Harmful Resident-to-Resident Incidents

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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
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
“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

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

Higher nurse aide “caseload” = Higher R-REM
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


“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

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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
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.”

“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... gender issue It is a
"...when walking about groped the faces of other patients and was often struck by them in return."

Nothing New

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

“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
"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:


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

"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
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)
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”
“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)


“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
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): [Link](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](https://tinyurl.com/mr3s6mt3)

The wrongful death lawsuit was settled out of court (5.10.2022): [https://tinyurl.com/w7nfpm28](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/
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
“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
“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):
#1 Reason police called to nursing homes in CT

Prevalent in Minnesota

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


Frank Piccolo

https://tinyurl.com/2u7a3km8
Review of Research Literature & Canadian Dataset

“One-third of reported abuse cases”

McDonald et al. (2015):
“Appalling rates of R-R homicides”

“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.”

Ontario Health Coalition, 2019
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:
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):

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

– CTV W5

Counting Canada’s care home homicides. 9.27.13: https://tinyurl.com/8vvtvrt
"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/2p94c3p](https://tinyurl.com/2p94c3p)

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

Roommates

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](https://tinyurl.com/ywvwujax)

NY Times (7.9.14) article on sentencing of 17 years in prison: [https://tinyurl.com/d4tk38x](https://tinyurl.com/d4tk38x)
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

Recommendation #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...

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/2bdkku6p
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?”

77 y/o James Parker

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

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

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?”

"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


Animation video: https://tinyurl.com/mrw47d3f
Video tour: https://www.youtube.com/watch?v=b02d8Zpes9w
“It’s a Horror Movie”

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

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

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

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


Terra Nova Films: [http://tinyurl.com/hveq5tr](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...

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

91 y/o Jessie McKinlay with “mild dementia”
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](https://tinyurl.com/2p88e9hh)
Evaluate and Fund Assistive Technologies


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

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


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

Ageism and Autopsies

Autopsy Rate by Age in 2008

More than 2.4 million people died in the U.S. in 2008. The autopsy rate was highest for those aged 15 to 24 and lowest for those aged 65 or older.
What did a Coroner find after ordering to exhume six bodies?

Arkansas Coroner
Marc Malcolm
“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](https://tinyurl.com/j2lc5fd)
“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
Untracked in U.S. Nursing Homes

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

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, Copyright © 2013 American Medical Directors Association, Inc.
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.”

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

MN Historical Society
1\textsuperscript{st} Study on Fatal RRI in U.S. and Canada

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

Note: The letter “A” represents a resident 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.
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

“When 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”


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/

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 \((5Ws/IOS)\)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>/</strong>/</td>
<td>Time</td>
<td>Location</td>
<td>Who was there?</td>
<td>Cause / Trigger</td>
<td>Describe intervention, if any</td>
<td>Describe outcome</td>
<td>Make a suggestion for future</td>
</tr>
</tbody>
</table>

**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
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, Karja Ocepek-Welikson, MPhil, Mildred Ramirez, PhD, Joseph P. Einnicke, MS, Stephanie Silver, MPH, Kimberly Van Haisma, PhD, Mark S. Lachs, MD, MPH, PhD, and Karl A. Pillemer, PhD

1Research Division, Hebrew Home at Riverdale, Bronx, New York.
2Division of Geriatrics and Palliative Medicine, Weill Cornell Medical College, New York.
3Division of Geriatrics and Palliative Medicine and the Center for Aging Research and Clinical Care, Weill Cornell Medical College, New York.
4Department of Human Development, Cornell University, Ithaca, New York.
5Address correspondence to Mildred Ramirez, PhD, Research Division, Hebrew Home at Riverdale, 5201 Palisade Avenue, Bronx, NY 10471.
“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)
“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.
Studies and Other Articles


• Benson, J. (2012). Relational Aggression and Subjective Well-Being in Independent **Senior Living Communities**. Mather LifeWays Orange Paper.


• Brazil et al. (2013). The character of behavioural symptoms on **admission** to three Canadian long-term care homes. *Aging & Mental Health, 17*(8), 1059-1066.

• Burns et al. (2021). **Process models** to understand resident-to-resident aggression among residents with dementia in long-term care. *JAG, 40*(10), 1236-1245.

Studies and Other Articles


• Caspi, E. (2016). Deaths as a result of resident-to-resident altercations in dementia in long-term care homes: **A need for research, policy, and prevention. JAMDA, 17(1)**, 7-11. [Editorial]


Studies and Other Articles

• Caspi, E. (2013). **M.D.S. 3.0** – A giant step forward but **what about items on resident-to-resident aggression? JAMDA, 14(8), 624-625.**

• 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.**


• Castle, N.G. (2012). Resident-to-resident abuse in nursing homes **as reported by nurse aides. JEAN, 24(4), 340-356.**


Studies and Other Articles

• Ellis et al. (2014), Managing resident to resident elder mistreatment (R-REM) in nursing homes: the SEARCH approach. *The Journal of Continuing Education in Nursing, 45*(3), 112-123.


Studies and Other Articles


### Studies and Other Articles


- Rosen et al. (2008). Resident-to-resident aggression in long-term care facilities: Insights from **focus groups** of nursing home residents and staff. *JAGS, 56*(8), 1398-1408.

Studies and Other Articles


• Schiamberg et al. (2015). Individual and contextual determinants of resident-to-resident abuse in nursing homes: A random sample of telephone survey of adults with an older family member in a nursing home. Archives of Gerontology & Geriatrics, 61, 277-284


• Sifford, K.S. (2010). Caregiver perceptions of unmet needs that lead to resident-to-resident violence involving residents with dementia in nursing homes (doctoral dissertation). University of Arkansas.
Studies and Other Articles

- Teresi et al. (2013). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition, and reporting: Results from a cluster randomized trial. *International Journal of Nursing Studies, 50*, 644-656.
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/
Review of the film: https://tinyurl.com/2v4pztt8
“Earthquake” in AL sector in Minnesota

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
Inhumane and Deadly Neglect Revealed in State Assisted Living Facilities

Funded by: Stevens Square Foundation

Link: https://tinyurl.com/y6zorqzu
From Sock, Trauma, & Grief to Leader of Change

Kris Sundberg, Executive Director, Elder Voice Family Advocates
Family Members Demand Change
Assisted Living Licensure

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

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

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

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/8xrhwvj](https://tinyurl.com/8xrhwvj)