resident-to-resident elder mistreatment and police contact in nursing homes: Findings from a population-based cohort. *JAGS, 55(6)*, 840-845. https://pubmed.ncbi.nlm.nih.gov/17537083/

Prevalent in Minnesota



11.14.17

4,031 complaints re RRI (that did not result in serious harm) were **not investigated** on-site by MDH during **FY 2016**:

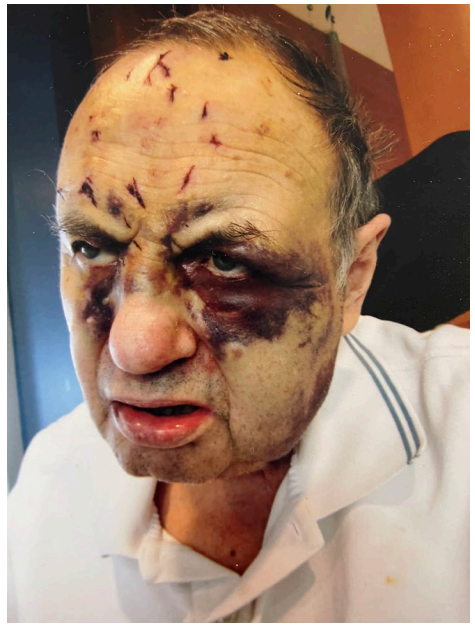
Second highest only after Falls with 4,128 complaints!

"Thousands of complaints are not investigated so maltreatment continues, and less severe issues may escalate to more serious harm"

– MDH (2017)

10,000 incidents in a single year in Canada

Toronto Star (2013): https://tinyurl.com/ynfdrnfa



Frank Piccolo

https://tinyurl.com/2u7a3km8

Review of Research Literature & Canadian Dataset

“One-third of reported abuse cases”

McDonald et al. (2015):

https://pubmed.ncbi.nlm.nih.gov/25752919/

“Appalling rates of R-R homicides”

Ontario Health Coalition, 2019

“**27 homicides** committed against a resident by another resident in Ontario LTC homes **in** the last **five years**.”

“Up to **four times the amount of homicide** in our LTC facilities **than** we have in **any of Canada’s largest cities.”**

CTV W5. 1.22.19. https://tinyurl.com/yckvjweh

Assisted Living

National study – Direct care workers and administrators

RRA "more common than staff abuse."

"Findings show RRA may be prevalent in AL."

Castle (2013). An examination of resident abuse in ALFs: https://www.ojp.gov/pdffiles1/nij/grants/241611.pdf

Pay Attention to Newly Admitted Residents

Study on Admissions to 3 LTC homes in Ontario

Assessment of 339 people at admission and 3 month after:

23% involved in an **incident** of “aggressive behaviour” to another resident

Brazil et al. (2013):
https://pubmed.ncbi.nlm.nih.gov/23777187/

Aggressive Behavior Risk Assessment Tool (ABRAT-L) for newly admitted residents:

https://tinyurl.com/268pk52y

https://tinyurl.com/4wvbhjan

– Kim et al. (2017, 2019); Berry et al. (2017)

Underreporting

"**Majority** of R-REM incidents are **not reported** in most nursing homes"
– Jeanne Teresi

Low or poor <u>quality</u> of documentation and reporting

Under investigated – Internally and externally…

Not Witnessed

- “Nearly **40%** of ‘resident-to-resident physical aggressive’ incidents **not witnessed** by staff” – Bharucha et al. (2008)

- **Majority of entries into** other residents’ **bedrooms** were **not witnessed** by direct care staff – MacAndrew (2016)

Media Coverage

”Around **half** of all nursing home homicides **make headlines**.”

– CTV W5

Counting Canada’s care home homicides. 9.27.13: https://tinyurl.com/8vvtvrjt

Pushing Death – Not Made Public – Nova Scotia

"It's **shocking** that **the information never left the facility** and got to the higher ups where it could have been more closely looked at."

”Expected NS Health Dpt would **try to learn from the tragedy.”**

"They are our most vulnerable population and we should do everything in our power to protect those people.”

Newspaper article: https://tinyurl.com/2p94c3pj

Debbie Stultz-Giffin
Daughter of 87 y/o Dorothy Stultz

Connecticut

“Immediate Jeopardy” citation in a nursing home in Farmington:

“Facility failed to ensure that the resident was free from abuse when another resident wasn’t adequately supervised & threatened to harm the resident with a knife.”

While holding a knife, called his roommate, and gestured that he/she was going to slit his/her neck and drink his blood.

Source: CMS 2567 Form (March 23, 2018)

New Haven Register (September 10, 2018): https://tinyurl.com/ssjk9br

Other RRI in Nursing Homes in CT

- "Actual harm" citation for incident in Waterford, CT

"punched in the face" (Investigation completed: 10.26.18)

- Incident in another nursing home in Waterford, CT

"…belittle, isolate, degrade, and scares…" (Completed: 2.7.19)

- "Scratched and struck" (Mystic, CT; Completed: 10.12.18)

- "Beat roommate with a belt" (West Haven, CT; Completed: 4.17.19)

- "Grabbed her breast in the lounge area" (Canaan, CT: 4.15.19)

Fatal RRI in Wilton, CT

Deceased: 82 years old Thomas Mullen

"…bludgeoned with the footboard of a bed…" by his roommate

"Your heart drops when you hear something like that could happen. **It's our job to make sure if there is anything to prevent this from happening in the future, that we do it**." – Chris Murphy, co-chair, Legislature's Public Health Committee

Christophersen, J. (2004). Killing in nursing home reflects nationwide problem. Associated Press, October 9, 2004: https://tinyurl.com/u9gohew

Roommates

12-item Emotional Bondedness Scale. Bitzan (1998): https://pubmed.ncbi.nlm.nih.gov/9814273/

Reflection Question

“Imagine that tonight you are at home having dinner with your family. There is a knock on the door, and two men come into your house or apartment, carrying a mattress and bedspring. The men set the bed up in your bedroom across from your bed, hang a thin curtain between the two beds, and then escort **a stranger** into the home who **will share your bedroom for the rest of your life**.

How many of you are ready and willing to take on this type of living arrangement?”

– Dr. Allen Power

New York

Two men shared a bedroom in a nursing home in Queens

One wanted the **curtain divider** open while the other wanted it drawn for more privacy

Around **1:20am**…
The 66 y/o man took a metal footrest of a wheelchair and severely beat his 71 y/o roommate in his head

He died within hours

“That something like this could happen is just mind-boggling to everybody” – Nursing home’s spokesman

NY Times (10.30.13): https://tinyurl.com/ywvwujax

NY Times (7.9.14) article on sentencing of 17 years in prison: https://tinyurl.com/d4tk38xj

Houston, Texas

Homicide detectives were called to the nursing home **at midnight**…

Resident with **Schizophrenia** beat his 2 roommates with a wheelchair armrest

Both died

The daughter of one of the victims stated that she and her father made repeated requests to move him to another bedroom

Newspaper article (4.23.14): https://tinyurl.com/357hmnc3

Casa Verde Nursing Home, Toronto (2005)

Inquest - 85 recommendations

74 y/o Piara Singh Sandhu – "Cognitively impaired"

East-Indian origin – **"Spoke little English"**

Emergency admission on a Saturday at 12pm → at 7:30pm two of his roommates were dead

Recommenndation #72: "Given Ontario's ever increasing multicultural population, **translation services should also be made available to all LTC facilities"**

"Ensure that language issues do not increase alienation or trigger aggressive behaviors…"

Delay admission until treatment plan addresses needs of individuals who do speak the same language

https://tinyurl.com/zh68jlu / https://tinyurl.com/nhe2396h

Residents Not Speaking English

Resident A: 70 y/o man with dementia (MoCA 6/30) and “No history of physical aggression”

Resident B: 84 y/o man with Alzheimer’s disease (MMSE 6/30)

6:45am in TV lounge – Resident B started to move a sofa → Resident A told him to stop

Resident B **only spoke and understood Cantonese** → Didn’t respond → Was pushed

Fell backwards → Hit head on floor → Skull fracture & subdural hematoma → Died same day

Source: GLTCRC 2020 redacted narrative (incident: September 3, 2019)

InterpreCare System ™ Intervention: https://pubmed.ncbi.nlm.nih.gov/8990595/

Massachusetts

58 y/o with brain damage and dementia beat his 86 y/o roommate over the head with a heavy ceramic flower pot

Suffered “severe head trauma” → Died next day

There were many warning signs in the months leading to the incident…

There was another fatal RRI at the same company 2 years earlier…

Boston Globe (10.14.17): https://tinyurl.com/2p8chyy7

New Hampshire

90 y/o woman required high-flow oxygen concentrator for her survival

Roommate with “severe dementia” **turned off oxygen** because it was “too loud”

She died as a result

Newspaper article (7.20.21): https://tinyurl.com/2bkdku6p

77 y/o James Parker

Minnesota

Attacked by roommate → Severe brain injury

"Based on a preponderance of evidence, the allegation of neglect is not substantiated." – MDH

"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:

"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**:** "How many times we were supposed to warn them?"

Sued for neglect and won

Australia

80 y/o and 78 y/o roommates with dementia on a secure / locked dementia care home

December 26: 80 y/o walks around with a belt stating he wants to put it around someone's neck

January 18: Dragged roommate across the bedroom and out the door, after telling him to get out of his room

January 20: "He was in my stuff so I dragged him out. I should kick him in the head until he is dead."

January 28: Saturday afternoon
The 80 y/o resident with dementia shoved his 78 y/o roommate with dementia → Fell → Died on February 10

"Warning bells should have been ringing after the assault, 10 days before" the incident – Professor Ibrahim

Newspaper article (10.27.19): https://tinyurl.com/mvm8xjcv

Israel

90 y/o Karina Beker

Early morning

Karina disrupts her roommate **saying** there's no staff in the hallway and that the **staff are on strike**

18:30

Insists again about the strike while roommate tries to rest in bed

Argument turned physical → Roommate pushed Karina → She died

Murder of an older woman in Haifa: What happened in room 105 of the nursing home? https://www.maariv.co.il/news/israel/Article-470387

Unwanted Entries into Bedrooms

“You wouldn’t want to live in a place where you’re **afraid someone is going to come in your room** and hit or hurt you. You and I wouldn’t want that. Why should anybody in a nursing home?”

– Professor Lynn McDonald

New York

Resident A enters bedroom of resident B → An argument

Resident A “repeatedly smashes Resident B’s head on the concrete floor” → Died

“This is a shock to everybody. I couldn’t leave work because everyone was crying: What went wrong? Why, why here?”

‘What went wrong?’ Elderly man charged with murdering fellow Bronx nursing home resident.
New York Daily News, 5.22.21: https://tinyurl.com/yff6vev9

“He just fell”

Dwayne lived with Alzheimer’s in a nursing home in South Carolina

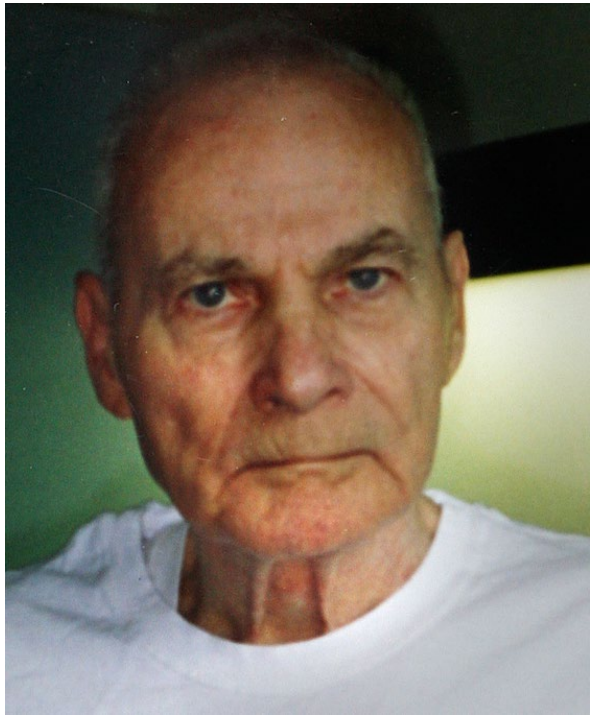
After **9:00pm,** walked into **a resident’s bedroom** & climbed into his bed

A resident with dementia whose bed was taken walked in…

He beat Dwayne repeatedly with his cane

Dwayne was found **severely injured**, bleeding, and unconscious in a fetal position on the floor with the man still beating him

He **died** a week later / Understaffing around the time of incident



76 y/o Dwayne E. Walls

Death certificate: “Pneumonia”

Toronto

- A former beloved science teacher
- Developed Parkinson's and dementia

- After **8pm**, a resident with dementia **entered his bedroom**
- He hit Frank repeatedly over the head with an activity board
- His physical condition declined → Died 3 months later

- Wife: "My husband couldn't defend himself or yell for help."

Frank Piccolo

“Memory Care” Unit in Florida

- Had history of entering residents’ bedrooms and getting into beds

- Around **1am, entered a resident’s bedroom** & got into his bed
- Got “mad” because she wouldn’t leave…
- Struck her in the head with an open hand…
- “Put her in a **choke hold**” and “put as much pressure as he could”
- Staff found her on his bed with face injuries and no pulse
- Preliminary cause of death: **Strangulation**

77 y/o Nancy Jean Barnard

Newspaper article (May 12, 2022): https://tinyurl.com/233y49xy

86 y/o man with Alzheimer's in Ontario

- Evening: PSW hears screams coming from **inside** resident A's **bedroom**
- Found resident B **punching** resident A
- Resident A sustained "facial injuries and was covered with blood"
- **Subdural hematoma → Died** 2.5 months later

Source: GLTCRC 2018 redacted narrative

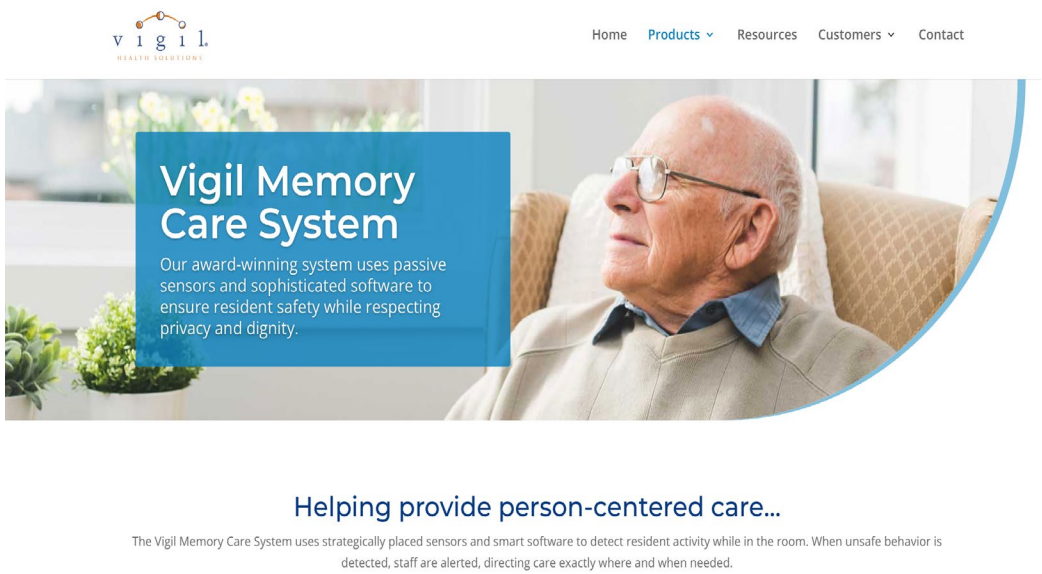
90 y/o woman with advanced dementia

- Around **6am**, she walked **into the bedroom** of another resident
- Male resident with **schizophrenia**, VaD, & TBI with “territoriality and impulsiveness”
- February 26 incident: Resulted in a **fall** and bleeding laceration on her scalp
- February 27: Resident said: “This woman was standing in his doorway and **bit his hand**.”

As a result, she “**fell** and sustained intracerebral injuries that led to her demise” (six days later)

GLTCRC 2018 (redacted narrative): “**Perhaps** in the future, **technology** **will** be able to **assist**.”

Evaluate and Fund Assistive Technologies



https://vigil.com/products/vigil-memory-care-system/

Animation video: https://tinyurl.com/mrw47d3f

Video tour: https://www.youtube.com/watch?v=b02d8Zpes9w

“It’s a Horror Movie”

84 y/o Meyer Sadoway

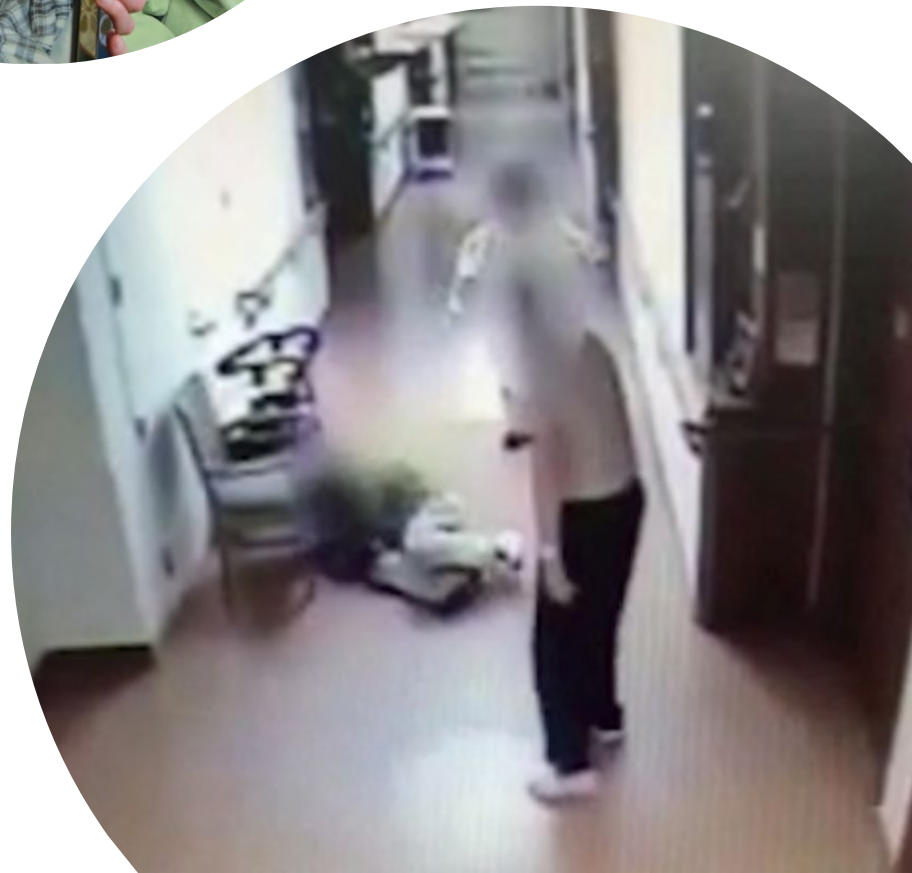
Baycrest staff told his family he’d **“fallen”** twice

Security camera footage – which the family said it had to wait SIX MONTHS to watch – **told a different story**…

Meyer was **standing guard in front of his bedroom**…

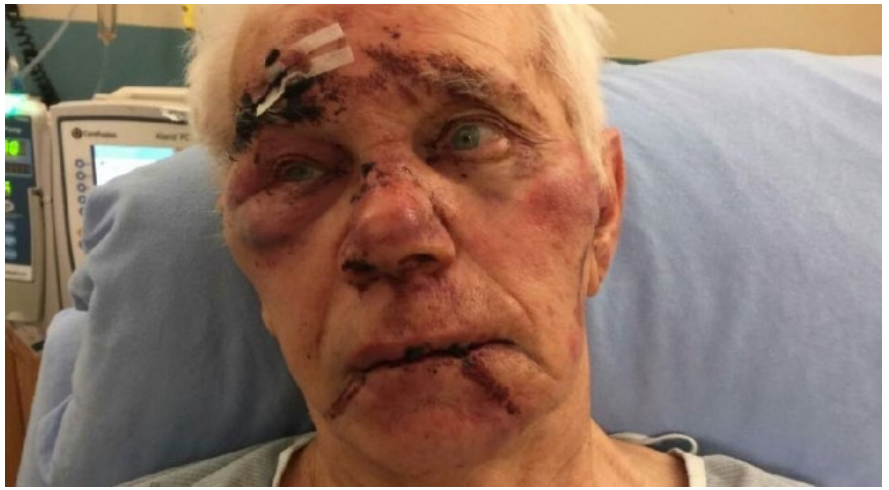
Physical incident → Shoved → Dead 4 days later

Newspaper article: https://tinyurl.com/4j4b7wu2



“If this happened to a child at Sick Kids hospital, people wouldn’t stand for it” – Daughter

85 years old James Acker with Alzheimer’s



Staff tried to stop it but was unable to until police arrived

Attacked **in his bed** on **Saturday** after **2am** by a resident with dementia in Dundas, Ontario

McLaughlin (Feb 3, 2017). CBC: https://tinyurl.com/74jvncjz

Mandatory Behavior Emergency Courses

Physical De-Escalation Techniques

Nonviolent Crisis Intervention Training (CPI)

http://tinyurl.com/mrl5ltz

Violence Prevention Course (SafeCare B.C.)

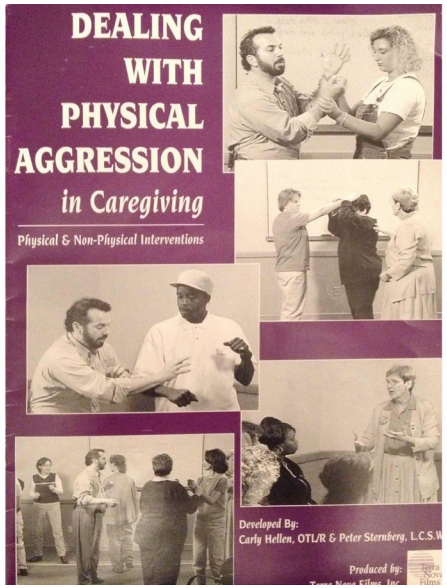
http://safecarebc.ca/violence-prevention-course/

Train all employees but also police officers…

DVD

Techniques demonstrated:

- Release from **a grab**
- Deflecting **a strike** or a **kick**
- Dealing with your **hair pulled**
- **Planned containment**
- **Unplanned containment**



Carly Hellen & Peter Sternberg (1999). Dealing with Physical Aggression in Caregiving: Physical and Non-Physical Interventions

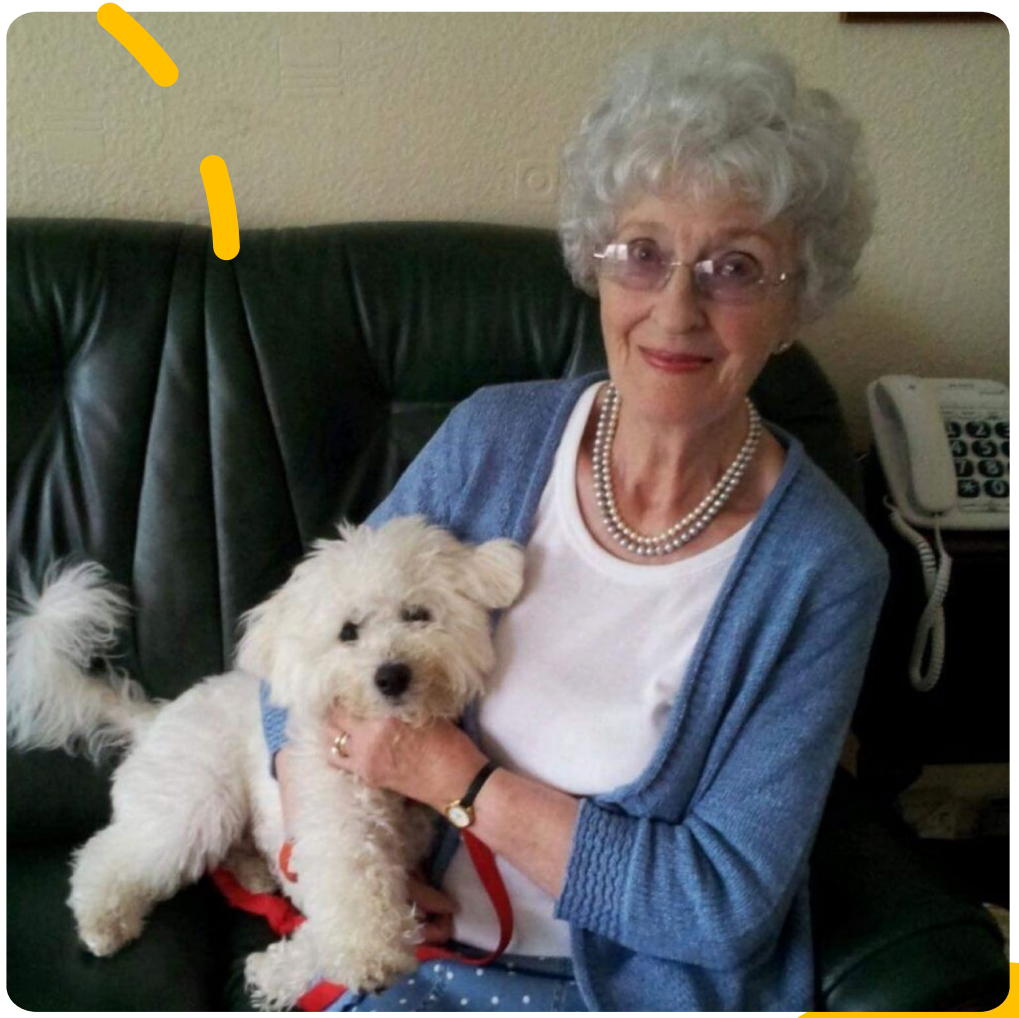
Terra Nova Films: http://tinyurl.com/hveq5tr

England

Pulled out of her bed by a man with dementia in **early morning hours…**

Punched and kicked her…

Died 2 months later…



91 y/o Jessie McKinlay with “mild dementia”

Freckleton woman, 91, fatally attacked by fellow care home resident. BBC. 12.15.21: https://tinyurl.com/34wu2xp7

New Zealand

Evening: Resident **enters Leonard's bedroom**

Leonard: "Get out, get out, this is my room."

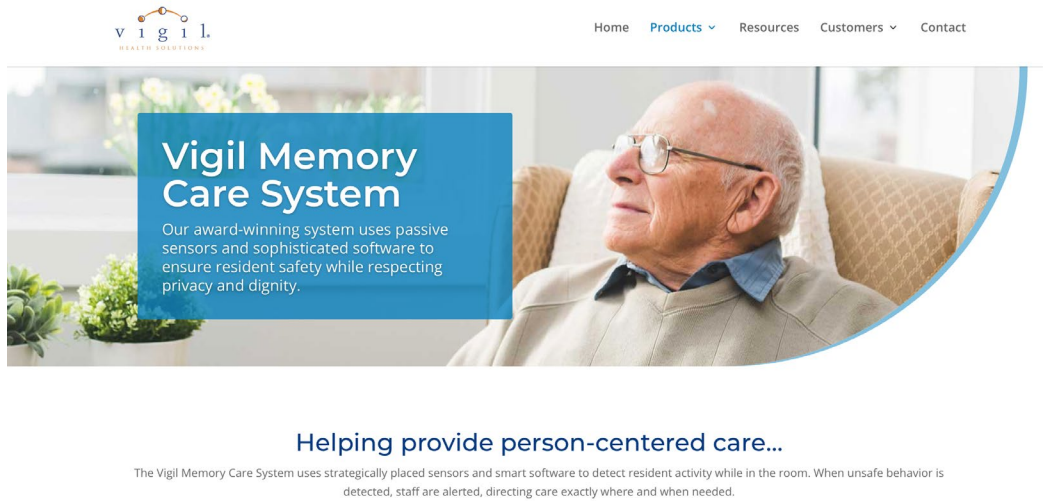
When staff arrived, he was "**knocked unconscious**."

Died a couple of days later

99 y/o Leonard Ralph Hewgill
with dementia

Stuff (9.28.19): https://tinyurl.com/2p88e9hh

Evaluate and Fund Assistive Technologies



https://vigil.com/products/vigil-memory-care-system/

Animation video: https://tinyurl.com/mrw47d3f

Video tour: https://www.youtube.com/watch?v=b02d8Zpes9w

Push-Fall Incidents

CBC News (2018)

Three “falls” → Hip fracture → Died

Surveillance video: “Shoved” by a resident with dementia

Family “shocked and traumatized” but didn’t blame resident

91 y/o man
with Alzheimer’s in
New Brunswick

Investigation: Involved in 9 episodes with several residents (pushed a woman into a wall causing her to crash to the floor) including the deceased

Toronto Star (2.15.22): https://tinyurl.com/2thxd5z5

NB Seniors’ Advocate:
https://tinyurl.com/4hxcnk6j

All You Need is 1 Push

Three studies showed **“push-fall”** constitute **44%**, **50%**, **63%** of fatal incidents

Caspi (2018): https://pubmed.ncbi.nlm.nih.gov/29851550/

Murphy et al. (2017): https://pubmed.ncbi.nlm.nih.gov/29131309/

DeBois et al. (2020): https://tinyurl.com/2aaec6nt

“If my mother had not been pushed, she would still be alive.”

Source: MDH investigation substantiated “Neglect” in Assisted Living “Memory Care Unit” (5.19.21): https://www.health.state.mn.us/facilities/regulation/directory/ohfcfindings/hl20004008m.pdf

Push-Fall Incidents

10 of 12 most recent fatal RRI reviewed by GLTCRC

Source: GLTCRC redacted narratives (2018, 2019, 2020)

Unwitnessed Push-Falls

Study in 2 LTC homes in Canada using video recordings in common spaces:

9% of falls took place during RRI (Robinovitch et al. 2013)

Another video-based study on causes of imbalance concluded:

"Aggressive behavior between residents is a frequent, and often **undetected**, **cause of falls in LTC**" (Yang et al. 2015)

Evenings – Vulnerability Time Period

Half of RRI between 5pm –8pm (Donat, 1986)

Half of RRI requiring police involvement between 4pm –10pm (Lachs et al. 2007)

Higher risk in Dementia SCUs

"Residing on a **dementia unit** was associated with **higher** rates of **R-REM**"

Lachs et al. (2016)

"Residents in Alzheimer's units were **almost three times as likely to be injured** than those living in other units" (Shinoda-Tagawa et al. 2004)

Died of “natural” causes

“In most places, little is being done to ensure that suspicious senior deaths are being investigated.”
– ProPublica

"Sometimes, if I don't want to sleep at night, I think about all the cases that we miss"
– Dr. Michael Dobersen, Coroner in Colorado

“A hidden national scandal”

– Professor Catherine Hawes

Death Review Teams are
“Absolutely essential”
– Paul Greenwood

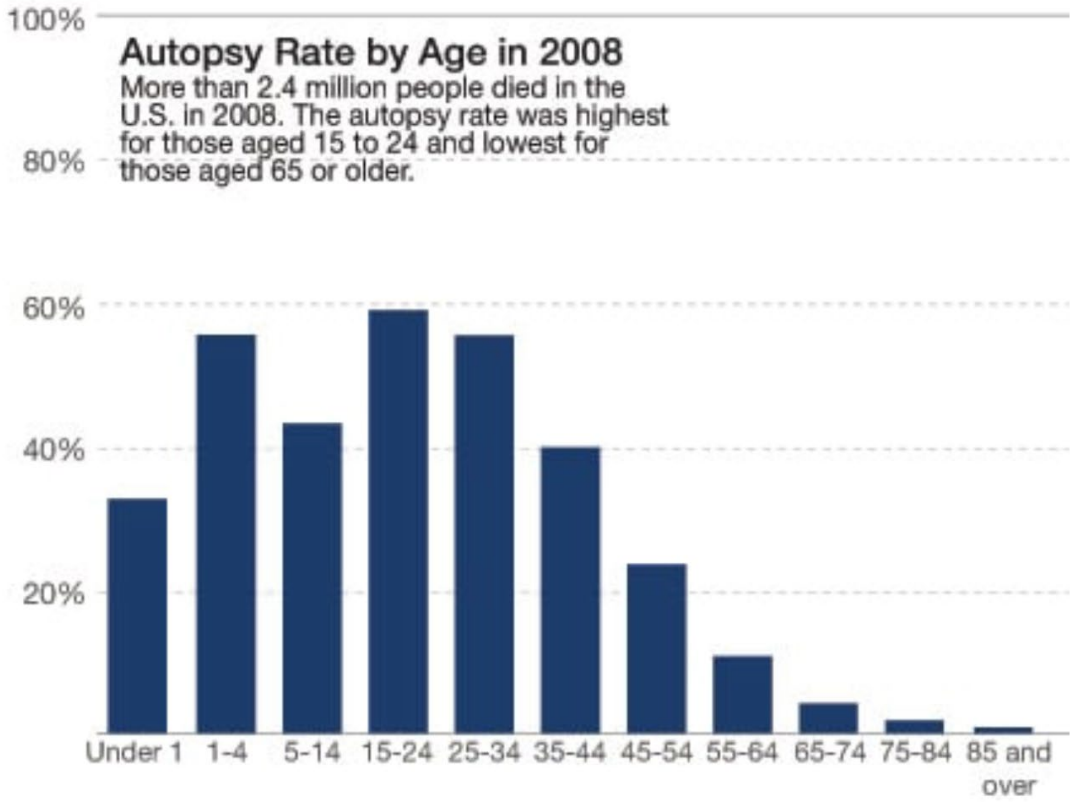
Gone without a case: Suspicious elder deaths rarely investigated (ProPublica, 2011): https://tinyurl.com/yfwbranb

Agesim in Autopsies

PROPUBLICA

Gone Without a Case: Suspicious Elder Deaths Rarely Investigated

Ageism and Autopsies



What did a Coroner find after ordering to exhume six bodies?

Arkansas Coroner
Marc Malcolm

Families Ask

"We want to see a solution. ***We don't want the death of our father to be in vain****....I want to see something done so this doesn't happen again."*

– Son of a resident with Alzheimer's who died 4 days after being pushed by another resident with dementia in Winnipeg

Inquest (2015): https://tinyurl.com/j2lc5fd

Expert's Prediction

"Due to the approaching retirement of the baby boomers and the estimated growth of elders with dementia, ***we are going to see increasing incidence*** ***of resident-to-resident violence****.*

There will be more and more pressure from family members and advocacy groups to keep the residents safe."

– Dr. Paul Raia, 2006

Dwayne Walls & Judy Hand

Untracked in U.S. Nursing Homes

JOURNAL OF ELDER ABUSE & NEGLECT
https://doi.org/10.1080/08946566.2017.1333939

2018

Routledge
Taylor & Francis Group

Check for updates

A federal survey deficiency citation is needed for resident-to-resident aggression in U.S. nursing homes

Eilon Caspi

Dementia Behavior Consulting LLC, Minneapolis, Minnesota, USA

United States Government Accountability Office
GAO
Report to Congressional Committees

June 2019

NURSING HOMES

Improved Oversight Needed to Better Protect Residents from Abuse

June 2019

Caspi, E. (11.29.21). Resident-to-resident incidents are a hidden source of harm in nursing homes. They shouldn't be. ***STAT***. First Opinion: https://tinyurl.com/yc6rmayb

“You have revealed a real flaw in the system.”

“In a sense, recognizing resident to resident assaults of any kind would **open the flood gates to more CMS and local interventions**.”

“The system is only able to respond to such behaviors in SNF and AL with meds, because that is the only way they know how to respond to the aggressive behaviors.”

– Dr. Paul Raia

Not Tracked in MDS 3.0

FULL TEXT ARTICLE

MDS 3.0: A Giant Step Forward, but What About Items on Resident-to-Resident Aggression?

Eilon Caspi PhD

Journal of the American Medical Directors Association, 2013-08-01, Volume 14, Issue 8, Pages 624-625,

Learn from Investigation Reports

"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."*

MN Historical Society

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

1st Study on Fatal RRI in U.S. and Canada


RESEARCH

Tracking the **untracked**

Study tallies deaths from resident-to-resident incidents with dementia

After analyzing 105 deaths, Eilon Caspi discovered 59 percent of resident-to-resident violence resulting in death occurred inside bedrooms.

MINNESOTA NURSING

JOURNAL OF ELDER ABUSE & NEGLECT
2018, VOL. 30, NO. 4, 284–308
https://doi.org/10.1080/08946566.2018.1474515

The circumstances surrounding the death of 105 elders as a result of resident-to-resident incidents in dementia in long-term care homes

Eilon Caspi, PhD

School of Nursing, Adult and Gerontological Health and Cooperative Unit, University of Minnesota, Minneapolis, MN, USA

Caspi, E. (2018). **Buried (Not) Forever**: A Hidden Source of Injuries and Deaths in Nursing Homes. ChangingAging: https://tinyurl.com/qm3wu7m

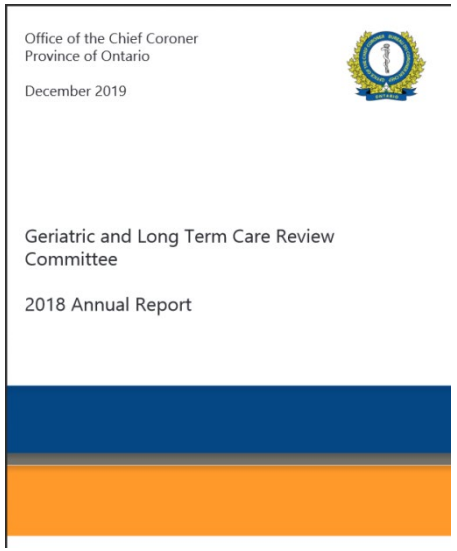
Methods of Study – 105 Deaths

- **Source of data** (All public records):
- Newspaper articles published online (over 150)
- Death Review Reports (GTLCRC to CCO, 1990-2016)

- **Comprehensive Internet search:** Spring 2012 – Fall 2017

- **Data detection and extraction:** Structured Guide

- **Data Analysis** (Time period: Summer – Fall 2017):
- Miles & Huberman (1994) approach
- Qualitative review and abstraction of narratives
- Complemented with tabulation by aggregation / counts
- Simple descriptive statistics



Findings

n = Number of deaths for which data were available

- Identified **105 deaths** of elders (> 60 y/o) as a result of RRI in dementia
- Time period: Deaths occurred between 1988 - 2017
- Type of LTC home (n=50): Majority in nursing homes; 26% assisted living
- Countries: Canada (n=51); USA (n=42);
  Australia & New Zealand (n=4 & n=2); UK (n=5); Singapore (n=1)

Findings

- **Characteristics of Residents**
- Age deceased (n=103): 84.5 years old (average)
- Age exhibitors (n=76): 75.2 years old (average)

- Gender deceased (n=100): Men 52%; Women 48%
- Gender other resident (n=99): Men 74%

- Newly admitted residents (< 3 months): 23 deaths

Findings

The Circumstances Surrounding the Deaths:

- Location (n=84): **Inside bedrooms (59%)**
- Time of day (n=63): **Evening (44%)** and Night (14%)
- **Weekend** (n=94): **38%**
- **Roommates** (n=77): **43%**
- **Not witnessed by staff** (n=84): **62%**
- Nature of physical contact (n=99):
  "Push-Fall" incidents **(44%);** Head and/or face beating (22%)
- Object used against target (n=88): 31%

Findings

- **Nature of physical injury** (n=79):
  Head/face or brain injuries (50%); Hip fractures (33%)

- **Cause of death** (n=69):
  Blunt head trauma (29%)
  Complications from fractures (20%)
  Pneumonia (11%); Strangulation/Suffocation (10%)

- **Time until death** (n=95): 16 days (average);
  One-quarter died on same day

Common Triggers

- Invasion of personal space
- Unwanted entries into one’s bedroom
- Taking personal belongings from others
- Reaching a breaking point
- Conflicts between roommates

Underlying theme:

Unmet needs and situational frustrations

Areas for Consideration

- **Eliminate stigma**
- **Break the silence and dangerous normalization**

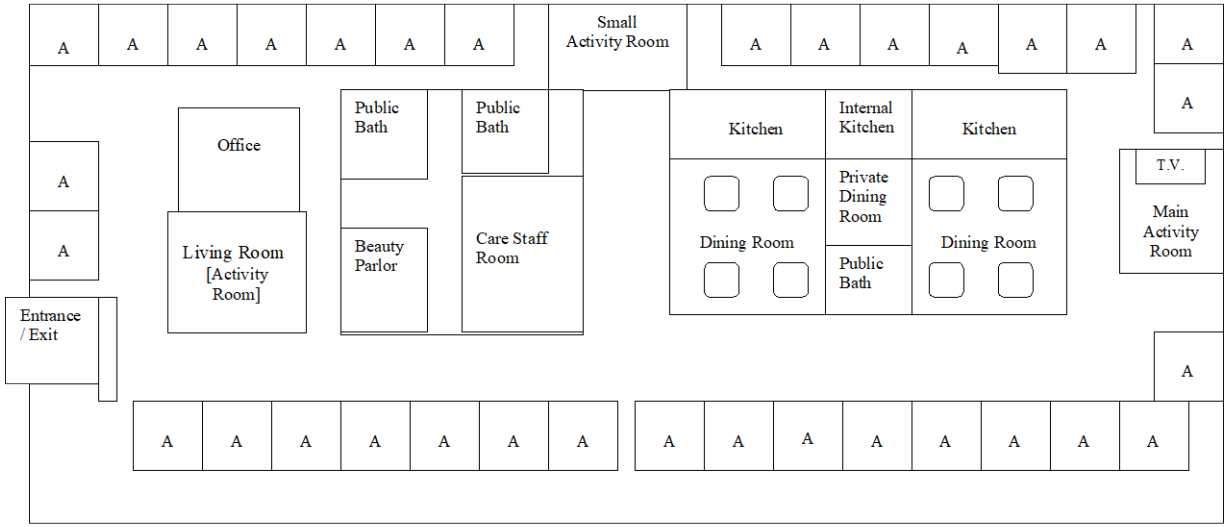
- Focus on proactively **creating emotional well-being** / “Human flourishing”
- **Treat** direct care **staff as the bedrock of LTC sector** – Put real meaning into the word “Heroes”
- **Safe people-to-people levels** at all times (adjusted for acuity; “mandatory & enforceable”)
- **Specialized education** (orientation, in-service, experiential learning, emergency de-escalation)
- Supportive **guidance from** qualified **managers**
- Personally **meaningful engagement**
- **Evenings and weekends** = Heightened **vulnerability time periods**

Areas for Consideration

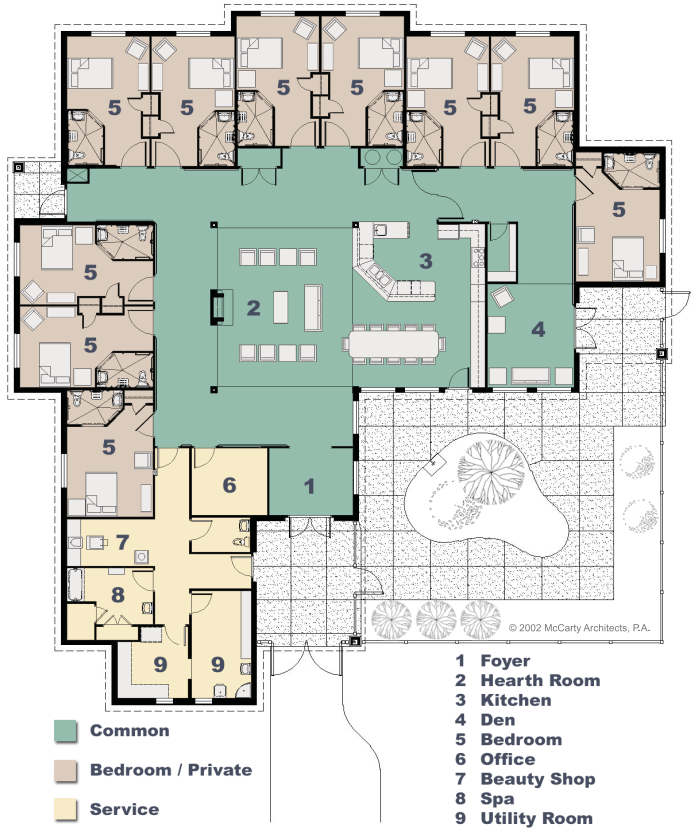
- **Physical environment** (Elder & dementia-friendly / Floor layout, private bedrooms)
- **Pre-admission** behavioral **assessment**
- Avoid admitting residents you care home is unable to care for safely
- Operate only within **scope of practice**
- **Screening and assessment tools** – The basis for Individualized Care Plans
- **Learning culture / Centralized tracking**
- Focus on person, not profit
- Strengthen government **oversight and** owner / care provider **accountability**
- **Criminal prosecution** for gross neglect

Floor Plan – Line of Sight

Figure 1. Floor Plan – Higher Functioning Unit



Notes: The letter "A" represents a resident's apartment; The four square shapes within each of the two dining rooms represent dining tables. The Floor Plan of the Higher Functioning Unit is basically identical to that of the Lower Functioning Unit.



Architects P.A.

Shift to (Mostly) Private Bedrooms

”**Since 2000**, all newly licensed residential care facilities under the Community Care and Assisted Living Act have been **required to provide private bedrooms** for residents.”

“Ideally, **every senior** living in a publicly funded nursing home in B.C. would **have their own bedroom**” – B.C.’s Seniors Advocate Isobel Mackenzie

Sharing of nursing home rooms saves dollars in B.C., but at what cost? Vancouver Sun (2.11.16): https://tinyurl.com/479uj7cc

Shift to (Mostly) Private Bedrooms

"While it is better for residents if most nursing home rooms and bathrooms are private, **reserving a small number of double-occupancy rooms for those who prefer to share a room is important**."

Source: Academies of Sciences, Engineering, and Medicine (2022, pp. 333-4)

Personally Meaningful Engagement

But the reality is…

Most residents are **not engaged** in **activities most of the time** (Cohen-Mansfield et al. 1992; Burgio et al. 1994; Schreiner et al. 2005; Wood et al. 2005)

Boredom = The enemy of a *subgroup* of residents with dementia…

“A resident most at risk of an assault is bored!” - Administrator of a nursing home

Dorot Magazine, Israel

Free Train-the-Trainer Program (IRRL)

“Improving Resident Relationships in Long-Term Care”

There 45-min sessions: 1. Recognition 2. Managing 3. Documenting

http://citra.human.cornell.edu/irrl

CITRA – Cornell Institute for Translational Research on Aging

The SEARCH Approach: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4178932/

Teresi et al. (2013). RREM Staff intervention increased knowledge, recognition & reporting: https://pubmed.ncbi.nlm.nih.gov/23159018/

Assessment-based "Anticipatory Care Approach" (Christine Kovach)

What's in your quiver?

- Recognizing Early Warning Signs of Distress (Caspi)
- Behavioral Expressions Log (Caspi)
- R-REM Instrument (Teresi et al. 2013)
- ABRAT-L for newly admitted residents (Kim et al. 2017)
- Brøset Violence Checklist (Almvik et al. 2007)
- Evaluation of Urgency of DHRRI Form (Caspi)

- Interdisciplinary Screening Form (DHRRI & dementia-specific) (Caspi)

- Behavior Intervention Plan Form (adapted from Dr. Paul Raia)

Behavioral Expressions Log (*5WsIOS*)

Date	When?	Where?	Who?	Why?	Intervention	Outcome	Suggestion
_/_/_	Time	Location	Who was there?	Cause / Trigger	Describe intervention, if any	Describe outcome	Make a suggestion for future
What? Detailed description of the behavioral expression and what happened (sequence of events) BEFORE and AFTER the episode: _____ _____							

Persistent use of the log often enables to identify patterns, causes, and situational triggers – the basis for individualized interventions

An Instrument Developed in NHs in New York

The Gerontologist Advance Access published February 28, 2013

The Gerontologist
Cite journal as: The Gerontologist
doi:10.1093/geront/gnt001

Development of an Instrument to Measure Staff-Reported Resident-to-Resident Elder Mistreatment (R-REM) Using Item Response Theory and Other Latent Variable Models

Jeanne A. Teresi, EdD, PhD,[1,2,3] Katja Ocepek-Welikson, MPhil,[1] Mildred Ramirez, PhD,[*,1,3] Joseph P. Eimicke, MS,[1,3] Stephanie Silver, MPH,[1,3] Kimberly Van Haitsma, PhD,[4] Mark S. Lachs, MD, MPH, PhD,[5] and Karl A. Pillemer, PhD[6]

[1]Research Division, Hebrew Home at Riverdale, Bronx, New York.
[2]Stroud Center, Columbia University, and New York State Psychiatric Institute, New York.
[3]Division of Geriatrics and Palliative Medicine, Weill Cornell Medical College, New York.
[4]Abramson Center for Jewish Life, Polisher Research Institute, North Wales, Pennsylvania.
[5]Division of Geriatrics and Palliative Medicine and the Center for Aging Research and Clinical Care, Weill Cornell Medical College, New York.
[6]Department of Human Development, Cornell University, Ithaca, New York.

*Address correspondence to Mildred Ramirez, PhD, Research Division, Hebrew Home at Riverdale, 5901 Palisade Avenue, Riverdale, NY 10471.

Expert's Recommendation

"We talk about violence-free schools.

Why we don't talk about violence-free NHs?

*What about ending violence in NHs as **a policy goal**?"*

"Develop a comprehensive and data-driven

national action plan to eliminate violence in NHs"

– Karl Pillemer (2018)

Thank You

"We are not trying to get rid of behavioral distress.

What we're trying to do is to create well-being."

– Al Power

It is the human right of older adults to live in safe long-term care homes

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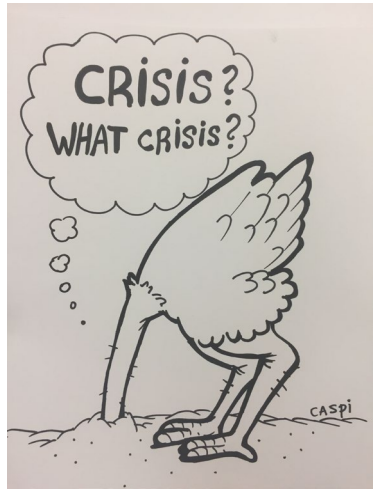
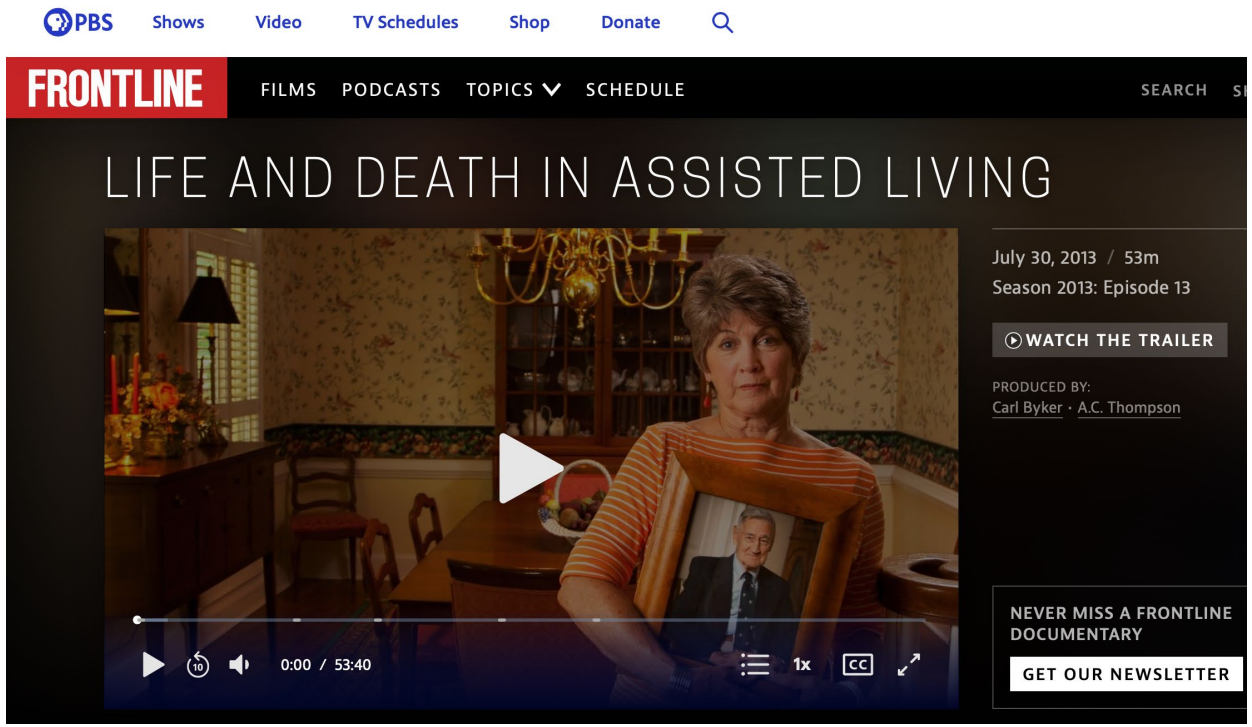
Extra Slides

Resources on Assisted Living

Caspi, E. (2018). Head in the Sand: The failure of the assisted living industry in Minnesota to Respond to **20 Years of Warning Signs** and Implement a Licensure. ChangingAging. 5.1.18: https://tinyurl.com/3764nbz4

LTCCC Webinar: Neglect leading to bodily injury and death of 300 LTC residents (3.16.22): https://nursinghome411.org/webinar-neglect/





PBS Frontline / ProPublica. 7.13.13: https://tinyurl.com/9b2dv52z

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OXFORD

On Film and Digital Media

Life and Death in Assisted Living

Eilon Caspi, PhD*

Institute for Collaboration on Health, Intervention, and Policy, University of Connecticut, Storrs, USA.

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Film: *Life and Death in Assisted Living* (53 min)

Correspondent and coproducer: A. C. Thompson

Producer: Carl Byker

Written by: Carl Byker and A. C. Thompson

Release date: July 30, 2013 (USA)

Distributor: PBS

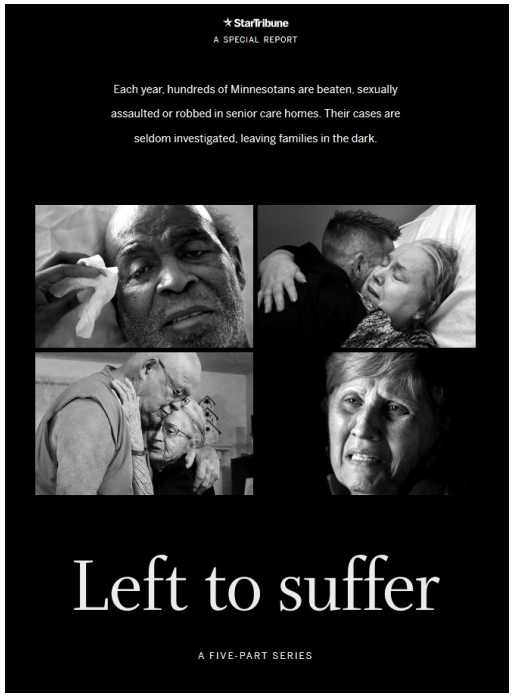
Review of the film:
https://tinyurl.com/2v4pztt8

“Earthquake” in AL sector in Minnesota

PART 1

ABUSED, IGNORED ACROSS MINNESOTA

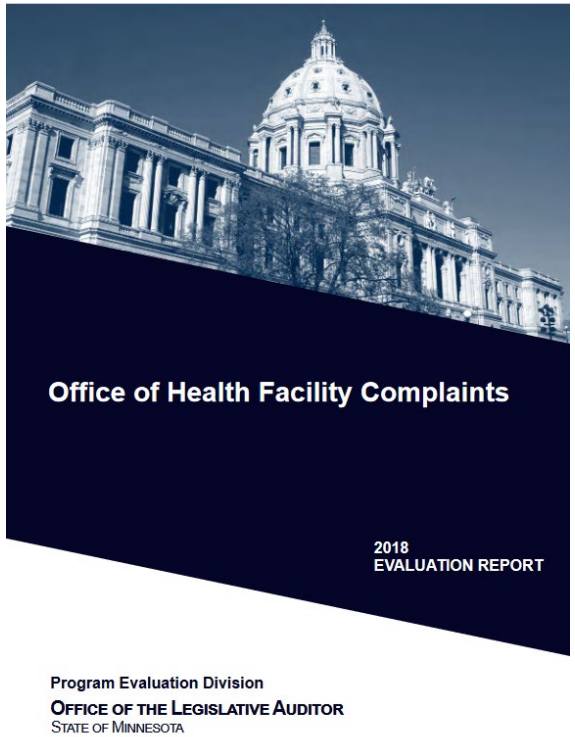
Story by Chris Serres • Photos by David Joles • Star Tribune • NOVEMBER 12, 2017



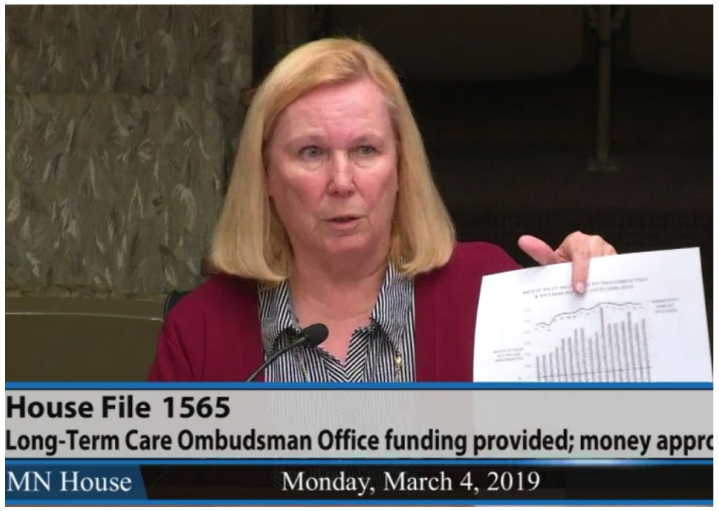
November 12-16, 2017

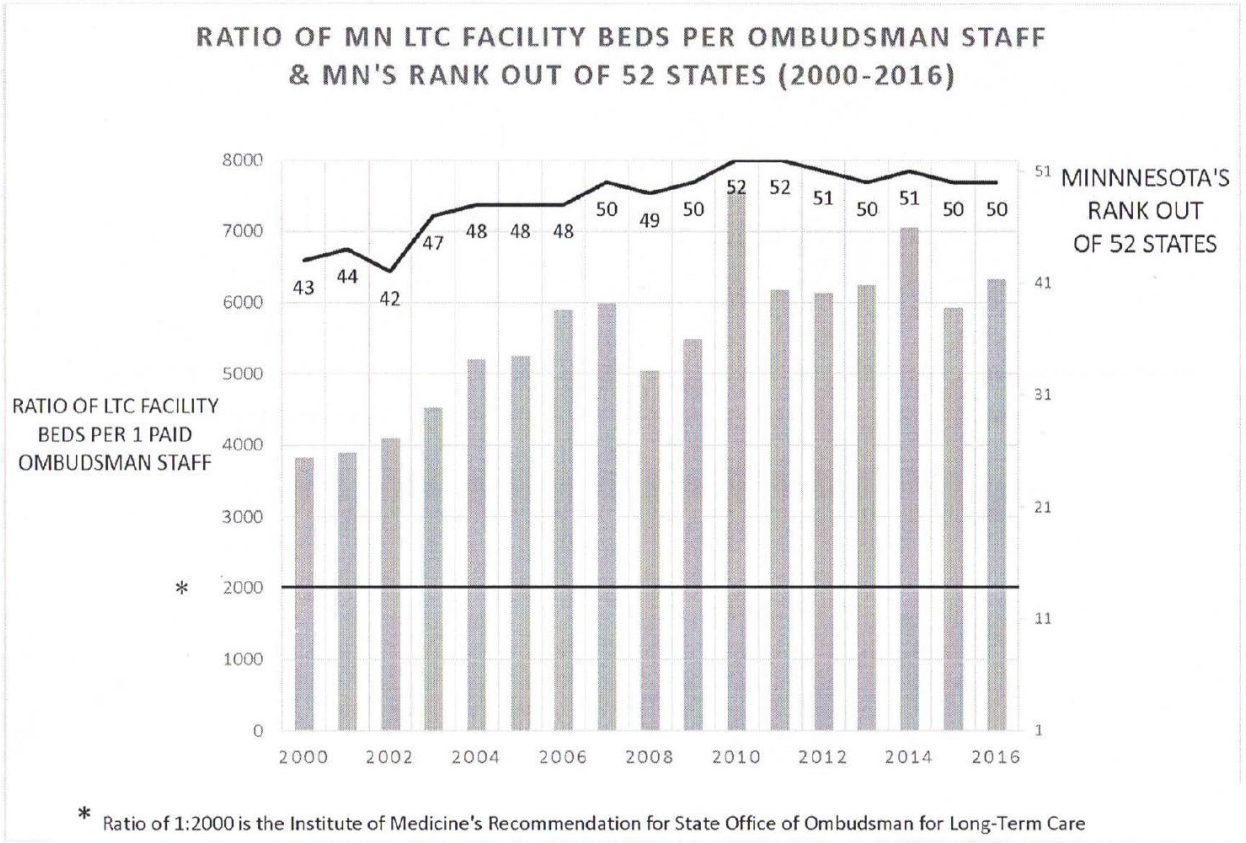
December 19, 2017

“OHFC has not met its responsibilities to protect vulnerable adults in MN”



Crisis at LTC Ombudsman in MN





Source: National Ombudsman Reporting System Data in Administration for Community Living AGing Integrated Database (AGID)

Compiled and designed by Eilon Caspi PhD for Elder Voice Family Advocates on February 17, 2019

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

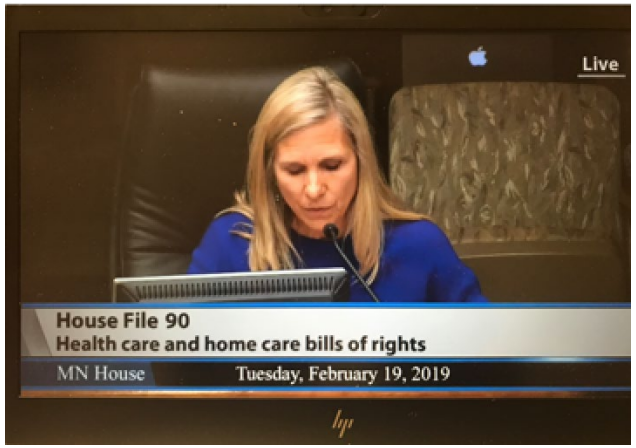
Kristine Sundberg, president of Elder Voice Family Advocates, second from left, led a group to meet with legislators. Also there are Jane Overby, Kristine Sundberg, Kay Bromelkamp, Brenda Roth and Bonnie Wenker.

From Sock, Trauma, & Grief to Leader of Change

Kris Sundberg, Executive Director, Elder Voice Family Advocates

Family Members Demand Change

Assisted Living Licensure



LOCAL

'Lives will be saved': New protections for Minnesota seniors in assisted living go into effect

Listen to this story
0:00 6:42

Nearly 55,000 seniors in assisted living gain sweeping protections.

By Chris Serres Star Tribune | JULY 31, 2021 — 3:44PM

DAVID JOLES - STAR TRIBUNE

Star Tribune, July 21, 2021: https://tinyurl.com/2p9evejm

Elder Voice Family Advocates

Close Collaboration with MDH

With Health Commissioner Jan Malcolm (center)

The Promise

ChangingAging (including voice over): https://tinyurl.com/8xrhwjvj