

Abuse and Neglect Investigation: Sitka Pioneer Home

Improper Response to Fall Results in Neglect of Resident

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**The Disability Law Center of Alaska
Community Integration Unit - Abuse/Neglect Investigation**

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I. General Information & Terms

The Disability Law Center of Alaska (DLC) is a private, independent, not-for-profit agency, and is Alaska's federally mandated Protection and Advocacy (P&A) system. Under its federal mandates, the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act),¹ the Developmental Disabilities Assistance and Bill of Rights Act (DD Act),² and the Protection and Advocacy of Individual Rights (PAIR) Program³, DLC has the duty and authority to investigate allegations of abuse and/or neglect involving individuals who experience a disability if the incident is reported to DLC, or if DLC determines there is probable cause that an incident of abuse and/or neglect occurred. The PAIMI and DD Acts and the PAIR Program give DLC the authority to access facilities, records, patients, staff and administration in order to complete its investigation.

The Sitka Pioneer Home is licensed as an Assisted Living Home (ALH), and authorized to serve individuals 18 years and older with a physical disability, who are elderly or suffer from dementia, but who are not chronically mentally ill.⁴ The Home is licensed to serve a maximum of 75 residents.

The Sitka Community Hospital is licensed as a General Acute Care Hospital, and certified under Medicare as a Critical Access Hospital; it is licensed for 12 beds.

The Assisted Living Home Licensing Unit is a part of Certification and Licensing. Its responsibilities include: Licensing assisted living homes according to state guidelines; investigating complaints alleging violations of state guidelines; monitoring homes to ensure they are clean, safe, sanitary and are providing meals and activities for their residents; and providing technical assistance and coordinates training to assisted living care providers.

Abuse "...means any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with ... disabilities, and includes such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue. 45 C.F.R. § 1386.19.

Complaint "...includes, but is not limited to any report or communication, whether formal or informal, written or oral, received by [DLC]... including media accounts, newspaper articles, telephone calls (including anonymous calls), from any source alleging abuse or neglect of an individual with a ... disability. 45 C.F.R. § 1386.19.

¹ Under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. § 10801 *et seq.*, DLC is mandated to protect and advocate for the rights of people with mental illness.

² Under the Developmental Disabilities Assistance and Bill of Rights Act (PADD or the DD Act), 42 U.S.C. § 6000 *et seq.*, DLC is mandated to protect and advocate for the rights of individuals with developmental disabilities.

³ 29 U.S.C. § 794e.

⁴ See <http://www.hss.state.ak.us/dph/cl/PDFs/ALHomes.pdf>.

Neglect “...means a negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with ... disabilities or which placed an individual with ... disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with ...disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff. 45 C.F.R. § 1386.19.

II. Introduction & Executive Summary

In August 2009, DLC received a complaint alleging an 80 year old resident (the resident) of the Sitka Pioneer Home (SPH) fell on June 7, 2009, and sustained a fractured hip. It was further alleged the SPH licensed nurse first on the scene failed to provide adequate and appropriate assessment and services to the resident immediately following the fall, which may have resulted in further harm to the resident. The resident, whose diagnoses included dementia, was transferred to the Sitka Community Hospital where she died 5 days later due to “complications related to hip fracture.”⁵ Following receipt of the report, DLC initiated an abuse and neglect investigation into the allegations.

As a result of the complaint received, and concerns identified during the course of its investigation, DLC sought to determine if:

- 1) the allegation of abuse and/or neglect could be substantiated;
- 2) staff responded appropriately following the resident’s fall on June 7, 2009;
- 3) SPH had conducted an adequate assessment of the resident’s previous falls;
- 4) SPH had provided appropriate and adequate services in order to prevent future falls;
- 5) SPH had provided adequate oversight to ensure medications administered to the resident by SPH staff were clinically reviewed for their safety and appropriateness.

Based on DLC’s investigation it was determined:

- 1) sufficient information was available to make a determination that neglect had occurred;
- 2) insufficient information was available to determine whether or not staff responded appropriately following the resident’s fall on June 7, 2009;
- 3) SPH failed to conduct an adequate assessment of the resident’s previous falls;
- 4) SPH failed to provide appropriate and adequate services in order to prevent future falls;
- 5) SPH failed to provide adequate oversight to ensure medications administered to the resident by SPH staff were clinically reviewed for their safety and appropriateness.

⁵ Handwritten “suspected cause of death” from resident’s Sitka Community Hospital record, “Management of Patient Death Checklist.”

III. DLC's Investigation, Findings & Analysis

In August 2009, DLC received a report that an 80 year old resident (the resident) of the Sitka Pioneer Home (SPH) fell and sustained a fractured hip. It was further reported that SPH staff failed to provide adequate and appropriate assessment or services following the fall, and that the resident died shortly after being transferred to the Sitka Community Hospital. The resident's diagnoses included: Chronic Dementia with Psychosis; Type II Diabetes Mellitus; Chronic Obstructive Pulmonary Disease (COPD);⁶ and a history of Severe Peripheral Vascular Disease.⁷

Overview

The initial report DLC received alleged the resident had experienced a fall on June 7, 2009, and the nurse first responding to the resident failed to conduct an adequate assessment of the resident before returning her to her wheelchair, thus failing to notice physical indicators that the resident may have suffered a broken hip. It was alleged the resident experienced severe pain when moved to her wheelchair, and there was concern that such movement may have exacerbated her condition.

DLC was informed the resident had been transferred to the Sitka Community Hospital. The day following her arrival at the hospital, discussions were held between the resident's primary physician, other medical staff and the resident's power of attorney. Based upon the resident's overall medical condition, advancing dementia, and additional factors, it was determined the resident was not a good candidate for surgical hip repair, and comfort measures were initiated. The resident died 5 days after her admission.

DLC initially sought to determine whether or not the allegations could be substantiated, and whether or not abuse and/or neglect had occurred. During the initial phase of the investigation, DLC discovered that the resident had experienced 3 other falls within the previous 2 weeks. It was also learned that the resident had been displaying more agitated and aggressive behaviors. DLC noted the resident had been receiving 3 psychotropic medications that posed potential risks for the resident given her age and medical condition.

Based on its preliminary findings, DLC initiated a more thorough investigation into:

- the resident's fall on June 7, 2009;
- the resident's prior falls;
- SPH's policies and procedures as they relate to fall assessments and prevention;
- medications this resident was receiving; and

⁶ Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that block airflow and make it increasingly difficult to breathe, <http://www.mayoclinic.com/health/copd/DS00916>.

⁷ Peripheral vascular disease, also known as peripheral artery disease, is a circulatory problem in which narrowed arteries reduce blood flow to one's limbs. When one develops peripheral artery disease (PAD), one's extremities, usually one's legs, don't receive enough blood flow to keep up with demand. This causes symptoms, most notably leg pain when walking, <http://www.mayoclinic.com/health/peripheral-arterial-disease/DS00537>.

- SPH’s process for reviewing medications.

During the course of its investigation, DLC reviewed the resident’s medical records and other pertinent records from the SPH as well as the Sitka Community Hospital. SPH policies and procedures were provided by the SPH, and other information related to the Home was obtained from the Pioneer Homes’ website. Telephone interviews were conducted with the Home’s administrator, director of nursing and pharmacist. The substance of those interviews is not included in this report as they were substantially mirrored in the documentation reviewed. A telephone interview was also conducted with the resident’s power of attorney.

Specific Activities and Findings:

1. Review of the Resident’s SPH and Sitka Community Hospital Records

The resident was first admitted to the SPH in August of 2007. Dementia was included in her admitting diagnoses; there was no indication the resident suffered from a mental illness. The resident’s Plan of Care described the resident as having impaired short-term memory, frequently getting lost and confused, and needing cues and reminders. She was also described as having a good sense of humor and pleasant to be around. The resident had been receiving Aricept.⁸ The medication had been discontinued in March of 2009, due to a determination that it was no longer effective.

In a note dated April 26, 2009, on a form named “Clinical Chart Review Checklist Nursing,” the resident was described as “delusional/accusatory.” In a progress note on the same date, the resident was described as going into other residents’ rooms and “telling them what to do.” The note went on to say the resident was not easily redirected, but that the episodes were “intermittent with normal behavior;” staff was to monitor.

Aricept was re-started at 5 mg per day on May 8, 2009. On the same day, Risperdal⁹ was ordered at 0.25 mg at night. A progress note dated May 12, 2009, described the resident as “actively hallucinating.” The note went on to quote various bizarre statements being made by the resident, and described the resident as yelling at people, frightening residents, going into other residents’ rooms, taking their wheelchairs and using their bathrooms. On May 16, 2009, the resident’s medications orders were changed to Risperidone (aka Risperdal) 0.25 mg in the morning and 0.50 mg at night.

A progress note dated May 20, 2009, stated the resident had been found “...by back stairs trying to go down them in her wheelchair.” The progress note went on to report the resident had gone into another resident’s room and threatened her; that she had

⁸ ARICEPT® (donepezil HCl) is used for the treatment of dementia of the Alzheimer’s type, <http://www.aricept.com>.

⁹ RISPERDAL® is an atypical antipsychotic agent indicated for the treatment of schizophrenia in adults and adolescents aged 13-17 years of age. Prescribing information for the product includes a warning that states: “Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. RISPERDAL® is not approved for use in patients with dementia-related psychosis,” <http://www.risperdal.com/safety.html>.

“punched” a certified nursing assistant in the chest; and “[t]ook a three pound dog by the neck off of another residents lap.” On the same date the resident’s Risperidone order was increased to 0.5 mg twice per day, and Aricept was increased to 10 mg at night.

On May 23, 2009, a progress note was written indicating the resident was still “actively hallucinating.” The resident was reported in her wheelchair making bizarre statements, and was “[v]ery difficult to redirect due to her delusions and hallucinations. Needs to be monitored at all times and she is going into residents rooms and yelling, frightening them.” The note concluded with a recap of the recent increase to her Risperidone with “No apparent change in her behavior, it appears to have worsened.”

According to the resident’s Sitka Community Hospital records, she was admitted to the hospital on May 23rd in response to her increasing dementia and escalating behaviors; she was discharged on May 28, 2009. Noted in her discharge summary was: “Initiation of Risperidone with increased dosage did not improve her behavior and in fact possibly was related to development of hallucinations...Shortly after admission the patient was found on back stairwell sitting with wheelchair on the steps; patient had small frontal contusion.”

Seroquel¹⁰ was added to the resident’s drug regimen on May 28, 2009, at 75 mg in the morning and 50 mg at night. Hydroxyzine,¹¹ was added on the same day to treat the resident’s anxiety. The dosage was 10 mg, 3 times per day.

The next set of progress notes for the resident are in response to falls she experienced on May 29th, June 4th, 5th and 7th, 2009. The fall on June 7, 2009, resulted in the resident being transferred and admitted to the Sitka Community Hospital.

Nothing was found in the resident’s SPH record indicating licensed nursing staff, who were administering medications to the resident, raised any questions or concerns to the resident’s physician regarding use of either Risperdal or Seroquel, although each had black box warnings indicating they were not approved for elderly patients with dementia-related psychosis.¹² Equally absent were any questions or concerns by licensed nursing staff regarding the addition of Hydroxyzine, which may have side effects such as dizziness, drowsiness, sleepiness, or confusion, blurred vision or a dry mouth, nausea or vomiting, that could increase the resident’s risk for falls.¹³

¹⁰ SEROQUEL® (quetiapine fumarate) is used for the treatment of schizophrenia and the acute treatment of manic episodes associated with bipolar disorder. Prescribing information for the product includes a warning that states: “Increased Mortality in Elderly Patients with Dementia-Related Psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk for death. SEROQUEL (quetiapine fumarate) is not approved for the treatment of patients with dementia-related psychosis,” <http://www1.astrazeneca-us.com/pi/Seroquel.pdf>.

¹¹Hydroxyzine is a piperazine derivative that is used as an antihistamine (especially for itches), anti-emetic (nausea reducing), and anxiolytic (anxiety reducing) drug, http://www.hydroxyzine.com/hydroxyzine_other.html.

¹² See <http://www.risperdal.com/safety.html> and <http://www1.astrazeneca-us.com/pi/Seroquel.pdf>.

¹³ See http://www.hydroxyzine.com/hydroxyzine_sideeffects.html.

DLC could also find nothing in the resident's record indicating that her power of attorney had been informed of the risks and benefits of the additional medications that were prescribed for and administered to the resident.

The resident's hospital records indicated that on the day following her admission for a fractured hip, two physicians assessed the resident as not being a good candidate for surgical repair because the resident would be placed at too high a risk for complications versus the potential benefits from surgery. The resident's primary physician discussed the risks and benefits of surgery with the resident's power of attorney (POA), and the POA agreed with the decision. Without surgery it was anticipated the resident would be bed bound for 1-2 weeks, but would potentially be able to bear weight after 4-6 weeks.

According to the resident's hospital record, she was medically stable for the first couple of days following her admission. Shortly thereafter, it was noted the resident became increasingly unresponsive, and was placed on comfort measures in accordance with the POA's direction and the physician's orders. It was suspected the resident may have had pneumonia. Five days after her admission, the resident died. As noted, the cause of death listed on the hospital's Management of Death Patient Checklist was "complications related to hip fracture."

2. Review of Falls

May 29, 2009

A progress note dated May 29, 2009, reported SPH staff "...discovered the resident in a semi-sitting position on the floor in the hallway on 2N. Her pants were partially down and there was a very strong odor of feces in the air. Resident denies any [complaint of] pain or discomfort...Appears that [the resident] was trying to defecate in the hallway on the floor and fell while trying to pull down her pants...Also of note: staff report that the Wander Guard¹⁴ placed by Maintenance/Staff this afternoon [is] no longer on her wrist and is unable to be found."

June 4, 2009

On June 4, 2009, a progress note stated the resident had been found at 5:45 am with a bruise under her left eye. An assessment by a registered nurse noted the resident was in her wheelchair, holding her left side, under her left breast, and was unable to take a deep breath without discomfort or grimacing. The nurse reported there were no other outward signs of injury. Various SPH staff were notified and the resident was to be monitored until she could be seen by her physician.

¹⁴ WanderGuard is a brand name for an electronic device which, depending on the model and features selected, can alert facility staff as to the location of the individual wearing the device, as well as provide other safety measures, <http://www.stanleyhealthcare.com/solutions/resident-safety/wander-management/wanderguard>

June 5, 2009

A progress note dated June 5, 2009, indicated the resident was observed falling down in a hallway as she was coming out of her room. The resident was on her back, able to move her lower extremities, complaining of right sided waist pain. No redness was noted, however the area was tender to the touch. Her power of attorney and physician were notified.

On June 6, 2009, a progress note indicated the resident appeared to be feeling better, and was "...able to ambulate with two person assist to [the bathroom] and bed. [Complained of] left sided pain...Still not making sense with her talk. Needs close supervision. Will monitor closely."

June 7, 2009

On June 7, 2009, a progress note reported staff finding the resident on the floor "...after hearing her yelling." The reported time was 5:40 pm. The resident was described as "...lying perpendicular to the leg rests on her [wheelchair]. Appears to have gotten up out of [wheelchair] without assist (again) and tripped over the leg/foot rests. [The resident] complained of only pain in her lower back and did not [complain of] left foot/leg pain until returned to her [wheelchair] and feet were put back on the foot rests. At that time it was noted that her left foot was rotated almost 45 degrees outward." Various SPH staff were notified as were the resident's power of attorney and physician. The resident was taken by ambulance to the Sitka Community Hospital, where she was later diagnosed with a fractured left hip.

SPH Falls Assessment

DLC staff requested policies and procedures used by the Home for the purpose of assessing falls. What was provided included a document entitled "Pre-admission Screening," "P&P No: NUR-020," with an effective date of June 2007. According to the document, the screening was to be completed by a social worker or his or her designee. One of the discrete elements of the tool was "fall risk." Further review of the assessment tool showed that the evaluation of fall risk was limited to identifying whether or not the resident had ever fallen, how many times, whether or not there was a history of multiple falls and/or fractures, and whether or not the resident required assistance at night.

Another document provided by the Home was entitled "Fall Response," "P&P No: NUR-091," with an effective date of June 2007. The document began by stating "It is the policy of SPH to assess resident and prevent further injury following a fall." Initial instruction to staff was that the resident was not to be moved until directed by a nurse. Staff were given instructions on what to do until a nurse arrived.

Instructions to nurses included "Assess the resident for injury and the environment for clues as to cause of fall. This may include head to toe assessment prior to any move. Will direct all movement of resident, including transfers and transport. The policy closed

with a statement that the Risk Manager would “...review all incident reports and follow up as necessary per Unusual Occurrence Policy and Procedure.”

A related document provided by the Home was part of the “Alaska Pioneer Homes Policy and Procedure Manual” and the section provided was entitled “Part D: Emergencies and Other Unusual Occurrences.” Under subsection “3D2. Incident Response and Reporting,” “5.0 – Definitions: Incident - Any occurrence, untoward event, condition or situation which is not consistent with the routine safe operation of the Home, or is not an expected consequence of routine resident care or clinical procedures. Examples include: resident falls or other injuries...” According to the document if an incident occurred appropriate staff were to complete the applicable sections of the “QA form.”

Review of Quality Assurance Tool

For falls, the QA tool is primarily a check-the-box instrument, with an opportunity for a narrative and narrative supervisory review at the end of the form. The first set of questions is “Type of Fall,” and the instrument instructs “Nurse **MUST** select one choice from below:” regardless of whether or not the fall was witnessed. Choices include: during ambulation; during transfer; from bed; from toilet/commode; from chair; from wheelchair; unknown.

The next section instructs “If **FALL**, then Nurse **MUST** select one “Observed Cause” choice from below:” Again, this direction is regardless of whether or not the fall was actually observed. The choices include: wet floor; balance issue; improper footwear; unstable floor; cognitive status; physiological factor; human factor; other.

The form next instructs “If **FALL**, the Nurse **MUST** select one “Patient Related Factor” choice from below:” This direction is regardless of whether or not the fall was actually observed. The choices include: bowel & bladder problem; physically weak; visually impaired; medication; impulsive; acute illness; chronic illness; other.

The next section instructs “For **ALL** Incidents, Nurse **MUST** select one “Health Related Factor” choice from below:” The choices include: hearing deficit; change in med dose; chronic med usage; mental health issue; movement disorder; osteoporosis; dementia; diabetic; dizziness; flu; head injury; dehydration; hip; hypotension; med error; confusion; cancer; fracture; new med; COPD (Chronic Obstructive Pulmonary Disease); stroke; TIA (transient ischemic attack);¹⁵ UTI (Urinary Tract Infection); NA (Not Applicable).

Next on the form comes a section for narrative in response to the question: “Describe if resident is experiencing an acute condition? For instance, a UTI, change in medication, room move, etc.:”

¹⁵A transient ischemic attack (TIA) is like a stroke, producing similar symptoms, but usually lasting only a few minutes and causing no permanent damage. Often called a ministroke, a transient ischemic attack may be a warning, <http://www.mayoclinic.com/health/transient-ischemic-attack/DS00220>.

After that is a section asking the writer to describe the injury (if any). The next section is for “Disposition,” (another check the box format), with a place to write who was contacted regarding the disposition, the date and time the contact occurred.

The next section is an opportunity for narrative, entitled “Nursing Report and actions taken (to be completed by the Licensed Nurse).” The following section is similar, and is entitled “SUPERVISORY REVIEW, Interventions, and follow up action (to be completed by supervisor/ALC.”

Analysis

According to the SPH records, 3 of the 4 falls experienced by the resident, and referenced above, were unwitnessed. Only the fall occurring on June 5, 2009, was witnessed. Despite this, the form SPH nursing staff are directed to use **requires** they select causal factors, even when the fall was unwitnessed. The assessment tool utilized by SPH (i.e., the Quality Assurance Tool) does not lend itself to a comprehensive review of possible risk factors and causes that may help in determining why a resident experienced a fall, and by extension, how future falls might be avoided. For example, while the QA tool offers “medication,” “chronic med usage” and “new med,” as boxes to be checked, none of the assessments for the 4 falls that occurred in the period of 10 days spoke to the fact that the resident had, just before the falls occurred, been placed on 4 new medications, all of which had potential side effects that could result in the resident being placed at a higher risk for falls.

For example:

- “Aricept may cause slow heartbeat and fainting. This happens more often in people with heart problems,” <http://www.aricept.com/importantsafetyinfo.html>.
- “Some people taking RISPERDAL[®] may feel faint or lightheaded when they stand up or sit up too quickly. High blood sugar and diabetes have been reported with RISPERDAL[®] and similar medications. The most common adverse reactions observed in all clinical trials with RISPERDAL[®] occurring at a rate of at least 10% were somnolence, increased appetite, fatigue, rhinitis, upper respiratory tract infection, vomiting, coughing, urinary incontinence, increased saliva, constipation, fever, tremors, muscle stiffness, abdominal pain, anxiety, nausea, dizziness, dry mouth, rash, restlessness, and indigestion. RISPERDAL[®] may affect alertness and motor skills; use caution until the effect of RISPERDAL is known,” <http://www.risperdal.com/sites/default/files/shared/pi/risperdal.pdf>.
- Seroquel warnings include the possibility of orthostatic hypotension with symptoms such as dizziness, tachycardia (faster than normal heart rate), and syncope (sudden, brief loss of consciousness), <http://www1.astrazeneca-us.com/pi/Seroquel.pdf>.
- “Side effects from hydroxyzine may include: dizziness, drowsiness, sleepiness, or confusion, blurred vision or a dry mouth, nausea or vomiting,” http://www.hydroxyzine.com/hydroxyzine_sideeffects.html.

Although there were numerous notes indicating the need for constant monitoring by staff due to the resident's increasingly bizarre behaviors (which were also reported to be frightening other residents), unsafe behaviors (e.g., note of May 20, 2009, "Resident attempting yesterday to get down cement steps in her [wheelchair]), and defecating in other residents' rooms and in places such as her closet, there is no clear evidence higher levels of staff monitoring occurred, or occurred with sufficient intensity to mitigate the behaviors referenced above.

Despite the resident's significant change in behaviors that resulted in her frightening other residents and placing herself at risk for injury, no changes had been made to her "Daily Care Plan" in the areas of transfers, toileting, bathing, grooming/dressing & undressing and night plan. Each of those areas indicated the resident was still independent in her functioning. Under "behaviors & approaches," the resident was described as "appropriate." According to the last date found, the plan had last been reviewed and approved on June 4, 2009. It was not clear if changes had been made to any other area of the care plan.¹⁶

Specific Review of Fall of June 7, 2009

As noted earlier, DLC received a specific allegation regarding the resident's fall on June 7, 2009, which resulted in her broken hip and transfer to the Sitka Community Hospital. The allegation was that the first nurse who responded to the resident after she fell failed to conduct an adequate, initial assessment of her injuries and status.

Specifically, it was alleged the nurse failed to complete a head-to-toe visual assessment, and therefore did not notice that the resident's left leg was "...rotated almost 45 degrees outward," and inappropriately directed staff to assist him in returning the resident to her wheelchair, causing extreme pain and possibly exacerbating her injuries.

DLC requested and received SPH documents related to their internal investigation into the allegation above. Interviews with SPH staff about the incident were documented. From those documented interviews it appeared 1 staff member (a Certified Nursing Assistant or CNA) who was present reported the nurse as not having conducted an assessment before directing the resident be placed back in her wheelchair; another CNA did not report if she did or did not believe the nurse conducted an assessment; and the nurse indicating he did conduct an assessment.

The SPH's administration concluded that there were inconsistencies in what was reported, and therefore there was "insufficient evidence to substantiate any allegation of misconduct..."¹⁷ A determination was made, however, that the nurse should enroll in and satisfactorily pass specific continuing education courses (i.e., Fall Assessment and

¹⁶ Unlike nursing homes, who are required to re-assess a resident and update the plan of care anytime the resident experiences "significant change" (*See* 42 C.F.R. § 483.20), assisted living homes are required only to evaluate and update assisted living plans at one-year intervals, or every 3 months if health-related services are provided (*See* A.S. 47 § 33.240).

¹⁷ Taken from letter dated September 1, 2009, from SPH Administrator to DLC investigator.

Prevention; Acute and Chronic Pain: Assessment and Management; Focused Gastrointestinal Assessment; Focused Neurological Assessment; and Focused Pulmonary Assessment).¹⁸

Analysis

As was mentioned earlier in this report, DLC reviewed the SPH's "Fall Response" policy (*see* page 10 of this report). In light of what occurred to this resident on June 7, 2009, the less than certain understanding of the degree to which the responding nurse evaluated the resident before instructing she be placed back in her wheelchair, and the fact that the SPH serves numerous residents who are at a higher risk for falls and subsequent serious injuries, DLC is concerned the SPH policy is lacking in breadth and direction for post-fall assessment.

Specifically, the assessment piece of the "Fall Response" policy is limited to: "Assess the resident for injury and the environment for clues as to cause of fall. This may include head to toe assessment prior to any move." As written, the assessment of the environment appears required, while assessment of the resident appears optional. Given that SPH residents are at a high risk for injuries should they fall, and that those with dementia are often unable to adequately or accurately convey injury or pain, DLC believes a head to toe assessment of a fallen resident should be a required aspect of a fall response instead of an optional component.

Note: While DLC found the assessment tool and process utilized by SPH for falls less than comprehensive, a review of the course materials for the "Fall Assessment and Prevention" remedial training required for the nurse as noted above shows that they are very comprehensive.

3. Review of Neurobehavioral Evaluations

A neurobehavioral assessment was conducted by a consultant on May 29, 2009 (prior to the fall occurring on the same day). The clinician wrote: "[Resident] was reported as being on Aricept for several years [without] significant benefit. Her Aricept was [discontinued] on 03/20/09 but she became agitated and aggressive. She was resumed on Aricept on 05/08/09 [5 mg per day] and Risperdol [0.25 mg at night] her behavior has continued to be aggressive and with delusions and hallucinations; on 5/16/09 she attempted to strangle a dog in residence. Upon questioning today, [the resident] is profoundly disoriented, disorganized/nonlinear in her thinking, confabulatory, perseverative on being abducted/kidnapped, delusion (i.e., paranoid), but denied auditory hallucinations."

Diagnostic impressions included ruling out Acute Confusional State/Delirium and a Vascular event producing agitation and fluent aphasia (aphasia being a defect or loss of expression by speech; fluent aphasia being where speech is well articulated and

¹⁸ The required courses are offered through rn.com, AMN Healthcare Education Services, <http://www.rn.com>.

grammatically correct but is lacking in content). The plan included another clinician was to evaluate the resident in 3 days, specifically her psychotropic medications.

The second evaluation was conducted on June 1, 2009. The psychiatrist described the resident as a "...75 year old woman with dementia who developed delirium and a worsening of her dementia about six weeks ago when her aricept was discontinued after she had been on it a couple of years. Since then the patient has gone back on and off of Aricept, on and off of Risperdal, and is currently on Seroquel 75 mg in the morning and 50 mg at bedtime. She did not appear to have any medical factors or other exacerbating factors at this time."

Under his Mental Status Exam the psychiatrist wrote: "...patient was sitting in a wheelchair very alert and aware. She appeared somewhat pale, but there was no tremor or gross weakness. Her conversation was essentially nonsense indicating severe dementia, and some emotion volatility was noted – she quickly went from an angry, threatening expression to laughing."

Under "recommendations" the psychiatrist wrote: "Most likely explanation for her delirium was the discontinuation of Aricept. She continues to have problems but there is a general sense that she may be stabilizing at this point. Aricept works through the acetylcholine system, and in general, it is a good idea to avoid any medications which decrease acetylcholine (anti-cholinergic medicines) in patients with dementia. In this case, I would taper off hydroxyzine [which has anticholinergic properties] and Seroquel as tolerated. I would consider the use of antipsychotic medicines in elderly demented patients to only be in emergency situations to control behavior when no other measures work. The blackbox warning on antipsychotic medicines indicate that they may hasten cognitive decline and shorten life expectancy in elderly demented patients. I might have recommended that Aricept be resumed, but it seems in this case that that has already been tried and it did not help. So perhaps it is better to just let time run its course in that respect, with hopes that she will continue to stabilize."

According to the resident's medication administration record, Aricept was not reordered on May 28, 2009. Hydroxyzine was discontinued on June 5, 2009. Also on June 5th, contrary to the recommendation by the psychiatrist, the physician increased the resident's Seroquel from 75 mg to 100 mg in the morning, and from 50 mg to 75 mg at night. According to the resident's "Treatment Sheet," she was also moved to a locked dementia unit on May 28, 2009.

4. Pharmacy Program & Pharmacy Reviews

Located on the State's Pioneer Homes website is a link to the Pioneer Homes Pharmacy Booklet (<http://hss.state.ak.us/dalp/docs/onlinePharmacyProgram.pdf>). The Introduction and Benefits pages of the booklet state the following:

The Pioneer Home Pharmacy program provides pharmaceuticals and pharmacist consultation for the residents of Alaska Pioneer Homes. The

pharmacy and staff are located in the Anchorage Pioneer Home. Staff members include licensed pharmacists, pharmacy technicians, and billing personnel.

The Pioneer Home Pharmacy program includes several beneficial services:

1. Pharmacists and pharmacy staff work in conjunction with other staff members and are dedicated to serving the Pioneer Home residents.

The primary benefit of having a single-source pharmacy program is to have on-staff pharmacists with knowledge, experience, background and interest in geriatric pharmacy. Prescriptions for Pioneer Home residents are appropriately filled, packaged, and delivered daily. The Pioneer Home pharmacists provide the following services:

- a) Clinical review of residents' medication regimens – our pharmacists review all medications a resident takes to help ensure that risks of interactions and side effects are minimized.
- b) Communication with residents' healthcare providers concerning medication regimens.
- c) Staff education concerning medications.
- d) Overall quality assurance program.
- e) Resident/family education concerning medications.

DLC requested a copy of the drug regimen or pharmacy review for the resident. Pharmacy chart reviews were found for February 21, 2008; November 14, 2008; and April 28, 2009. Those reviews appeared to adequately assess the medications being taken by the resident during the period of review, raising questions and indicating communication with medical staff appropriately.

The period between chart reviews varied (i.e., the time between the first review and the 1 that followed was approximately 9 months; the time between that review and the 1 that followed was approximately 5 months). DLC was unable to determine how the pharmacist was made aware of changes to residents' medication orders between chart reviews. Pharmacist reviews for this resident, for example, included comments on medication changes on May 13th, May 18th, and May 23rd, with a final note on June 8, 2009, after the resident had already been transferred to the Sitka Community Hospital (see below).

Prior to another full chart review were the following notes by the pharmacist:

Started on 5/13/2009 risperidone 0.25mg at bedtime and donepezil [Aricept] 5mg daily; discontinued ambien. (Per provider note of 5/8/09: "Per Staff since about late 3/09 coincidine (sic) with DC [discontinued]

Aricept, increase paranoia, aggressive behavior, legs restless... On questioning on orientation [resident] states “no idea” time, place, ...”

5/18/2009 Risperidone increased to 0.5mg twice a day after a psychiatric consult and increased donepezil [Aricept] to 10mg at bedtime. (Per nursing staff observations: “resident attempting yesterday to get down cement steps in her [wheelchair]. Today punched a [Certified Nursing Assistant], took a 3 lb dog off another residents lap, called a resident “There is one of the murders,” went into a residents room – “if you don’t let me in I will shoot you” & another room “I have come to take the baby.” Resident just had Aricef re-started about 2 weeks ago.

5/21/2009 – Resident moved to dementia neighborhood.

5/23/2009 – Risperidone discontinued and quetiapine [Seroquel] started at 75mg [by mouth] every morning and 50mg at bedtime.

6/8/2009 – Quetiapine [Seroquel] increased to 100mg every morning and 75mg in the evening.

Of the records received by DLC, nothing could be found that:

- showed evidence that the pharmacist brought any questions or concerns forward regarding the introduction of Risperdone, even though there are manufacturer’s black box warnings about its contraindications for elderly, demented individuals. Included in the warnings are increased mortality and side effects that may make the individual more prone to falls.
- showed evidence that the pharmacist was aware of the physician’s order for Seroquel on May 28th, which was increased on June 5, 2009. As with Risperdone, there are manufacturer’s black box warnings about the use of Seroquel with elderly, demented individuals. Included in the warnings are increased mortality and a statement that the medication is not approved for the treatment of patients with dementia-related psychosis.¹⁹ Additional warnings²⁰ include the possibility of orthostatic hypotension with symptoms such as feeling lightheaded or dizzy after standing up, confusion, weakness, tachycardia (faster than normal heart rate), and syncope (sudden, brief loss of consciousness).²¹ The only mention by the pharmacist regarding the use of Seroquel was a note dated June 8, 2009, a day after the resident had been transferred to the hospital following a fall and broken hip. That note was limited to acknowledgement that the initial dosage had been increased.
- showed evidence that the pharmacist was aware of the physician’s order for Hydroxyzine that was also added to the resident’s medication regimen on May 28th. The

¹⁹See <http://www1.astrazeneca-us.com/pi/Seroquel.pdf>.

²⁰ *id.*

²¹ See <http://www.mayoclinic.com/health/orthostatic-hypotension/DS00997/DSECTION=symptoms>.

manufacturer's list of possible side effects include dizziness, drowsiness, sleepiness, confusion, and blurred vision that may place the individual at increased risk for falls.²²

While it appears the SPH has a system that alerts the pharmacist to changes in medications between full chart reviews, for this resident, the system was not sufficient to alert the pharmacist to the changes noted above, or ensure the pharmacist conducted an adequate clinical review.

5. Resident's Right to Participate in Decisions Regarding Care

Unlike nursing facilities or nursing homes that have regulations that specifically state a resident's right to refuse treatment, participate in treatment decisions, and receive information about medications and treatment,²³ regulations governing assisted living homes and Pioneer Homes do not. Nevertheless, in the Pioneer Homes' brochure entitled "A Matter of Rights," the following statement is found:

① **Residents' Rights**— In an assisted living home you, of course, have all the legal rights which you enjoyed before you came to live here. The rights on the following pages reemphasize those personal rights you've always had. They include your right to privacy and your right to be involved in decisions regarding your care.

Part of a resident's care is arguably the medications prescribed, and in order to make informed decisions regarding one's care, one must be informed regarding what the risks and benefits of treatment options and or decisions are, including those for medications.

Given the clear and consistent documentation showing the resident's cognitive decline, she was dependent on licensed nursing staff regarding the medication they were administering (i.e., SPH licensed nursing staff were administering the resident's medications versus assisting her to take her medications). Also, because of the resident's cognitive decline, she was not in a position to make informed decisions about her care, and so her right to be involved in such decisions fell to her legal representative, in this case, her power of attorney.

In the documents DLC reviewed, nothing was present that indicated the resident's power of attorney was ever informed of the introduction and subsequent administration of Seroquel, Risperdone or Hydroxyzine. As was noted earlier in this report, each of those medications had the potential for significant side effects, and both Seroquel and Risperdone had black box warnings indicating their risks for increased mortality and that they were not approved for use for elderly patients with dementia-related psychosis.

During an interview with the resident's power of attorney, it was confirmed that she never received written notice or verbal information that the resident was receiving the above medications, nor was she informed of the risks and benefits of those medications.

²² See http://www.hydroxyzine.com/hydroxyzine_sideeffects.html.

²³ See 7 A.A. C. § 12.890 and 42 C.F.R. § 483.10.

6. Report to State Licensing & State Licensing's Response

DLC received and reviewed the "Mandatory Incident/Notification Report" submitted by SPH staff to the State's Certification and Licensing unit. In addition to identification of the resident, the date, time and location, was an area for describing the incident/emergency. In that section the SPH nurse wrote: Resident found lying perpendicularly on floor to [wheelchair] footrests. Physical evidence & past history suggests [the resident] got up out of [wheelchair without] assist & fell over footrests, landing on [left] side/hip.

The next section of the form asked the writer to describe the precipitating circumstances. In that area the nurse wrote "Dementia."

The following section asked the writer to describe the action(s) taken. In that area the nurse wrote: "Removed from floor [after] resident denied any pain [except] in low back (obvious injuries/falls). [Resident complained of] severe pain in [left] leg [after] trying to [raise] it on footrest. [Left] foot rotated slightly outward."

Under follow up action to be taken was a note the resident was sent to the Sitka Community Hospital by ambulance. Last on the form was a note that the resident's primary physician and power of attorney were contacted, with the nurse's signature and date.

Along with the Notification Report, it appears the SPH Quality Assurance Tool for the incident was sent. Section 1 of the form is entitled "Observer's Description of Incident: (to be completed by the first staff to discover the incident/error)."²⁴ Written in that section was the following: "The resident was screaming. The resident was found on the floor right next to her chair. Left hip/bottom on the floor. Complaint of pain especially when we move her left leg." A box was marked in the section indicating the fall was not witnessed.

The box checked for "Type of Incident" was "fall." The box checked for "Type of Fall" was "From Wheelchair." The box checked for "Observed Cause" (although it wasn't observed) was "Cognitive Status." The box checked for "Patient Related Factor" was "Impulsive." The box checked for "Health Related Factor" was "Dementia." Under "Describe if resident is experiencing an acute condition?" was written "None," even though the resident had been actively hallucinating, delusional and had experienced 3 other falls in the weeks preceding this incident.

Under "Describe Injury" was written: [Left] foot rotated outward & [complaint of] extreme pain when [left] leg lifted to place on foot rest."

²⁴ This incident was reported as an unwitnessed fall. While the individual filling out this section of the QA Tool appears to have been the first staff to find the resident, she did not witness the fall. DLC believes the title of the section, therefore, is misleading to a reader (i.e., "Observer's Description of Incident").

The above documents were faxed to the individual licensing staff assigned to the SPH, with a note stating “Resident was hospitalized for [left] hip fracture.” The facsimile copy was sent to licensing on June 8, 2009. Based on the records DLC received, the only other documented contact SPH had with licensing regarding this incident was an update, dated June 17, 2009. The note on the facsimile cover sheet read: “[The resident] – Did [fracture] hip & sent to hospital. Went into total system failure. Resident put on comfort care and deceased.” Four (4) other documents appear to have accompanied the cover sheet, however DLC does not know what those documents were.

DLC contacted Assisted Living Home Licensing to determine whether or not they had initiated or conducted an investigation into the incident. DLC’s letter to Licensing was dated August 5, 2009, and included the following:

We have received a report that, in the past few months, a resident of the Sitka Pioneer Home died following an accident. To elaborate, we were informed a resident recently experienced a broken hip and sometime shortly thereafter, passed away. We were further informed that there was some question as to whether or not the broken hip was avoidable (i.e., possible abuse or neglect in relation to the action or in-action of one or more staff providing care), and the possible relationship between the resident’s broken hip and subsequent death. It was also reported that your office was conducting an investigation into the incident.

In a letter dated August 17, 2009, Licensing’s Program Manager wrote back indicating: “In review of the incident report and other available information we did not determine a violation of licensure occurred and will not be issuing a report of investigation at this time.”

IV. Summary, Conclusion and Recommendations

DLC received a complaint alleging the nurse first on the scene after a resident fell had not conducted an adequate assessment before directing she be placed back into her wheelchair. As a result of the fall, the resident broke her hip, was transferred to the hospital, and died 5 days later. The suspected cause of death was “complications related to hip fracture.”²⁵ It was further alleged there was a possibility that the trauma experienced by the resident by having been placed back into her wheelchair prematurely and/or when it was not appropriate, resulted in increasing her injuries, pain and emotional distress, and potentially contributed to her death.

Based on the records received, the resident, who had come into the Home with a diagnosis of dementia, was displaying increasingly bizarre behaviors, thought by professional staff and others to represent hallucinations, delusions and psychosis. These behaviors were reported to be frightening to other residents, resulting in the resident entering other residents’ rooms without permission, and placing the resident, other residents and staff at risk for injury or harm.

Sitka Pioneer Home staff investigated the actions of the nurse referenced above, and found there was insufficient evidence to show that the nurse had acted outside the Home’s policies or nursing standards of practice. Their inconclusive investigation notwithstanding, administrative staff directed the nurse to enroll in and successfully complete certain continuing education courses. The Home had notified Assisted Living Home Licensing of the incident, as required.

During DLC’s investigation, the resident’s records were reviewed from both the Home, as well as the Sitka Community Hospital. Certain of the Home’s policies and procedures were reviewed, as well as various assessment forms. DLC staff also interviewed SPH staff as well as the resident’s power of attorney.

As was noted earlier in this report, DLC found the Home’s policies, procedures and assessment tools for resident falls to be insufficient for conducting a thorough and adequate assessment to determine how and why the resident fell, and to prevent future falls. DLC was also concerned about certain psychotropic medications ordered for and administered to the resident. Two of these medications, Seroquel and Risperdone were of particular concern to DLC in that both had manufacturer’s black box warnings of increased mortality and were not approved for treating dementia-related psychosis in the elderly. In addition, both medications, as well as Hydroxyzine that was also prescribed, had potential side effects that could have increased the resident’s risk for falls and exacerbated her other symptoms. DLC could find nothing in any of the records it received where the SPH pharmacist or licensed nurses questioned the use of these medications, or ensured the resident’s legal representative received information regarding their benefits and risks.

²⁵Handwritten “suspected cause of death” from resident’s Sitka Community Hospital record, “Management of Patient Death Checklist.”

Based on its investigation and the information available, DLC determined neglect²⁶ had occurred as a result of the Home's failure to:

1. conduct a comprehensive assessment of the resident's falls, which if adequate assessment(s) had been conducted, may have prevented or mitigated the potential for future falls;
2. provide sufficient supervision of the resident to ensure her safety as well as the physical and emotional safety of other residents;
3. update the resident's plan of care in response to the changes in the resident's behavior;
4. ensure the Home's pharmacist and/or licensed nursing staff clinically reviewed and evaluated the medications being administered to the resident to, at the very least, ensure the resident's legal representative was informed of the risks and benefits of medications that placed the resident at higher risk for increased mortality and side effects that could place her at greater risk for falls.

Specifically, DLC determined the above omissions by individuals responsible for providing treatment (the SPH) caused or may have caused injury or death to the resident (individual with disabilities), or placed the resident at risk of injury or death.

Recommendations

Based on its finding of neglect, DLC recommends the Sitka Pioneer Home take the following actions:

1. Develop and implement policies and procedures to provide a more comprehensive evaluation of resident falls. If such assessment utilizes a falls evaluation form or tool, it is recommended a different tool than what is currently in use be developed and utilized. DLC recommends that the SPH look to the training materials from the Fall Assessment and Prevention through rn.com, AMN Healthcare Education Services, as a starting place for revising its falls evaluations and protocols.
2. Develop and implement policies and procedures for the ongoing review of medications residents of the Home are receiving to ensure the services promised under the Pioneer Home Pharmacy program occur on an ongoing basis.
3. Develop and implement policies and procedures that indicate under what circumstances a resident's plan of care should be updated.
4. Develop and implement policies and procedures to ensure residents or their legal representatives are fully apprised of the care, services and treatment options they receive in the Home, including medications, risks and benefits, so that they may make informed decisions about and participate in their care.

²⁶Neglect "...means a negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with ...disabilities or which placed an individual with ...disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with ... disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff." 45 C.F.R. § 1386.19.