

**Connecticut's System for Reviewing the Deaths of
Individuals with Intellectual Disabilities; Lessons Learned
from 10 Years of Mortality Reviews and Investigations**

STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
60B WESTON STREET, HARTFORD, CT 06120-1551

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James D. McGaughey, Executive Director

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Introduction

Fatality Review: How does it work and why is it important?

Questions of trust, blame, respect, confidentiality and fear of consequences and/or liability surround all mortality review processes including those affecting people with intellectual and developmental disabilities. The stakes are high for everyone: for individual human beings who are trying to chart their own courses through life but who may depend, to varying degrees, on the competence and commitment of care givers to help them navigate through the world's complexities; for families seeking answers to agonizing questions; for providers and practitioners whose reputations and ability to continue to practice their professions are on the line; and for leaders in health and human service systems who are trying to implement policies that genuinely respect personal autonomy and individual choices on the one hand, yet establish reasonable safeguards and accountability mechanisms on the other.

Ten years ago, in response to questions about the levels of accountability and trustworthiness with which its developmental services system was monitoring client deaths, Connecticut created a mortality review process which is characterized by independent checks and balances. In contrast to previous practice, the current system has both internal and external components. It assures that the death of each individual who receives even minimum levels of service through the developmental services system is reviewed, that suspected abuse and neglect are independently investigated, and that trends and systemic problems are identified so they can be addressed. After ten years of operation, a much more complete picture of the mortality experience of people with Intellectual Disability has emerged and a number of important issues have been identified. Many of those issues have been addressed while others still require action.

Also emerging is a more sophisticated understanding of what the more persistent "problems" represent. When there has been an error or significant omission which has led to an individual's death – something that never should have happened and never should be allowed to happen again – it is tempting to respond by imposing new procedural requirements, or by mandating universal training on a particular topic, or by adding additional layers of oversight. Sometimes such responses are warranted and actually helpful. But, sometimes, the 'problem' is not so easily isolated and addressed; sometimes it is a symptom of an underlying issue, like the slow starvation of the State's chronically under-funded network of community service providers over the past fifteen years; or the naïve, yet widespread assumption operating within the culture of the developmental services system that it can do little to affect outcomes once its clients become "patients" in healthcare environments. Sometimes, too, the underlying problem can be best understood as one of misplaced administrative emphasis – too much reliance on regulatory requirements, bureaucratic detail and the myth of organizational perfectibility, and too little investment in cultivating competence and renewing commitment within the "human infrastructure" that is the blood and bones of any human service. Just as Gandhi warned against "systems so perfect that nobody needs to be good", one of the most significant lessons fatality review teaches involves the critical importance of good values and a sense of shared responsibility on the part of people at all levels of the service system.

The good news is that now that Connecticut has a comprehensive mortality review system, it is clear that most – the vast majority – of deaths reviewed do not suggest the existence of pervasive problems with services or care. In fact, the records reviewed by the Fatality Review Board indicate that many of the individuals who died were genuinely respected, well supported, very much cared about by others, and that a number of those who had terminal conditions were able to pass away in their homes, supported to the end with dignity, respect and affection. At the end of our lives, we should all be so fortunate. Clearly there are many competent and committed caregivers supporting people with Intellectual Disabilities. But, an honest look requires that we acknowledge that too many things still go wrong, and that there are important lessons to learn by vigorously reviewing those cases. We owe it to those whose deaths were untimely to continue to pursue those lessons. In the end, a commitment to continual learning – to relentlessly pursuing an accurate understanding of what happened in each case - what worked and what didn't, what contributed and what interfered, what needs to change – may be the most important way we can honor those people.

Background

In response to media reports and concerns voiced by family members and other advocates about the adequacy of existing mechanisms to review and investigate deaths of clients of the Department of Mental Retardation (now known as the Department of Developmental Services and hereinafter referred to as DDS), Governor Rowland issued Executive Order #25 in February, 2002. The Executive Order re-configured DDS' mortality review/quality assurance process, and also established an independent Fatality Review Board (FRB) attached to the Office of Protection and Advocacy for Persons with Disabilities (OPA).

The following year, the Legislative Program Review and Investigations Committee issued a report recommending improvements in mechanisms to ensure the health and safety of DDS clients. The resulting legislation, Public Act 03-146, codified certain parts of the Executive Order in statute, assigned responsibility for conducting investigations into abuse/neglect-related deaths of DDS clients to OPA, and required DDS and OPA to establish information-sharing protocols. Taken together, Executive Order #25 (as updated in 2010 by Governor Rell's Executive Order # 42), coupled with the provisions of the P.A. 03-146 created a system that assures that the death of each person receiving DDS services is reviewed, that questions about both individual circumstances and systemic issues are pursued, and that allegations of abuse and neglect are independently investigated.

Mortality Review Process:

As indicated above, Executive Order # 25 established two distinct, multi-member boards to review DDS client deaths – one intended to enhance DDS' quality assurance efforts (the IMRB), and the other to ensure accountability and serve as an independent, external safeguard (the FRB). More specifically:

1. The Independent Mortality Review Board (IMRB) assumed the quality assurance functions of DDS's previous internal mortality review body (the Medical Quality Assurance Board), but with an expanded membership and a mandate to provide independent, objective evaluations regarding matters related to the care and treatment of DDS clients. The IMRB also oversees a comprehensive mortality review process operated by the three DDS service regions. Most IMRB members are appointed by the Commissioner of DDS, or represent designated member agencies. It also includes two persons appointed by the Executive Director of the Office of Protection and Advocacy for Persons with Disabilities (OPA), one of whom is the Program Director of OPA's Abuse Investigation Division. The IMRB reviews the facts and circumstances of those deaths which are referred to it by the three DDS regional mortality review boards, and also reviews a sampling of cases that are otherwise reviewed and closed by those regional boards. According to DDS's annual mortality report, Connecticut law

requires that DDS review the death of anyone for whom it has direct or oversight responsibility for medical care. “The review must cover the events, overall care, quality of life issues, and medical care preceding the death to ensure that a vigorous and objective evaluation and review and objective evaluation and review of the circumstances surrounding untimely deaths take place. [The IMRB] does not review the deaths of individuals who lived at home with their families or were placed by their family/guardian into a licensed nursing facility.” Information supplied by DDS indicates that during the period covered by this report (January, 2004 – December, 2010), the IMRB reviewed approximately 31% of total DDS client deaths reported to OPA/FRB.

2. The Fatality Review Board for Persons with Disabilities (FRB) is supported by the Office of Protection and Advocacy for Persons with Disabilities (OPA) and chaired by OPA’s Executive Director. Its five other members are appointed by the Governor, and are drawn from the medical, law enforcement and the human services professions. The DDS Director of Health and Clinical Services represents the Commissioner of DDS on the FRB as a non-voting member, and a representative from the Office of the Chief Medical Examiner (OCME) also participates. Under the Executive Order, the FRB is authorized to conduct independent investigations into the circumstances surrounding deaths that raise particular concerns. Because the Executive Order was enacted prior to passage of P.A. 03-146, it was initially contemplated that the FRB would only conduct a limited number of full, independent investigations into those deaths which OPA’s Executive Director determined warranted such investigations. However, since late 2003, questions of abuse and neglect related to DDS client deaths have been directly investigated by OPA’s Abuse Investigation Division. The FRB tracks and reviews all of those investigations, but now focuses most of its attention on ensuring that each reported death is reviewed, that healthcare and human service organizations are accountable for the care they provide, and that systems issues that are identified as part of its review process are addressed.

Unlike the IMRB, the FRB does review deaths of all clients who received services from DDS, irrespective of where they lived or whether DDS was responsible for providing or overseeing their healthcare. Information concerning each death is transmitted to OPA on a weekly basis, and is reviewed by the FRB. Reports of deaths occurring under unusual circumstances, those of unknown cause or those where information (or the absence of information) suggests questions about care and treatment are identified for further inquiry by the Board and, if warranted, in-depth review and investigation. In cases requiring in-depth review or investigation, OPA staff obtains pertinent records, including autopsy reports, medical and other clinical records, police and ambulance reports and investigations completed by other agencies for the Board to review. OPA staff also contact family members, agency staff, medical professionals and others having knowledge of the person’s history and/or the circumstances surrounding the person’s death. Investigative activities may also include site visits and consultations with Board members and other experts. Information concerning these cases is prepared for the Board to review. The Board then informs DDS and relevant agencies of its findings and any concerns it may have, and makes recommendations. On several occasions, the FRB has also pursued in-depth analyses of case trends and, most recently, participated in a training initiative intended to increase advocacy skills amongst human service staff whose clients must interface with healthcare providers. The OPA staff investigator assigned to the FRB also works with OPA/AID investigators in the investigation of those deaths where abuse or neglect is suspected to have played a role.

During the reporting period, the FRB reviewed a total of 1361 reported deaths, and conducted in-depth reviews and/or investigations into 445 of those (33% of all reported deaths).

Abuse/Neglect Investigation Process:

Public Act 03-146 mandates that DDS report to OPA within 24 hours whenever it determines that there is reasonable cause to suspect or believe that abuse or neglect may have contributed to a client's death. That reporting requirement applies to anyone for whom DDS has direct or oversight responsibility for medical care, and who was 18 years of age or older at the time he or she died. The legislation also mandates OPA to directly conduct investigations into those deaths. (Previously, OPA would "monitor" internal investigations that had been conducted by DDS, and had no authority to investigate allegations regarding individuals aged 60 or over.) While "reasonable cause" can often be directly inferred from the circumstances surrounding a person's death, it sometimes only becomes apparent after the DDS Division of Investigation conducts a "Medical Desk Review" of the client's treatment records – a process which may take up to 30 days following the client's death. OPA maintains week-end and holiday phone coverage in order to ensure that it can initiate investigation activities (e.g. preservation of evidence, pursuit of autopsy, etc.) in a timely way when it receives a report that abuse or neglect is suspected to have contributed to the death of a person with an Intellectual Disability.

Once a report of suspected abuse or neglect is received by OPA, an investigation is conducted by the agency's Abuse Investigation Division (AID). The investigation focuses on: 1) determining whether abuse and/or neglect can be substantiated, and if so, whether it contributed to the client's death; and 2) whether protective services are needed or other recommendations are indicated in order to protect the health and safety of other individuals.

Because other agencies may have primary jurisdiction over certain types of allegations (e.g. police agencies in criminal investigations, the Department of Public Health in questions concerning practitioners' scope of practice or allegations arising in hospitals and nursing homes), OPA/AID refers those allegations to those agencies, and defers to their investigation processes for those matters that fall within the scope of their responsibilities. However, OPA monitors those investigations and pursues additional inquiries into aspects of such cases that fall outside the jurisdiction of the other investigatory agencies. OPA also consults with medical and law enforcement representatives on the FRB regarding the pursuit of any additional follow-up inquiries. (Most such follow-up inquiries involve additional questions about the quality of healthcare that was delivered, and are initiated through the FRB.)

Of the 1,361 deaths reported to OPA/FRB during the period covered by this report (January, 2004 – December, 2010), 82 involved suspected abuse or neglect, and 81 were directly investigated by OPA/AID. To date, 79 of those investigations have been completed. In 55 of those cases (70%), an allegation of abuse or neglect was substantiated, although in 5 cases there was insufficient evidence to determine that the particular neglect that was found to have occurred contributed to the person's death. 40 of those substantiations (2.9% of total deaths reported) arose in programs operated or funded by DDS. An additional 25 reports of suspected abuse and neglect-related deaths involved discrete questions about the care and treatment of individuals in healthcare facilities or by medical professionals. Those cases were investigated by the Department of Public Health, whose findings were reviewed by the FRB.

Overall Mortality Statistics (January 1, 2004 – December 31, 2010)

Pursuant to the reporting protocol established in the Memorandum of Understanding (MOU) that OPA and DDS developed to implement the Executive Order, DDS reports the death of any person who was receiving any form of DDS services at the time of his or her death to OPA/FRB. This includes both individuals who received residential support services and persons who lived independently or with family members, or who had been placed by family

members into long term care, and who received some other form of support (e.g. vocational or respite services, or, in some cases, case management services only). Between January 1, 2004 and December 31, 2010, one-thousand-three-hundred-sixty-one (1,361) such deaths were reported to OPA by DDS.

According to the information reported, seven-hundred-twenty-nine (729) or 53½% of the people who died had “Do Not Resuscitate” (DNR) Orders, and two-hundred-fifty-seven (257) or 19% received Hospice services. Autopsies were performed in one-hundred-two (102) or 7% of all cases. Seven-hundred-twenty-seven (727) or 53% of those who died were men, six-hundred-thirty-four (634) or 46½% were women.

Residence at Time of Death

434 (32%) of the individuals whose deaths were reported to OPA/FRB were living in nursing homes at the time of their deaths; 403 (30%) were living in community living arrangements; 228 (17%) at home with their families; 138 (10%) at Southbury Training School; 50 (4%) were receiving individual supports in their own homes; 35 (2½%) in State-operated regional centers; 25 (2%) in their own homes with minimal support (case management services only); 22 in licensed community training homes (1½%); 15 (1%) in hospital settings, such as the Hospital for Special Care; 3 in residential care homes (board and care homes); 2 in foster homes; two while staying with a respite provider; 1 in a correctional facility; 1 in a Hospice facility; 1 listed as location “unknown” and 1 listed as location “other.”

Age and Mortality

As may be expected, the largest number of deaths occurred in the over-60 age group, with 636 (47%) deaths reported. 284 (21%) occurred in the 51 to 60 age group; 172 (13%) in the 41 to 50 age group; 86 (6%) in the 31 to 40 age group; 88 (6%) in the 21 to 30 age group; 60 (4%) in the 11 to 20 age group; and 35 (2½%) in the age group birth-to-10.

Causes of Death

Cardiac arrest, cardiopulmonary arrest, cardiovascular disease and congestive heart failure accounted for a total of 416 (30½ %) of all deaths during this time period. Other causes of death listed in rank order include: 230 (17%) attributed to pneumonia; 158 (12%) to respiratory arrest or disease; 132 (10%) to cancer; 93 (7%) to sepsis; 47 (3%) to cerebral hemorrhage, embolism or stroke; 40 (3%) to Alzheimer’s dementia; 39 (3%) to renal failure; 29 to seizure disorder; 18 each to terminal illness process and metabolic disorders; 10 to aspiration of food; 9 to internal hemorrhage; 8 each to bowel obstruction, accidental trauma and surgical complications; 7 to gastrointestinal disease; 6 to infectious disease; 5 each to pancreatitis and asphyxia; 4 each to acute illness and drowning; 3 to fire/burns; and 2 each to age-related factors, diabetes, drug overdose, homicide and suicide. Thirty-three (33) deaths were recorded as having “unknown cause”; seventeen (17) as “other”; and four (4) were recorded as “undetermined.” *(NOTE: References to “unknown” or partial information in these statistics most frequently arise from situations where DDS has provided minimal supports and has had very limited contact or involvement with the person or the person’s family. Despite efforts by the FRB to contact family members or others knowledgeable about the circumstances of the person’s death, the requested information may remain unavailable, and there is little likelihood of obtaining it.)*

The causes of death listed were generally consistent throughout the reporting period, and were also largely consistent with statistics for the general population. According to the Center for Disease Control, the following are the fifteen

(15) leading causes of death for the general population in the United States, for year 2008, in rank order: diseases of the heart; cancer; chronic lower respiratory disease; accidents; Alzheimer's disease; diabetes; influenza and pneumonia; renal diseases; suicide and sepsis.

Statistics made available in the 2007 DDS Mortality Annual Report indicate that in both Connecticut and Massachusetts, the leading causes of death for persons with intellectual disabilities for the years 2002, 2003 and 2004 were heart disease, respiratory disease (including aspiration pneumonia), cancer and sepsis.

Lessons Learned: Ensuring Accountability and Systemic Learning

Since the establishment of the FRB in 2002, and the passage of legislation in 2003 mandating direct investigation of abuse/neglect-related deaths by OPA's AID, OPA has been uniquely positioned to independently review the circumstances surrounding DDS client deaths. Deaths of all DDS clients are reported to OPA pursuant to the FRB/MOU, and those deaths where abuse or neglect is suspected to have played a role are also reported to OPA's AID pursuant to a separate Abuse/Neglect Reporting & Investigation MOU. In addition, by participating on the DDS-sponsored IMRB, OPA staff is able to directly observe the Department's internal review processes and its mechanisms for addressing issues and improving quality.

The vast majority of the 1,361 client deaths reported to OPA during the reporting period raised no concerns about quality of care. In fact, many of the reports reviewed by the OPA staff and the FRB reflect considerable competence and commitment on the part of care-givers and service providing organizations. However, some systemic issues have been identified both in the non-abuse/neglect cases reviewed by the FRB, where questions of quality, best practice and previously un-recognized risks are likely to surface; and in the course of abuse/neglect investigations which have sometimes found evidence of a lack of awareness or responsiveness to known client needs, the absence of clear protocols for communications and decision-making, or of unmet staff training needs.

What follows is a listing of activities undertaken by OPA, including issuance of reports and recommendations to address such systemic issues.

Issues Identified by the FRB: The FRB has identified a number of recurrent issues meriting close attention by providers, service planners and policy makers. In recognition of those issues and in line with the intention of the Executive Order, the Board has issued a number of recommendations in investigation reports, annual reports, a professional journal, and, most recently, by participating in a series of trainings designed to increase the ability of service system personnel to advocate for their clients' needs in health care environments. Examples of these efforts are arranged chronologically below:

2003

- The FRB issued its first full investigation report concerning the circumstances surrounding the death of a man with an intellectual disability who died following his admission to a nursing home in Norwich, CT. The FRB investigation uncovered a long list of problems and alarming oversights at the nursing facility and concluded that multiple lapses in the quality of the man's care and failures in communicating critical information constituted significant neglect of his needs. Staff from the Community Living Arrangement (CLA) where the man had been living experienced particular frustration because, when they visited, they

attempted to share important information about caring for him but found the information was not acted on. As a result of the investigation, recommendations were made to DDS, which were intended to lessen the risk of similar occurrences for other DDS clients. The ARC of the United States distributed press accounts of the report around the country, underscoring that its members not assume that people with developmental disabilities will be well-served in skilled nursing facilities. The nursing home was also cited by the Connecticut Department of Public Health (DPH), which required it to hire an independent monitor to ensure patient safety. It ultimately closed.

- The FRB issued its first annual report, summarizing issues which emerged as recurrent themes in the untimely deaths of DDS clients. These issues included: (1) Faulty communication of important information between health care providers; (2) Some individuals with chronic health problems who live independently appeared to need more support with health management than they were receiving; (3) Some individuals with developmental disabilities who had been placed in nursing homes died as a result of receiving poor care; and (4) In some situations it appeared that licensed practical nurses employed by private service providers were not working under the supervision and direction of a registered nurse, as required by law.

2004–2005

- The FRB issued its second full investigation report concerning the circumstances leading up to and surrounding the death of Ricky W., a thirty-nine-year-old Hartford man with an intellectual disability who died following a vicious assault in the lobby of his apartment building. The FRB report chronicled the circumstances leading to the fatal assault, and questioned the determination of the Medical Examiner that the manner of death was natural. Perhaps even more importantly, it also described the failure of support staff to understand the significance of Ricky W's serious health problems and to coordinate his medical care. Following the release of the FRB's investigation report, DDS issued a public statement indicating that DDS conducted an evaluation of quality assurance systems for persons living in similar circumstances. The Commissioner of DDS also directed his staff to "make a comprehensive evaluation of the FRB's report and develop any additional safeguards necessary to best protect the safety and well-being of the Department's consumers."
- In November 2005, DDS hosted a Supported Living Symposium for staff and persons receiving DDS-funded support. The symposium was dedicated as a tribute to the life and death of Ricky W. and organized in response to the issues raised and recommendations made as a result of the FRB investigation into his death.
- The FRB issued its second annual report, which identified a number of recurrent issues meriting close attention by providers, service providers and policy makers. Recommendations made by the FRB included: (1) Significantly improve health care coordination for individuals living in the community who have chronic medical problems; (2) Develop health and wellness education programs specifically designed to reach people with intellectual disabilities; (3) Avoid nursing home placements; where possible establish a network of preferred nursing home providers to meet short-term rehabilitation needs; (4) Clarify expectations for nursing supports in residential and day programs; (5) Provide detailed, timely information regarding untimely and un-witnessed deaths to the Office of the Chief Medical Examiner (OCME); and (6) Increase staff support to the FRB.

- As part of its 2004-2005 annual report, the FRB released “Health Care: An Emerging Challenge as DDS Consumers Become More Independent,” a policy analysis requested by OPA and produced by staff of the A.J. Pappanikou Center for Excellence in Developmental Disabilities (UCEDD), University of Connecticut Health Center, which, along with OPA and the Developmental Disabilities Council, is a member of the Developmental Disabilities Network.

2005-2006

- The FRB issued its third annual report. Recommendations made as a result of its case reviews included: (1) that the Commissioners of DDS, DSS and DPH jointly issue a letter to all licensed nursing facilities in Connecticut, reminding them of the State and Federal mandates that require that DDS be notified of any significant change in condition of any nursing facility resident who has an intellectual disability; (2) that DDS clarify the responsibilities of Case Managers, regional health services Directors, Regional Directors and Central Office personnel with respect to information received indicating that a nursing facility resident with an intellectual disability has undergone a significant change in condition; (3) that DDS pursue a process to develop more consistent standards regarding nursing support services for all residential programs; and (4) As increasing numbers of people with significant disabilities rely on personal life-support technology, state investigative agencies develop plans and resources to ensure that such equipment can be tested when, in conjunction with a fatality investigation, the functioning of that equipment is called into question.
- Between 2002 and 2005, the FRB and the OPA/AID investigated a number of deaths where individuals’ health care needs were not properly understood or adequately provided for by those responsible for supporting them. P&A pressed for comprehensive, proactive reviews of the healthcare needs of all DDS clients with chronic health conditions who live in their own homes and apartments. DDS responded by revising its Level of Need assessment tool, and including Healthcare Coordination as a Medicaid waiver service for which community providers can obtain reimbursement. In response to other cases where P&A investigations substantiated neglect on the part of both institutional and community providers or their nursing staff, DDS also clarified expectations for the active involvement of Registered Nurses in coordinating medical care for individuals. While some aspects of this issue remain unresolved, the discussions between DDS and P&A, and those occurring within DDS and its provider network, are moving things in a better direction.

2006-2008

- In response to concerns that emerged concerning the deaths of DDS clients living in nursing homes, and in collaboration with the Connecticut Council on Developmental Disabilities and the University of Connecticut Center for Excellence in Developmental Disabilities, OPA hosted a symposium, “*Including Our Elders with Disabilities: A Symposium on Aging in Place*” for policy makers, people with disabilities, advocates, and public and private service providers. The purpose of the symposium was to provide an opportunity for invitees to participate in a facilitated discussion with the intention of developing an action plan to ensure that people with disabilities have the freedom and support to age in place in the community.
- In response to a continuing concern voiced by the FRB regarding the failure of nursing homes to fulfill their obligation to keep DDS informed of any significant changes in the condition of persons with intellectual

disabilities who have been placed into skilled nursing facilities, a second letter signed by the Commissioners of DDS, the Department of Public Health (DPH) and the Department of Mental Health and Addiction Services (DMHAS) was sent to all nursing homes in Connecticut reminding them of the State and Federal mandates, which require that DDS be notified of any significant change in the physical or mental condition of any nursing home resident who has an intellectual disability.

- Subsequent to the 2006-2008 reporting period, DDS hired a statewide Coordinator for Aging Services and a nurse located in its Central Office to work with the DDS Ombudsperson to visit clients in nursing homes and review their records. In addition, the DDS Frequency of Case Management Contact Procedure was revised to require a minimum of one face-to-face Case Manager visit per year and quarterly case management contact to individuals who live in long-term care facilities. The procedure also stipulated that DDS Case Managers develop an Individual Plan and Level of Need (LON) for clients living in nursing homes, and update the plan and LON at least annually.
- In response to a concern raised by the FRB that the Office of the Chief Medical Examiner's (OCME) decision not to assert jurisdiction in a particular case may have been unduly influenced by a person's having a disability, the OCME completed a general review with its staff to reinforce the criteria for which cases should be reported and brought in for autopsy examinations.
- Over a three-year period beginning in 2003, P&A's Fatality Review Board (FRB) reviewed the deaths of several DDS clients who had died of necrotizing pancreatitis. All of the individuals had been taking the commonly prescribed anti-seizure medication Valproic Acid (brand name: Depakote), and all had complained of abdominal discomfort for several days prior to developing acute symptoms. Upon further research, P&A learned that the FDA had instituted a "black box" warning on package labeling for Valproic Acid precisely because data had emerged linking its use to an increased risk of pancreatitis. Many DDS clients take anti-seizure medications, which are also sometimes prescribed to enhance behavioral control. P&A's Fatality Review Board formally informed DDS of its concerns. DDS responded by issuing a Medical Advisory, alerting practitioners to the risks associated with Valproic Acid and instructing that if anyone taking the drug exhibits any symptoms of abdominal discomfort, prompt and aggressive diagnostic follow-up is needed. In addition, DDS has begun reporting all cases of pancreatitis associated with Valproic Acid to the FDA.

The 2006-2008 Annual Report also highlighted a number of additional concerns raised as a result of reviews completed during this time period, including: (1) Emergency department discharge practices; (2) the role of the OCME and law enforcement professionals in investigations involving questionable causes of death, such as unexplained drug overdoses, and the apparent lack of formal mechanism to ensure that law enforcement officials are notified and conduct follow-up inquiries, as circumstances dictate; (3) difficulties encountered by the service system in supporting people whose intellectual disabilities impact their ability to appreciate and manage their chronic health problems on their own; and (4) accessing care in the appropriate setting at STS. A number of individual deaths reviewed concerned individuals who were admitted to the STS Healthcare Unit (HCU) in lieu of being transferred to a local hospital. These admissions were problematic as the HCU did not offer hospital-level services and was not intended to treat acutely ill people. Ultimately, STS revised their HCU admissions policy, directing that STS residents be sent to local emergency departments for evaluation of acute medical conditions.

2008-2010

- In 2008, the FRB initiated a review of a sample of deaths of DDS clients occurring in nursing homes over a five-year period between January 1, 2002 and December 31, 2007. The primary purpose of this inquiry was to examine variables which might influence nursing home placement and the length of nursing home stay.
- In September 2010, the results of the Board’s inquiry, *A Pilot Study Analyzing Mortality of Adults with Developmental Disabilities Residing in Nursing Homes in Connecticut*, were published in the Journal of Policy and Practice in Intellectual Disabilities. Authors of the study included Dr. Kerins, a member of the FRB, staff to the FRB and faculty from Quinnipiac University. The following findings were of significant note:
 - Many individuals were admitted to nursing homes at an earlier age than for the nondisabled general population.
 - People with intellectual disabilities stayed in nursing homes longer, and died later than the general population of non-disabled individuals admitted to nursing homes.
 - About half the sample received case management on at least an annual basis; a third had no documented case management.
 - Lack of appropriate alternate residential settings, lack of support services for families, and lack of case management resources for adults with intellectual disabilities residing in nursing homes in Connecticut were all apparent from the findings.

The authors concluded that better standards of care and medical practices must be developed, more effective administrative and support services must be coordinated, and ultimately, family supports must be increased in order to prevent non-medical need admissions to nursing homes.

2011 -2012

- FRB member Dr. Gerard Kerins and OPA staff, in collaboration with The University of Connecticut A.J. Papanikou Center for Excellence and The Kennedy Center, have been offering training entitled, “Making Sure that Persons with Developmental Disabilities Get the Best Medical Care.” The training highlights real-life stories, drawn in part from cases reviewed by the FRB. It focuses on practical solutions to improve medical care for people with intellectual disabilities at the doctor’s office, in the emergency room, in the hospital and in nursing home settings. Training attendees represent public and private administrators, residential services staff, nurses, case managers, healthcare coordinators, and family members.
- Recognizing the concerns raised by the FRB and IMRB about the experiences of DDS clients in Long Term Care facilities, DDS Commissioner Terry Macy issued an order aimed at limiting DDS placements into nursing homes. The Commissioner’s Order requires that any community provider accepting placement of an individual from Southbury Training School pursuant to the *Messier* decision must have a plan for supporting that individual as he or she “ages in place” and through the end of life. DDS is pursuing the development of a formal policy that will apply this requirement system-wide. The Commissioner has informally shared the Department’s expectations in this regard with its network of community providers.

Issues Identified From Abuse/Neglect Investigations: The following are additional examples of issues brought to the attention of the service system as a result of abuse/neglect investigations. (**Note:** Some of these issues were identified by AID investigators during the course of investigating allegations involving similar fact patterns; others developed as a result of the FRB's reviews of AID investigations.)

Choking Deaths – In 2006, P&A spotted a spike in the number of client deaths due to choking. In most cases, P&A found that the individuals who died had been identified as being at risk of choking on food or other objects, but that individual service plans, which addressed those risks, had not been consistently followed. P&A made protective services recommendations requiring systemic corrections: DDS reviewed its policies and training curricula, and organized a Safety Summit for department and provider staff. New assessment and screening tools were designed to identify specific, individual food preparation and feeding support needs, and a major educational campaign was initiated to raise awareness about the issue throughout the service system.

Burns and Deaths Associated with Scalding – In 2001 and again in 2004, P&A investigated the deaths of DDS clients who had been severely burned by scalding hot water while bathing. P&A found that water temperatures were dangerously high in the community residences where the individuals had lived – a condition that could have been prevented if the plumbing in those homes had been equipped with state-of-the-art anti-scald technology. At the conclusion of the second investigation, P&A sent DDS a formal recommendation that included retro-fitting all licensed residential programs with anti-scald devices, ensuring that future DDS inspections include a water temperature check, and providing that all public and private service providers and residential staff throughout the state be specifically alerted to the necessity of checking water temperature immediately before assisting individuals into a bath or shower. Since these measures have been implemented, no one has died as a result of being scalded.

Drowning Associated with Swimming – Between 2004 and 2007, P&A investigated two deaths due to drowning at recreational swim locations. In both cases, P&A found that the individuals were permitted to enter the water without proper flotation devices and staff support, even though attending staff were supposed to be aware of their inability to swim. As a result of P&A's findings and recommendations, DDS directed that an Aquatic Activity Screening, which identifies both the individual's swimming ability and the level of support they require, be completed for all individuals, irrespective of the type of residential program in which they are living. Staff is required to become familiar with the resulting information prior to pursuing any recreational swimming opportunity.

Bathtub Drowning – Prior to 2002, two individuals who had significant disabilities, including seizure disorders, drowned in bathtubs in their group homes. In both cases, staff who were bathing those individuals had been called away to respond to other needs. In the relatively short time they were unattended, both individuals apparently experienced seizures, and their heads slipped below the water. Investigating those tragedies was less an exercise in blaming than it was an attempt to learn what could be done to prevent future deaths. In the end, the most important lesson involved simply getting people to recognize the serious risk involved in leaving individuals who have frequent seizures unattended in the tub. This information is now a component of training for all new employees, and an area of inquiry for quality assurance reviews.

2004 – 2010 Abuse and Neglect Related Client Deaths – Summary of Investigation Results and Recommendations

The following summaries reflect allegations reported to OPA indicating that abuse or neglect may have contributed to the death of a person with an intellectual disability, the findings of the OPA investigation, and any resulting recommendations. (Note: the term “DMR” refers to Department of Mental Retardation, the official name of the Department of Developmental Services (DDS) prior to 2007.)

1. **Age:** 41. **Residence:** DMR (DDS) Regional Center Campus. (**OPA/AID intake:** 2/11/2004).

Nature of Allegation: Possible neglectful medical care.

Finding: OPA conducted an investigation and determined there to be sufficient evidence to substantiate neglect with regard to the client's care and treatment during the later months of 2003 and the early part of 2004. This finding was based in part upon OPA's review of the client's medical and behavioral records, and in part on the findings of a Department of Public Health (DPH) investigation into the care and treatment of the client at the facility, which is certified under the federal ICF-MR program. Among the deficiencies DPH cited were:

1. The facility failed to develop and implement a protective service plan to prevent injury due to falls.
2. The facility failed to obtain orthostatic blood pressures as ordered.
3. The facility failed to monitor drugs used to manage inappropriate behavior for adverse side effects.
4. The facility failed to ensure that interventions to manage inappropriate behavior were employed with sufficient safeguards and supervision.
5. The facility failed to ensure that nursing services implemented appropriate protective and preventative health measures including the training of direct care staff in detecting the signs and symptoms of dysfunction required to meet the health needs of the client.

OPA's review found that the client was a person with a history of on and off aggressive behavior, as reported by his treating psychiatrist. For a number of years this behavior had been treated with Haldol, a “first generation” neuroleptic drug often associated with undesirable side effects. In September 2003, a decision was made to stop the Haldol and initiate a newer psychotropic drug, Seroquel. The psychiatrist indicated that changing from older psychotropic medications to newer drugs with fewer undesirable side effects was common practice and consistent with established recommendations. The evidence indicated that the decision was made to initiate Seroquel with the consent of client's guardian.

However, the client was observed by staff to be unsteady on his feet and losing his balance at the end of September, 2003, only days after he began receiving Seroquel. On 9/28/03, the client fell and sustained a cut above his eye. On 10/12/03, after several more days of exhibiting an unsteady gait and three significant increases in his Seroquel dosage level, the client collapsed, hit his head and was taken to the hospital to address his head injury. Though he was briefly examined at the hospital for the injury on 10/12/03, there was no indication that the client ever received a full work up for the symptoms of unsteadiness he was experiencing and possible problems associated with his taking Seroquel. Furthermore, routine monitoring by nursing staff was deficient. For example, the client's orthostatic (standing) blood pressure was not checked as ordered. (A sudden drop in blood pressure upon standing can cause a person to fall.) The client was observed to be increasingly unsteady in November and December, 2003. Although he was twice referred for neurological consultations, evidence indicated that the neurologists' recommendations were not

implemented. There was no evidence that the guardians and family were fully apprised or informed of the client's condition during this time period. He continued to experience a number of dropping/falling incidents, so much so that by mid-January 2004, he required being restrained in a wheelchair.

Neglect was substantiated with regard to the care and treatment the client received in late 2003 and early 2004. A Nurse-Investigator intern from Quinnipiac University's Forensic Nursing Program assigned to OPA's Fatality Review Board researched and prepared a timeline correlating the medication change and dosage increases with the increasing frequency of episodes of falling. However, staff at the Regional Center apparently did not consider this possibility, or assumed that medical/nursing staff would have addressed it. Had the Regional Center's nurses checked the client's orthostatic blood pressure and pursued the other recommended health monitoring, it is likely that they would have been alerted to the connection between the medication and the client's falling, and the medication could have changed or the dosage adjusted. The OPA finding was also based upon the findings of the Department of Public Health's investigation. As a result of the DPH and OPA investigations, DMR's Director of Health Services assumed responsibility for developing new health monitoring procedures at the regional center and ensuring that all staff were trained in their use.

Status: Closed AID - Substantiated.

Recommendations:

1. That the Regional Center establish and implement falling behavior protocols which ensure client safety during falling episodes, track the frequency of falling behavior of the individual and ensure timely referrals for hospital evaluations and specialist examinations.
2. That the DMR develop standards in association with the use and administration of Seroquel and other neuroleptic/atypical anti-psychotic drugs, which include frequent monitoring of blood levels and ongoing monitoring for possible side effects.
3. That the DMR ensure family/guardians are apprised of all changes in health status associated with clients including increased frequency in falling behavior, significant changes in medications and dosages, increased frequency of seizure activity and changes in diet.
4. That the DMR establish protocols for clients who exhibit behavioral and medical challenges in order to ensure that both issues are properly and continually monitored.
5. That the DMR should establish criteria for evaluating clients who demonstrate an unexplained or unexpected decrease in their functioning level.

2. **Age:** 39. **Residence:** Private CLA. (**OPA/AID intake:** 3/4/2004).

Nature of Allegation: The client died from extensive acute and chronic bronchial pneumonia with a foreign body granuloma. The client also had pulmonary edema and congestion. There was a concern regarding the care the client received during the final months of her life. Although the client died in March, 2003, suspected neglect had been investigated by DMR when the matter was linked to the client's death and reported to OPA.

Finding: An investigation completed by DMR and monitored by OPA did not substantiate neglect. Investigators noted an apparent lack of what would be considered normal and appropriate nursing documentation during the days which lead up to the client's death. However, neither the DMR investigation nor OPA's review found evidence of neglect in the care afforded to the client prior to her passing.

Status: Closed Monitor of DMR – No substantiation.

Recommendations:

That agency is familiarized with DMR Nursing Documentation Guidelines and all other DMR nursing standards.

3. **Age:** 59. **Residence:** Private CLA. (**OPA/AID intake:** 3/17/2004).

Nature of Allegation: CLA staff assisted the client into bathtub sometime before 4:52 a.m. When the client stepped out of the tub her skin was peeling from her arms and entire lower body. The client was transported to a local hospital, where it was determined that she had burns over 40-45% of her body, primarily her lower extremities and buttocks area. She was subsequently transported to a hospital with a special burn unit. The client died as a result of these burns.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect by the private provider and two of its employees. The CLA did not have an appropriately functioning water heater system in place and, as a result, the water temperature was dangerously high. The problem involved one of the thermostats on the water heater. The private provider staff did not test the water temperature in the bath prior to assisting the client into the tub. The evidence indicated the client was unable to bathe herself and was dependent upon agency staff to ensure that she was safely bathed. The agency did have a written bathing protocol which required water temperatures to be monitored while clients were bathing. Two CLA staff members were in the bathroom when the client stepped into the bathtub to take her bath.

Protective Services were deemed warranted based on information OPA obtained during the course of this investigation. (Protective Services requested in this case ultimately resulted in DMR issuing a policy requiring the temperature of bathing water to be tested by staff for those individuals unable to independently bathe themselves, and the installation of anti-scald valves in all CLA bathing areas.)

Status: Closed AID – Neglect Substantiated.

Recommendations:

1. That the DMR require all DMR licensed residential facilities to have anti-scald devices installed in their domestic hot water systems.
2. That DMR ensure that facilities inspections conducted by the Division of Quality Management include water temperature checks for all facility hot water fixtures.
3. That DMR ensure all public and private service providers and residential staff throughout the state are specifically alerted to the necessity of checking the water temperature immediately before assisting a client into a bath or shower and that such alert be issued as a medical advisory or as some other official DMR communication.

4. **Age:** 50. **Residence:** Private CLA. (**OPA/AID intake:** 4/22/2004).

Nature of Allegation: The client's death was anticipated due to an irreversible, terminal cardiac condition. Nevertheless, it was alleged the client did not receive appropriate medical or nursing care prior to his death.

Finding: OPA conducted an investigation and determined there was sufficient evidence to substantiate neglect. Although the client's death was anticipated due to her cardiac anomaly and poor prognosis, no formal Do Not Resuscitate (DNR) order had been requested and entered on her chart, no hospice services were in place, no medical

assessment was arranged when she began to experience respiratory distress, and appropriate end-of-life care, including appropriate medication, was not delivered.

Status: Closed AID – Neglect Substantiated

Recommendations:

1. That the DMR ensure that clients possessing a DNR status be registered and affiliated with regional hospice services to properly institute supportive care.
2. That the DMR ensure procedures and protocols mandated by regional hospice services be followed regarding all clients having a DNR status.
3. That the DMR ensure all staff caring for a DNR status client receive in-service training regarding appropriate treatment protocols.

5. **Age:** 40. **Residence:** Public CLA. (**OPA/AID intake:** 5/11/2004).

Nature of Allegation: Reported concern involved whether or not the client received appropriate care prior to being hospitalized. The cause of death listed on the death certificate was Disseminated Intravascular Coagulation and sepsis secondary to peritonitis. The client's medical history included a number of long-term, chronic health problems and diagnoses, including malnutrition, cranio-cerebral trauma, s/p left craniectomy and right hemiparesis, seizure disorder, hypothyroidism, osteoporosis, organic affective disorder, s/p aspiration pneumonia 10/96, dysthymic disorder and decubitus ulcer.

Finding: OPA conducted an investigation and determined there to be insufficient evidence for substantiating neglect. The evidence indicated that the support staff kept the client's primary care physician fully informed of the client's current condition as the days/months passed, and that significant efforts were made to boost nutritional intake, including surgical insertion of a feeding tube. Ultimately, those efforts to reverse the client's weight loss and "failure to thrive" syndrome were not successful.

Status: Closed AID – No substantiation.

Recommendations: None.

6. **Age:** 43. **Residence:** SNF. (**OPA/AID intake:** 7/9/2004).

Nature of Allegation: The client was on a strict diet due to diabetes, and also had sodium restrictions. Although he lived in a nursing home, he participated in a vocational day program. Vocational staff took the client to eat at a local restaurant, where the client experienced a choking incident which led to his death.

Finding: An investigation completed by the vocational provider and monitored by OPA did not substantiate neglect. OPA verified that the client did not have food consistency restrictions or a history of choking/aspiration, and concurred with the finding.

Status: Closed Monitor of vocational provider – No substantiation.

Recommendations: None.

7. Age: 37. **Residence:** Private CLA. (**OPA/AID intake:** 7/21/2004).

Nature of Allegation: The client died five days after experiencing a fall down the porch stairs at his group home. The death certificate indicated that the client died of a sub-dural and epidural bleed, which was due to a closed head trauma as a consequence of a fall. The death certificate also stated the fall occurred after the client experienced a seizure. However, it was not clear whether the client experienced a seizure before falling or after falling.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect on the provider agency. CLA records indicated the agency was aware of a previous incident where the client had fallen down the same steps. The client's seizure activity had significantly increased in frequency since the beginning of 2004 and staff was aware of the risk of falling if he was not properly supervised during a sudden seizure. Nevertheless, no protocols for preventing and or monitoring the client while on the stairs were ever developed by the agency.

Status: Closed AID – Substantiated.

Recommendations:

1. That the DMR ensure that all agency staff members are fully trained regarding individual care needs for all clients residing in their facilities.
2. That the DMR ensure changes in a client's functioning which require additional supervision are effectively communicated to all direct care staff in a timely manner.
3. That the DMR ensure the agency is apprised of its reporting responsibility as defined in C.G.S. § 46a-11b.

8. Age: 25. **Residence:** DMR operated apartment. (**OPA/AID intake:** 8/4/2004).

Nature of Allegation: The client had a severe seizure disorder for which he took medications. He had recently moved to a DMR supervised apartment. One morning staff found the client at about 8:15 AM to be non-responsive and he was later pronounced dead. The client was on the floor in the living room wearing only his boxers and tee shirt, which was what he usually wore to bed. It was documented that his seizure medications had been administered as prescribed.

Finding: OPA determined there to be sufficient evidence for substantiating neglect against the direct care staff and DMR. The client was observed to be purple in color and rigid when found at approximately 8:15 AM. CPR could not be administered due to the inability to compress the client's chest cavity or insert an airway. The death certificate indicated the cause of death to be status epilepticus. According to Dr. H. Wayne Carver, Chief Medical Examiner, that activity accelerates the post mortem processes and makes time of death more difficult to determine. While no autopsy was conducted to confirm the cause of death, Dr. Carver stated that based on the information provided, it appeared the client died closer to the last documented bed check of 4:00 a.m. than when his body was found at 8:34 a.m. According to Detective Brown, of the Connecticut State Police, the condition of the client's body when found suggested that he had been deceased for several hours, suggesting that staff did not check on him as was required.

The evidence indicated that three nights per week the client was receiving one to one support staff throughout the night but the other four nights, including the one on which the client died, there was no one-to-one supervision provided for him. When interviewed, the DMR staff indicated confusion as to whether she needed to check on the client every half-hour or every hour. Documentation indicated that the client had been checked on only once at 4:00 a.m.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR ensure that staffing levels in DMR facilities are such that clients are not at risk for neglect based on the number of staff on duty. Functioning levels, physical disabilities and medical needs should be fully considered when making such determinations.
2. That the DMR ensure all staff members are made aware of the supervision requirements for clients in their care and that (the direct care staff involved in this matter) are in-serviced about information recording requirements.
3. That the DMR ensure that residential facilities receiving transitioned clients are keenly aware of the care each client requires.
4. That the DMR ensure staff physically enter sleeping areas and determine whether clients are breathing when such clients are designated as requiring "checking" while sleeping.
5. That the DMR ensure staff document all sleeping "checks" as they happen and not at the end of their shift.

9. Age: 30. **Residence:** CTH. (**OPA/AID intake:** 8/4/2004).

Nature of Allegation: A CTH operator brought the client to a campground whereupon she allowed the client to go swimming and lost sight of the client, who was found under water 10 minutes later, unresponsive. 911 was called. CPR was performed and the client was rushed to the hospital where she was pronounced dead. Connecticut's Chief Medical Examiner, H. Wayne Carver II, M.D., determined the client's death to be caused from asphyxia due to submersion.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating abuse and neglect against the CTH operator. The evidence indicated that the client had entered the water at the campground swimming pond without the life jacket required by her Person-Centered Plan of Care. The client's 2003 and 2004 Person-Centered Plans of Care contained swimming assessments that were discussed and signed off on by the CTH operator. These swimming assessments documented that the client was required to use a life jacket whenever she entered water due to her inability to swim. Eyewitnesses present at the campground swimming pond stated that the deceased client and another client entered the water together while the CTH operator sat on the shore. All eyewitnesses corroborated that the client was not wearing her life jacket, but was using a tube. The CTH operator admitted in her interview that she was cognizant of the fact that the client required a life jacket, but told OPA Investigators that the client had not wanted to wear the life jacket on that day.

The CTH operator also indicated that she, herself, was unable to swim or put her head under water and moreover, stated that she knew no life guard was on duty that particular day. OPA found that the CTH operator's actions on 08/04/04 evidenced a conscious disregard for the necessary supervision and swimming safety precautions as outlined in the client's Person Centered Plan of Care. Therefore, consistent with C.G.S. Sec. 46a-11a. (2003) abuse was substantiated against the CTH operator for the willful deprivation of services which were necessary to the client's ongoing health and safety. Similarly, neglect was also substantiated. A copy of the OPA investigation report was forwarded to the appropriate State's Attorney for follow-up and review.

Status: Closed AID – Abuse and neglect substantiated. DMR took action to remove other clients from the CTH and rescind the CTH operator's license.

Recommendations: (PSP)

1. That the DMR ensure all clients are removed from the CTH, especially any and all clients residing at the facility who are not able to swim without assistance.
2. That the DMR review the operator's license to operate a CTH in light of this substantiation and the facts involved in this case.
3. That the DMR consider initiating policies to preclude any individual caretaker from resuming caretaking responsibilities when that person's misfeasance results in the death of a DMR client.

10. Age: 23. **Residence:** SLA. (**OPA/AID intake:** 9/21/2004).

Nature of Allegation: The client had a seizure disorder and resided in a private Supported Living Arrangement (SLA) with approximately 4 hours of staff support per day. One Sunday afternoon, staff found the client unresponsive in her apartment. Staff called 911 and began CPR. EMS arrived and pronounced the client dead at her home. The time of death was unknown. The reporter indicated that the client had been diagnosed with Seizure Activity and Post Traumatic Stress.

The client had been successfully living in her apartment for three years. During the week prior to her death, she had been sick on the Tuesday and Wednesday, and staff had taken her to see her Primary Care Physician (PCP) on Thursday. The PCP's Physician Assistant examined the client, prescribed medication and ordered blood work to be drawn on the following Monday. On Saturday, SLA staff called and spoke with the client to check up on her and remind her to take her medication. On Saturday evening, the staff again called the client who did not answer the phone. Apparently assuming she was asleep, they left a voicemail message on her answering machine.

Finding: OPA conducted an investigation and determined there to be insufficient evidence for substantiating neglect. The agency did take the client to see her PCP who had assessed her condition, prescribed medication and arranged for follow-up care. The evidence indicated that the client ordinarily required no direct weekend supervision or support at her residence, and was not considered to be acutely ill at the time of her death. Although the client did have problems filling and refilling prescriptions, and staff periodically reminded her to take her medications, interviews with agency staff and a review of the program records indicated that no particular frequency of such reminders had been established as being necessary. Further, when they did not hear back from the client on the morning after they left a voicemail message, the agency staff did drive to her apartment to follow up.

Status: Closed AID – No substantiation.

Recommendations: None.

11. Age: 51. **Residence:** Private CLA. (**OPA/AID intake:** 9/22/2004).

Nature of Allegation: The client collapsed at around noon in his group home and was unable to be revived at a local hospital. Group home staff initially believed the client was having a heart attack but emergency responders to the scene noted that the client had a bolus of "toilet paper" in his throat, leading to the hospital's determination that client died of an aspiration incident. The client reportedly had no history of prior choking incidents.

Finding: OPA conducted an investigation and determined there to be insufficient evidence for substantiating neglect with regard to staff actions on the day of the client's death, when he choked at his CLA on toilet paper. The client's PICA guidelines, bathing guidelines and behavior program did not require staff to remove inedible objects from the

environment, or assist the client while using the bathroom, or provide line of sight supervision in the home. The staff was CPR trained and immediately called 911 upon observing the client collapse, then began attempting to administer CPR. (The bolus of toilet paper lodged in the client's throat was apparently not visible to staff attempting CPR.)

However, OPA found that there did exist sufficient evidence to substantiate agency neglect. The client had a significant psychiatric history and was known to have mood swings and, periodically engaged in PICA-like behaviors (e.g. ingesting or chewing on non-food items). Although the agency had some guidelines and programs in place at the CLA to address the client's challenging, ongoing support needs, those behavior programs and support measures were inadequate for ensuring the client's ongoing health and safety in his mostly unstable condition. In November, 2003, the agency developed PICA guidelines following a few incidents where the client ingested inedible substances such as a bathroom washcloth and garden mulch. However, those PICA guidelines did not call for staff to remove inedible objects from the client or otherwise pro-actively take precautions even though the client had also been placed on a ground diet in earlier in 2003 due to swallowing concerns. It further appeared that the client's several protocols and programs - such as the Behavioral Support Plan, Psychiatric Guidelines, Bathing Guidelines, Supervision Guidelines and PICA guidelines – were not inter-related or coordinated so as to be of any real benefit either to the client or the staff working with him.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR should ensure psychiatrically involved clients residing in CLA's receive periodic nursing assessments and evaluations as necessary for establishing appropriate and up to date individualized plans of care.
2. That the DMR ensure all behavioral, nursing and psychiatric programs for individual clients living in CLAs are regularly evaluated and updated so that direct care staff are able to competently follow such guidelines.
3. That the DMR ensure CLAs develop protocols to protect psychiatrically involved clients from becoming overly dependent upon any one particular staff person's subjective assessment of their ability to participate in scheduled daily activities.
4. That the DMR review provider practices in which client behaviors tracked through behavior data collecting programs which create no unusual incident report record.

12. Age: 50. **Residence:** Hospital. (**OPA/AID intake:** 10/5/2004).

Nature of Allegation: The client was discovered deceased in a seclusion room at a Connecticut hospital at approximately 10:30 pm by unknown hospital staff. CPR was performed on the client for twenty-five minutes but was not successful. The client had no known physical issues that could have contributed to her death. The client had been admitted to the hospital approximately fifteen days prior to her death because she had decompensated after the discontinuation of two medications.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect on the hospital for failing to properly ensure the client's health and safety during her 17 day stay on the psychiatric unit. The Department of Public Health also conducted an investigation with which OPA concurred. The DPH investigation determined that upon admission the client "was not provided a physical examination, neither did the hospital perform and document a medical history. An undated physical examination form in the clinical record identified that the patient (client) had right middle lobe inspiratory wheezing and mild bilateral edema." Repeated requests were made by the private residential provider agency to the hospital to check client's lungs.

According to the DPH investigation report: "RN was asked to examine (client on a specific date), and documented that assessment on the physical examination form. It was on this date that (client) expired. Hospital rules and regulations identified that admissions from the emergency department to a general care area will have a history and physical performed and documented within 12 hours of admission.

In addition, (the hospital) failed to develop and keep current, a treatment plan specific to the identified needs of (client). (Client) was placed upon admission into a seclusion room. The patient's treatment plan was reviewed by the Department of Public Health and it lacked details on how staff would maintain the patient in this non-traditional setting, such as infection control issues related to mattresses on the floor, safety measures including gaps between the mattresses, whether the door was to remain open or closed, and how personal care would be provided."

The DPH investigation also stated, "The plan failed to address safety interventions, per hospital policy, and failed to identify the patient's condition on admission, measures to prevent further injuries, or how to care for the injury to (client's) toe, an injury she sustained while in (the hospital)."

OPA's review of the hospital's internal investigation indicated that several staff working at that facility reported that they felt inexperienced working with a patient with developmental disabilities.

Status: Closed AID – Neglect substantiated.

Recommendations:

That the hospital medical staff members receive training in providing medical services to patients with disabilities, especially patients with physical disabilities and/or intellectual disabilities.

13. Age: 46. **Residence:** Hospital/SNF. (**OPA/AID intake:** 10/29/2004).

Nature of Allegation: The client, who lived in a nursing home, was sent to a Connecticut hospital for dental work under anesthesia. A full mouth extraction (32 teeth) was performed, after which the client began to hemorrhage. He and was kept in the hospital overnight for treatment and observation. The client had not had pre-operative blood work, which would have provided an indication of his "clotting time", and could have resulted in a decision to schedule multiple visits in order to reduce the risk of significant bleeding by limiting the number of teeth extracted at any one time.

The client also had a diagnosis of MRSA or Methicillin Resistant Staphylococcus Aureus (Antibiotic resistant infection). The client was discharged to a Skilled Nursing Facility (SNF). Three days later he was diagnosed with septic arthritis in his knee and ankle. Reportedly, a person who has MRSA can develop septic arthritis from a wound in the mouth, as the bacteria can travel through the blood stream to the joint. The client was sent back to the hospital emergency room for a PIC (Peripherally Inserted Central) line to receive IV antibiotics. The hospital was unable to establish the PIC line. Instead of admitting the client, he was discharged back to the nursing home without the administration of IV antibiotics. The client was received antibiotics through his G-tube and developed a body temperature of 101 degrees. A few days later the client was admitted to the hospital. He was pronounced dead 13 hours after admission. The hospital listed the cause of death as Cardio-Pulmonary Arrest.

The hospital failed to notify the Medical Examiner as required if a death occurs within 24 hours of admission.

Finding: An investigation completed by DPH and monitored by OPA substantiated neglect against both the hospital and skilled nursing facility. The SNF was found to have failed to implement medically indicated dental care, which

resulted in the client's hospitalization. Neglect was also substantiated against the hospital for failing to initiate a full code when the absence of a pulse was noted.

Status: Closed Monitor of DPH – Neglect substantiated against the hospital and SNF.

Recommendations:

That the DMR ensure clients residing in nursing homes receive routine dental care.

14. Age: 59. **Residence:** Private SLA/CLA. (**OPA/AID intake:** 12/10/2004).

Nature of Allegation: The client resided in the first floor apartment of a duplex apartment building which, in its entirety was considered to be a licensed CLA but which had two separate apartment units – one on the first floor, the other on the second floor. One Sunday afternoon staff found the client unresponsive in the living room of his apartment. Staff reported performing CPR and contacting 911 upon discovering the client. The client was pronounced dead. No autopsy was performed but according to the DMR Medical Desk Review Report, the cause of death was listed as Asystole per death certificate.

The client's family raised concerns that there may have been an inadequate level of supervision provided to the client on the day of his death. The facility staff members were required to be on-site either assisting upstairs or downstairs residents. The family was concerned that the client may have been alone at the time he experienced symptoms of ill health in the moments leading up to his death.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect. There was no indication that staff members were not present as required, and staff members were performing CPR when first responders arrived at the residence. EMTs confirmed that the client was warm to the touch, and continued the CPR per standard protocols.

Status: Closed AID – No substantiation.

Recommendations: None.

15. Age: 53. **Residence:** Private CLA/DMR CLA. (**OPA/AID intake:** 12/30/2004).

Nature of Allegation: OPA received an allegation indicating that the client had been sent by his CLA to his day program with pneumonia, and although he was taking medication, his condition had not improved. OPA received a second report three months later indicating that the client had moved from a private CLA to a DMR CLA, weighing only 55 lbs. The client's condition worsened and he was taken to the ER and passed away in the hospital two days later of cardiac arrest.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect with regard to the ongoing care and treatment of the client in the months prior to his death. The evidence indicated the client did not receive services necessary to maintain his health and safety even though his condition of deteriorating health was well known and actively monitored by both DMR and the private provider agency.

The private agency was neglectful in sending the client to the day program in December, 2004 with an active case of pneumonia and without a doctor's note indicating that it was reasonable and appropriate for him to return to work. However, this event occurred nearly four months prior to the client's death, and was not directly associated with it.

DMR failed to provide the client with the services necessary to maintain his health and safety by not acting on an Immediate Protective Service Plan (IPSP) initiated by OPA and faxed to the Central Office of DMR and DMR/North Central. The guardians at this time were refusing to have a PEG- tube put in place for the client. The primary care physician PCP deemed the PEG-tube a necessary and crucial medical procedure.

The IPSP stated: "DMR should ensure that (the client) is immediately provided with all recommended medical interventions for the purpose of diagnosis and treatment. These services should be provided to (the client) without delay and over any objections made by the guardian. Should (the client's) guardian attempt to prevent the provision of these Protective Services, DMR should appeal to the appropriate probate court for review of this matter." OPA never received a response to this IPSP request and there is no evidence to indicate that the probate court was ever petitioned consistent with the IPSP request.

DMR failed to provide the client with the services necessary to maintain his health and safety by delaying his transfer to a higher level of care. The determination of need for a higher level of care was made by the client's interdisciplinary team, his physicians, guardians and the DMR nurse consultant. The initial request for a higher level of care was made by the private agency's Executive Director in February, 2004 to the DMR Regional Director. The formal transfer packet was submitted in October of 2004. Additionally, OPA requested in the form of an IPSP that client be provided appropriate medical treatment notwithstanding the objections of the guardian. The client was not transferred until January, 2005 to a DMR-operated group home.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR establish an emergency procedure for expediting transfers which involve persons with complicated and life threatening medical conditions. DMR should also consider establishing more homes designed to handle persons with complicated medical conditions.
2. That the DMR ensure immediate protective service requests are effectively communicated to the party responsible for following through on the IPSP recommendation.
3. That the provider agency develop policies for addressing situations where participants are returning to work after a serious illness has been diagnosed.

16. Age: 21. **Residence:** Privately supported SLA. (**OPA/AID intake:** 2/17/2005).

Nature of Allegation: A newspaper article appeared in the Hartford Courant regarding the death of a 22 year old client who died in a one-car accident. According to the article, the client was driving the automobile at the time of the accident even though he did not possess a driver's license. The article indicated that the automobile was being driven at a rate of speed faster than the posted 30 mile an hour speed limit when it crossed the lane, flipped on its side and hit a row of trees.

The article indicated that the car belonged to the client's girlfriend, who indicated to the Courant reporter that she had moved into the client's (Supported Living Arrangement) apartment a few months earlier. The newspaper also indicated that a 15 year old minor was in the car with the client at the time of the accident. According to the article, the minor passenger sustained a fractured leg and head injuries as a result of the accident. The Hartford Courant also reported that the local police department and the private provider were conducting investigations into the events which led to the client's death.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect on the part of the provider agency. The agency contracted through the Department of Mental Retardation to provide the client with 35 hours of direct staff support each week. Through eyewitness testimony and documentation it was determined that client was not provided with the above-mentioned level of care and was instead provided only minimal direct staff support.

The client's girlfriend stated she lived with him in his apartment for over one month. The girlfriend stated she had her own key to the client's apartment and that during the entire time she lived with him no staff ever visited the apartment. The girlfriend stated she was in the client's apartment at all times of the day (morning, afternoon, nights, weekdays and weekends). The client had told her that some people may stop by the apartment but they never did.

The client's neighbor stated that he had only witnessed staff in the client's apartment a few times over the course of 2004. The neighbor also stated that he witnessed the client drive his girlfriend's car on a daily basis and stated that the client referred to his girlfriend's car as being his own. The neighbor indicated that client even had a new stereo system installed in the car.

The client had a curfew listed in his Follow Along Plan to be in by 10:00 p.m. on weekdays and 1:00 a.m. on weekends. However, staff responsible for the client's care and supervision believed there was no formal written protocol or guideline for the curfew. Based on interviews of the staff members it appeared as though each staff had their own interpretation of whether the curfew still applied after the client turned 21 and how the curfew should be conducted. Provider staff indicated that all direct support hours were documented in the Daily Progress Notebook kept in the client's apartment. The Daily Progress Notebook revealed that during the last 39 days of the client's life, only 13 days were documented as being days where staff actually met with him. The majority of these contacts were providing the client with transportation to work or to court.

Witnesses interviewed throughout the course of the investigation identified the client as a "ladies man", "having lots of girlfriends", "went from one relationship to another in a serial manner", "he loved women", and one staff mentioned that he didn't understand the ramifications of dating girls who were under the age of 18. The client was also known to have had a drug problem prior to being admitted to the agency. This issue was not addressed during the time the client received services from the provider. Even though the agency pledged to provide the client with transportation and assistance with his attendance at NA meetings, the evidence indicated that he never attended these meetings. Agency staff stated that there was no indication that the client ever used marijuana while under their care, but the client's girlfriend stated he smoked "weed" (Marijuana) on a daily basis. The client's neighbor also stated that the client smoked marijuana whenever he had the chance.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency include all team members and the client, if the client desires, in the IDT process. All issues should be addressed and documented at the IDT meetings.
2. That the provider agency establish a formal documentation system for client programming.
3. That the provider agency establish a formal tracking system for staffing hours spent with individual clients.
4. That the DMR require SLAs to be more accountable in regard to client programming. (i.e. tracking direct hours with client, more client specific DMR inspections, formal tracking of client programming and require risk assessments and evaluations).

5. That the provider agency establish a formal assessment tool to determine client direct support needs.
6. That the provider agency establish formal written procedures for client specific needs such as curfews. Protocols and guidelines should be put in writing and documentation should be kept on file for staff in-services.
7. That the provider agency ensure clients are provided with the direct support staffing hours that have been determined necessary and have been contracted through DMR by way of the IDT.
8. That the provider agency compile a pool of trained substitute staff in the event of sickness, leave or transfer.
9. That the provider agency complete psychosexual assessments on all SLA clients in SLAs and that sex education be provided for SLA clients.
10. That the provider agency ensure clients receive counseling around mental health and substance abuse issues.

17. Age: 48. **Residence:** Private agency supported SLA. (**OPA/AID intake:** 5/23/2005).

Nature of Allegation: The client died after a four story fall from his apartment. EMS arrived at the scene where the client was found to have agonal respirations and a weak radial pulse. CPR was initiated. The client was intubated and the EMS noted a lost weak pulse as the client went into a pre-electrical activity (PEA). The client was taken to a local hospital where he was pronounced dead. The Medical Examiner's Office determined the client died of multiple blunt traumatic injuries. The Medical Examiner also determined that manner of death was suicide.

Three days prior to this incident, the client was discharged from an inpatient psychiatric facility after a three week hospitalization. Symptoms leading to his admission included hallucinations and paranoid thinking, including voices telling him, "he should kill himself or they would put a knife in him." The client also had several previous psychiatric hospitalizations for unstable behavior.

Psychiatric hospital discharge plans called for the client to have increased staffing levels at his residence. However, reportedly, at the time of discharge, neither the hospital nor the provider specified how much increased staff support was to be available. Agency staff records showed the client was to receive staffing support on the date of his death from 8:00 AM to 1:00 PM and from 4:00 PM until 10:00 PM, meaning there was no staff scheduled or present with the client at the time of his apparent jump at 3:20 PM. There was also no documentation to verify that the client was taking his medication after being discharged from the psychiatric facility even though he was known to have a history of not being medication compliant and even though the discharge plan indicated that the agency was to provide medication monitoring.

Finding: The OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect on the part of the provider agency. Interviews with supervisory staff indicated that the decision to provide the client with 21 hours of supervision rather than 24 hours on his second day of release from the hospital was made independently and without any specific criteria guiding the decision. The agency did not contact DMR during either of the client's hospitalizations which occurred prior to his death. The DMR documentation indicated that agencies providing services to DMR clients are required to notify DMR in the event of an unusual behavior or hospitalization that could be life threatening.

The client indicated that he was fearful of being alone within his apartment. The evidence indicated that he jumped from the balcony of his apartment at about 3:20 p.m., about two hours after being left alone by agency staff. The agency provided services to the client for 15 years, and was aware that he had a long history of having serious psychiatric issues, including suicidal ideation.

Status: Closed AID – Neglect substantiated.

Recommendations: (PSP)

1. That the DMR ensure that all clients with a mental health diagnosis (supported by a mental health worker) have a representative from their mental health agency present at IDT meetings.
2. That the DMR ensure that case managers who have clients that are dually diagnosed, receive training in safety issues and staffing considerations relevant to this population.
3. That the DMR ensure Spanish speaking case managers are assigned to clients who speak Spanish only.
4. That the DMR establish interagency agreements with mental health care agencies and hospitals that ensure DMR will be included in team meetings at time of a client's admission and discharge.
5. That the provider agency adhere to DMR policy directing that the Department is notified when a client is hospitalized or staffing needs necessitate changes.
6. That local and regional mental health providers include the Department in the planning and implementation of recommendations made for DMR clients.

18. Age: 52. **Residence:** STS. (**OPA/AID intake:** 6/13/2005).

Nature of Allegation: Reportedly, the client was en route to the Special Olympics in a STS vehicle when staff stopped at a McDonald's for lunch. To prevent choking, the client's dining guidelines dictated specific consistency of food to be provided as well as staff monitoring of the rate of consumption. However, on the day of her death, the reportedly client choked on a hamburger she was eating while sitting in the back seat of the car. Initially, the staff driver reported that she flashed her lights at another STS car that was traveling ahead of her, and both vehicles pulled over into a parking lot whereupon one staff performed the Heimlich maneuver while another staff called 911. The client was transported by EMTs to a local hospital and placed on life support, but died the next day.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating abuse and neglect against the STS staff. A parallel personnel investigation was conducted by STS, and a criminal investigation conducted by the Connecticut State Police resulted in arrests and prosecution of several of the STS staff members. The evidence indicated that the three staff members on duty at the time were aware that the client presented a choking risk due to her having a history of stuffing large amounts of food in her mouth. The agency records indicated that about one month prior to this incident, the client had experienced a previous choking incident. Also, one of the staff present on the date of client's death had also been present during the previous choking incident. The client received 24 hour 1 to 1 support staff and her plan of care required that she receive all her meals in a specific "cut-up" form (e.g. small pieces), in order to reduce the likelihood of her experiencing a choking incident. The evidence indicated that the three staff members were also aware that the client at times exhibited manic behavior around other clients, which behavior in part was responsible for her being removed from a congregate living arrangement and being placed in her own on-grounds apartment. The three staff members were also aware, or should have been aware, that eating and drinking in an agency vehicle had been prohibited for the last several years as a direct consequence of a previous client choking incident.

The evidence also indicated that on the day the client died, one of the three staff members represented that she was going to take the client off-campus to a Special Olympics event. On that same morning, the other two members took five other clients off-campus in another car. A STS campus dispatch notice indicated that these two staff members

represented that they would be taking the five clients to church and then go shopping in two locations. However, the evidence indicated that the three staff members had planned to meet up just off-campus, and in fact did meet as planned, whereupon they followed each other to a city green. There was no evidence to indicate that any supervisor, charge staff or co-worker was ever made aware of this plan. In fact, two of the three staff members eventually admitted that they repeatedly denied and lied about the plan because they were aware that the one client who eventually died was not allowed to be with other clients off-campus.

The evidence also indicated that instead of going to a Special Olympics event, the three staff members drove the clients around while they pursued their own personal shopping trip in and around the city green area. The three staff members implicated initially lied about any shopping activity but later admitted to one degree or another that personal shopping and banking did occur on the off-campus trip. A receipt found in one of the agency cars indicated that the staff driving the client who died had purchased approximately \$10.00 worth of fast food chicken and a soft drink at 11:53 AM on the date of the incident near the city green while traveling with the client. The staff at first denied ever purchasing any food and later, when confronted by investigators with a purchase receipt, told a somewhat convoluted story about buying lunch for yet a fourth staff member worker who was overseeing the Special Olympic event. The fast food chicken purchase was relevant to the degree that it demonstrated the staff purchased food at around noon that day and yet by all accounts none of the six clients taken on the outing were fed lunch at that time.

The evidence also indicated that same staff member later purchased a hamburger from a McDonald's restaurant which was intended to serve as the one client's lunch. The initial statements of all the alleged perpetrators indicated that both STS vehicles left the city green area and drove to a location outside the city in order to stop at a McDonald's. OPA and STS investigators believe that such a stop was in fact made at one particular McDonald's. In fact, a McDonald's employee's statement corroborated one STS staff member's representation that the restaurant was able to provide only handwritten purchase receipts on the date that the client passed away.

However, the three staff members initially offered differing accounts about whether the group ate inside McDonald's and whether the one client ate with the other five clients. One staff member initially indicated that she took the one client (who died) and attempted to feed her at an outside table, where the one client allegedly ate only some of the hamburger. When informed that there were no outside tables at that particular McDonald's, the staff member represented that she had been confused about that fact and remembered feeding the client inside the restaurant. The staff member demonstrated for investigators how she crushed and then cut the entire hamburger into little pieces and indicated that she assisted the client with eating at the restaurant without any choking incidents. The staff indicated that about a third of the hamburger was not eaten when she finished feeding the client and that she placed the remaining hamburger pieces into a wrapper with no bag and left it in the console which separated the driver's and passenger's side of the car as she began driving. The staff represented that the client then grabbed the remaining hamburger pieces while she was driving and stuffed them into her mouth. When informed that a search of the vehicle found no little pieces of chopped hamburger and that moreover, an EMT report indicated large chunks of hamburger were taken out of the client's throat, the staff changed her story yet again and stated that perhaps she had not cut the entire hamburger up as she had described and that the client had stuffed as much as a half a hamburger uncut into her mouth. The staff then excused herself from the interview to speak to her union delegate for a few moments. Upon returning to the interview, the staff stated that after thinking about the matter, she was sure that she had in fact did cut the entire hamburger into little pieces.

All three staff initially represented that the two vehicles left the McDonald's to proceed back toward the city green and attend the Special Olympics when suddenly the one client began choking. The three staff all initially indicated

that one staff was alone with the one client in the car when the incident occurred and that she flashed her lights at the other agency vehicle traveling in front of her just after leaving the McDonald's parking lot. The three staff all initially indicated that they pulled into a retail-center parking lot, whereupon the client was allegedly immediately pulled from the car and staff began CPR.

However, an eyewitness stated that the two agency vehicles were parked just 92 feet away from a retail store, in two parking spaces which were facing each other and separated by one space. These spaces were approximately 167 feet from the entrance to the mall parking lot. The spaces identified did not evidence in any way that the vehicles were parked under exigent circumstances. The eyewitness also indicated that it was a hot day and that the five clients in one vehicle were sweating so profusely that she herself boarded the vehicle and turned on the air conditioner.

One of the alleged staff perpetrators eventually admitted she had misrepresented the truth about the choking incident. This staff member's revised statement indicated that one of the other two staff stated in the city that she wanted to go shopping and so both vehicles then went to a retail center outside the city, where they first stopped at a McDonald's drive thru near the retail center and purchased food for all six clients. Staff then bought a hamburger and soft drink for the one client and the group proceeded to drive across the street to the parking lot near the retail store. Staff then left the one client alone in the one vehicle with the hamburger and proceeded to go shopping inside the retail store. According to this account, the two staff in the other vehicle watched the client mostly from the vehicle while they fed the five clients in their own vehicle food which they had also purchased at McDonald's. After about an hour, they noticed the one client choking in the vehicle. In this account, the two staff then ran to assist the one client and pulled her out of the vehicle. One staff reported that she initially wanted to call 911 but the other staff told her to first run into the retail store and find a third staff member and driver of the other vehicle. Whereupon, the staff member went into the retail store and found the staff standing near the jewelry display with shopping bags in her hand. This revised version of the choking incident was corroborated by the statement of the Assistant Manager of the retail store, who stated that on 6/11/05 he was alerted to an incident in the parking lot when a female came running into the store yelling and screaming to someone near the jewelry counter. The Assistant Manager then observed both individuals run out of the store and observed that a woman was lying on the ground outside the store in the parking lot. The Assistant Manager also recalled that the woman near the jewelry counter had the retail store's shopping bags in her hand.

The emergency dispatch log indicated that three 911 calls were placed beginning at 1:38 PM regarding a woman choking in the Shopping Plaza parking lot. It is believed by OPA and DMR investigators that one of the STS staff was the first person to place the emergency call. It is further believed that one staff member did attempt to perform the Heimlich maneuver on the client and that the other two attempted to perform CPR. The eyewitness indicated that she observed one staff person performing CPR albeit at first incorrectly. However, a firefighter/paramedic of the responding Fire Department indicated that when he arrived no person was performing CPR. It is believed by OPA and DMR investigators that staff stopped administering CPR when she heard or saw the approaching ambulance. The paramedic noted a blockage when he attempted to intubate the client and stated that he pulled, "pieces of hamburger and a thick pasty substance like dissolved bread," out of the client's windpipe before he was able to intubate. The paramedic recalled that the dissolved bread also appeared to be mixed with pieces of the hamburger wrapping paper.

There was no post mortem examination. However, hospital records indicated that during the several hours the client was at the hospital, procedures were undertaken to rule out whether a cardiac event had occurred. A DMR nursing review of those records found no evidence to indicate that the client experienced a cardiac event independent of the choking incident. The client's death certificate listed the cause of death as Anoxic Brain injury/Airway obstruction.

Status: Closed AID – Abuse and neglect substantiated. Staff members were terminated and criminal charges brought.

Recommendations:

1. That the Unit Director ensures all cottage staff notify the shift charge concerning the destination of any community outing, including which individuals are attending and estimated time of return, and document accordingly.
2. That the Unit Director ensures all cottage supervisors / charges of shifts understand the importance of obtaining and documenting pertinent information regarding the destination of any community outing, and document accordingly.
3. That the Unit Director ensures all cottage staff notify the proper individuals should there be a change in the destination of any community outing.
4. That the Unit Director ensure that “STS Resident Activity Monthly Record” data is completed in its entirety to include; date of community outing, hours & minutes, where & what activities, and responsible staff.
5. That the Unit Director ensures all cottage staff accurately document information on mileage forms and vehicle request sheets for each community outing.
6. That the Unit Director ensure all staff in C-12 re-review the STS Transportation Policy to ensure proper implementation and the June 14, 2005 Memorandum titled, “Employee Responsibilities” and document accordingly.
7. That the Unit Director ensures all cottage staff re-review the July 1, 1998 Memorandum titled, “Ensuring Special Diet Requirements in the Community,” and document accordingly.
8. That the Unit Director ensures all cottage staff provide receipts for purchases made with client’s money for accountability purposes, and document accordingly.
9. That the ARD for Residential must ensure that all staff responsible for supporting clients on community trips have read the June 14, 2005 Memorandum titled, “Employee Responsibility,” and document accordingly.
10. That the Director of Personnel ensure there is an administrative investigation following the criminal investigation regarding certain case features.
11. That the facility take appropriate disciplinary action as warranted.

19. Age: 43. **Residence:** Private Residential and Day Program Provider. (**OPA/AID intake:** 6/22/2005).

Nature of Allegation: The client required line of sight supervision at all times. Reportedly, the day program manager was assigned to supervise the client but left the building without re-assigning supervision. The client was able to access food from the refrigerator. Two staff members who were changing another participant discovered the client with a peanut butter sandwich in one hand and a ham sandwich in the other hand. The two staff noticed the client was choking and that her lips were turning blue. Staff began the Heimlich and called 911. The client became unconscious while staff continued stomach thrusts, rescue breathing and finger sweeps. The staff reported observing a chunk of peanut butter lodged deep in the client’s throat but were unable to retrieve it. Police arrived approximately five minutes after the 911 call was placed. EMT and ambulance arrived approximately one minute

after the police. The client died two days later. Reportedly, there had been numerous meetings regarding the client's propensity to aggress towards food and stuff large quantities of food in her mouth.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect on the part of the day program. Food items were not secured and were accessible to the client in the absence of effective supervision. The need to prevent the client's direct access to food for health and safety reasons was clearly and repeatedly documented by all of the primary disciplines at the private agency, including behavioral, habilitative, residential and medical. Nevertheless, the client was able to obtain, ingest ultimately choke on the sandwiches from a fellow participant's lunch box due to the required level of supervision (line of sight) not being provided.

The evidence indicated the client was one of about ten participants being temporarily supervised by only one staff at the time of the incident. That staff briefly removed herself to a separate room in order to get some puzzles, thus leaving all of the participants in her immediate care, including the client, without their required level of supervision. Neglect was substantiated on this staff person as well as the agency

Status: Closed AID – Neglect substantiated.

Recommendations:

During an unannounced visit to the day program by Investigators it was evident that several critical client care issues brought to light had already been effectively addressed. They included the securing of food in transit and on site, increased staff: client ratios and staff training with documentation. Although these measures and the memory of the unfortunate incident which resulted in the client's untimely death may operate to minimize the likelihood of a similar future incident occurring at this facility, this case is representative of several choking death cases involving DMR clients which have occurred in the last year.

Therefore, the Office of Protection and Advocacy recommended that the DMR develop statewide training and policy initiatives to address the problem of Connecticut choking deaths, which are usually preventable when proper precautions are in place.

20. Age: 44. **Residence:** Private CLA. (**OPA/AID intake:** 7/22/2005).

Nature of Allegation: Reportedly, the client had a cough and fever of 100.3 degrees. The client was seen that day (Thursday) by a doctor, who prescribed the antibiotic Zithromycin for five days. The doctor's note also directed the staff to "call if not improvement each day or call if any worsening." Medical Progress notes (written by non-medical staff) indicated that two days later the client spiked a fever of 103 degrees. Staff notes indicated the staff gave the client Tylenol. Staff notes also indicated that the client's mother refused to send the client to the hospital when recommended to do so by staff. However, staff notes did not anywhere indicate that an on-call nurse was notified. There was also no notation to indicate that the primary care physician was ever notified of the change in the client's condition as per his written request.

On Sunday, the next day, the client woke up with a temperature of 102.2 degrees. His urine was noted by staff to be dark and concentrated. The client seemed to be tired and breathing was more rapid. Fluids were encouraged but the client was not drinking well. The client's mother visited and staff again suggested the client go to the hospital, but the client's mother wanted to wait until the next day and take the client to see his PCP. The client had sporadic coughing and breathing changes throughout Sunday evening.

On Monday, the client was noted to be more lethargic with a temperature of 102.2 degrees. An appointment was made with the client's doctor for 5 P.M. that same day. Upon being examined by his physician, the client was

immediately referred to the local hospital ER, where the client received a chest X-Ray, inhalants, IV antibiotics and was diagnosed with having pneumonia. The client never recovered from this condition and died about two weeks later.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect against the residential provider. A review of documents and statements provided to OPA demonstrated that the provider agency did not ensure the delivery of services to the client which were necessary for his ongoing health and safety. The evidence showed that on Thursday the client was sufficiently ill to warrant a trip to his primary care physician. At that time the doctor prescribed antibiotics and instructed agency staff that if his condition did not show improvement or if his condition worsened, further medical attention should be sought. Over the course of the next few days, the client's condition fluctuated, with his temperature rising close to 103.0 degrees on Saturday. In addition to the client's febrile condition, he also exhibited signs of weakness, coughing, dehydration and difficulty breathing in the days prior to his hospitalization on Monday. Despite clear signs that the client was not improving, agency staff did not elect to seek further treatment until that Monday afternoon. The evidence showed that agency staff acquiesced to the will of the client's mother and did not insist on seeking medical attention and that as a result the client's condition remained untreated by a qualified medical professional.

A contributing factor to the substantiation of neglect on behalf of the agency was their lack of having any on-call nursing component available to group home staff during a time of the client's greatest need for a competent medical assessment. Further review of the agency's failure to provide on-call nursing in this case revealed what appeared to have been a systemic failure on behalf of the agency that extended beyond this particular client's dilemma. Statements provided to OPA indicated that the standard practice of the agency was to rely on non-medical personnel to make decisions regarding individuals with medical issues. Statements provided to OPA by DMR, including the Regional Director of Health Services, indicated that the agency was aware that for regulatory purposes a nurse needed to be on-call or available to staff at all times. Despite this knowledge, the particular agency had chosen to continue using a system that was insufficient to ensure the health and safety of the clients they served.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR should ensure the private residential provider recognizes its responsibility to provide appropriate medical treatment and services even in situations where the parent/guardian may disagree with the administration of such services.
2. That the DMR should ensure the private provider maintains comprehensive nursing services which operate to provide clients with timely nursing assessments. All agency staff should be in-serviced as to the parameters of the on-call system put into effect.

21. Age: 30. **Residence:** Day Program. (**OPA/AID intake:** 8/8/2005)

Nature of Allegation: Reportedly, at about 9:15 am, the client ingested a piece of wallpaper from a sample book while attending her day program. The Heimlich maneuver was applied. The client stopped breathing for 5 to 7 minutes before the ambulance arrived and took the client to the hospital. The client had a 2 to 4 staff to client ratio at her residence. Both residence and day program reported that they kept track of the client's PICA behaviors. The client was pronounced dead at about 11:30 am.

Finding: OPA conducted an investigation and determined there to be sufficient evidence for substantiating neglect against the day program. The evidence indicated that the client was a person who was known to exhibit infrequent pica behaviors. Yet there was no comprehensive plan or protocol in place to monitor or supervise the client in connection with these behaviors. On the day of the incident there was no single staff person assigned to maintain either line of sight or one to one supervision for the client. Instead, all staff members were sharing the responsibility for monitoring the client's whereabouts. At one point the client was observed by a Senior Instructor to be sitting alone at a table handling wallpaper. There was no indication that this staff person took notice of or responded to the inherent danger that such wallpaper represented in light of the client's history of ingesting inedible objects. Another day program staff later observed that the client had wallpaper in her mouth for, "a while" before she approached the client and directed her to remove it from her mouth. Unfortunately, by then it was too late. The client began wheezing and choking on the wallpaper.

The evidence also revealed no consistent strategy or approach to the client's pica behavior on the part of any of the agencies responsible for providing her programming and care. Witness interviews revealed that there was a high degree of confusion with regard to the client's infrequent pica behaviors as well as confusion about her required supervision levels. There was also a lack of sufficient communication between all agency professionals responsible for ensuring client's safety and well being. Although OPA determined the day program to be primarily responsible for failing to provide the client with sufficient supervision on the day of the incident, documents and procedures prepared and generated by other agencies and intended as a guide for the day program did not appear to consistently and properly alert the reader to the especially dangerous risks associated with her behaviors .

Status: Closed AID – Neglect substantiated.

Recommendations:

This case demonstrates that infrequent pica behaviors reflect a great need for documentation to be shared between agencies, intensive arm's length supervision and consistent communication between all involved agencies and their staff responsible for the safety and well being of DMR Clients. The following recommendations appear warranted at this time.

1. That the DMR re-evaluate all Clients who have exhibited pica behaviors, even if they don't have a pica diagnosis, and conduct a risk assessment.
2. That the DMR ensure protocols are consistent with all program areas when addressing clients who have exhibited pica behaviors even if the behavior is infrequent.
3. That the DMR ensure pre-pasted wallpaper books are banned from all program areas and not used by clients unless under the direct one to one supervision, i.e. arm's length, of responsible staff.

22. Age: 60. **Residence:** Private CLA. (**OPA/AID intake:** 8/25/2005).

Nature of Allegation: Reportedly, an ambulance was called to the client's CLA at around 11:23 pm due to the client being unresponsive. The client was observed by first responders to be in respiratory distress and had low blood pressure. The client went into cardiac arrest while being transported to the hospital. CPR was initiated and the client was intubated. While at the hospital, CLA staff reported that the client had had cataract surgery earlier in the day and that the staff had given her 2 mg. of Ativan at 5 p.m. The CLA staff also told the ER nurse that the client had vomited five hours prior to staff calling 911 and the staff went on to describe an incident that sounded like aspiration. The client died 13 days later.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency, two CLA staff workers and an agency RN who failed to follow the hospital discharge instructions that required them to contact the doctor in the event of any nausea or vomiting following the client's cataract surgery.

Neglect was substantiated against the agency RN, for failing to follow the hospital discharge instructions to contact a doctor in the event of nausea or vomiting following the client's cataract surgery. The nurse was informed at 8:00 pm that the client had experienced multiple episodes of a small amount of vomiting, but she failed to provide appropriate medical assessment and/or monitoring parameters for the CLA support staff. Neglect was also substantiated against the provider agency for failing to have in place an effective method of communicating medical issues/updates and the need for additional support between the residential facility and the on call nurse.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency consider initiating disciplinary action against the agency RN in connection with the events and omissions which occurred the evening the client failed to receive appropriate medical attention while under the agency's care and custody.
2. That the DMR should ensure the agency implements more effective communication and response systems between staff and on-call nurses. Such systems should include on site assessments and administrative contacts for deciding whether the need exists to provide more facility staff support in light of a particular medical issue. The systems should also ensure that an on call nurse is available at all times thereby eliminating the confusing and vague secondary directive to follow the "chain of command," in the event that no nurse responds.
3. That the DMR ensure the provider agency review staffing coverage policies due to the lack of staff on duty on 08/23/05.
4. That the DMR ensure all provider agency staff are in-serviced regarding changes that are brought about as a result of these recommendations.

23. Age: 62. **Residence:** Private CLA. (**OPA/AID intake:** 12/5/2005).

Nature of Allegation: Reportedly at 7:15 pm the client was discovered to be unresponsive by CLA staff. Initial information indicated that upon discovery, 911 was called and that the EMS arrived, attempted resuscitation and transported the client to a local hospital ER. The client had been on 15 minute checks and was reportedly checked and found to be OK at 7:01 pm. The agency administration, upon review, found evidence that the CLA staff did not attempt to resuscitate (CPR) after the client was discovered to be unresponsive. The client did not have a DNR order in place at the time. The client was pronounced dead at 8:20 pm by the ER physician. The cause of death was listed as cardiac arrest.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency, two CLA staff workers and an agency LPN. A DMR Incident Report form which was completed by a CLA staff on the day of the incident stated that he went into the client's room and observed the client to be very pale and cold. The staff subsequently reported to another staff that "(the client) was dead." When interviewed, the staff person stated that he did not perform rescue breathing or CPR and that no one told him to perform rescue breathing. The staff person also indicated that the CLA LPN, who was on duty for the first shift only, had informed him that afternoon that, "there was not much urine," and that the client might have to go the hospital. A second CLA staff person was interviewed. She indicated she also did not initiate CPR because, "From what she could tell (the client) was gone and I would be

doing CPR on a dead person.” The staff person indicated that she touched the client and felt him to be cold and without a pulse. The staff person also indicated that she contacted an agency LPN before calling 911.

Contrary to the staff representations made to OPA, the agency administration reported that both CLA staff had earlier represented that, “It didn’t come to their minds to do CPR.” When interviewed by OPA, the LPN stated that when she was contacted by the CLA staff on the day of the incident, she did not instruct them to begin CPR. The LPN also stated that the CLA’s 2nd shift Sunday nursing position had been vacant for three years (excluding an initial short term hire and a recent short term per diem hire).

A statement from one of the first responders to the 911 call read as follows: “This call was toned at 19:39 hours (7:39 PM), as an untimely. I did not see any of the staff attempting any procedures such as CPR. Staffers seemed to be congregated in the kitchen area with other residents. The patient was warm to the touch according to the first responders from the fire department on scene. The patient was placed in the ambulance as I was doing respirations with the bag mask, and we seemed to be getting good oxygen with the bag and the oral airway. I explained that the patient was warm when we arrived (at the hospital) and that is why we transported. ER staff agreed that we had no choice but to do what we did.”

OPA found that the CLA staff were neglectful in failing to initiate CPR. OPA also found that the LPN was neglectful in failing to meet basic LPN nursing responsibilities to ensure the client’s health and safety. On the day of the incident, the LPN was aware of the client’s medical history and his immediate medical condition, including a temperature and low urine output. The LPN was also aware that no nursing staff was scheduled for 2nd shift. The LPN postponed sending the client to the ER, while instructing 2nd shift staff to be prepared to transport him to the hospital and moreover, informed no other medical personnel of the client’s medical condition.

OPA also found the provider agency neglectful for failing over an extended period of time to provide 8 hours of nursing staffing for 2nd shift Sunday at the agency’s residence with the most medically fragile population. The level of nursing staffing on the day that the client died was not an anomaly. The agency had not filled the vacant Sunday 2nd shift nursing position for 3 years.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR ensure that provider agency CLA staff are recertified in CPR.
2. That the DMR ensure that the CLA staff receive training regarding the location of CPR masks and that easy access to the masks be available.
3. That the DMR ensure the provider agency implement procedures to ensure that nursing shifts are staffed at the CLA.

24. Age: 43. **Location:** Day Program. (**OPA/AID intake:** 12/29/2005).

Nature of Allegation: The client was attending his regular day program run to pick up bread from a local grocery store and deliver it to a local soup kitchen. The client reportedly had done the same run three times per week for 12 years. When leaving the store parking lot, staff heard a loud noise from the back of the van. Staff looked back and saw something "shoot" out of the client’s mouth. The driver pulled over and noticed the client was having breathing difficulty. One staff attempted to perform the Heimlich maneuver, but was unsuccessful. The second staff also attempted with some result, however the client still appeared to be in distress. The client was assisted to the ground

where staff initiated CPR and 911 was called. The client was transported to the hospital where he was put on a ventilator and was noted to be unresponsive. The client died seven days later. The client did not have a history of opportunistically taking food; however he required 24 hour supervision and required that his food be cut up before eating.

Finding: OPA conducted an investigation and determined there was insufficient evidence to substantiate neglect. The client's records indicated that he had a diagnosis of Impulse Control Disorder. However, it was noted by OPA investigators that the client had participated in the food exchange program for a number of years without experiencing any food related incidents. A review of the client's records as well as interviews and statements indicated that the client did not have a history of "stealing" (e.g. unauthorized taking) food.

(Although neglect was unsubstantiated, in light of the recent cases involving clients and ingestible materials in vehicles, OPA made the following recommendation: "DMR should ensure universal precautions are developed and implemented with regard to all scenarios where clients of the Department are being transported in vehicles which also carry food and ingestible items.")

Status: Closed AID – No substantiation.

Recommendations:

That the DMR ensure universal precautions are developed and implemented with regard to all clients of the Department being transported in vehicles which also carry food and ingestible items.

25. Age: 30. **Residence:** DMR Regional Center. (**OPA/AID intake:** 01/03/2006).

Nature of Allegation: Reportedly, at approximately 8:45 pm, the client got out of his bed and began yelling, talking to himself, throwing objects and physically "going after" staff, whereupon at about 9:10 pm, the two staff members on duty restrained the client due to his escalating behaviors. The client's behavior response protocol involved a restraint component, and he typically had to be restrained approximately once a week due to behaviors such as the ones listed above. On that night, the client was held by his legs and arms on the floor in a supine (face-up) position. Staff released the client from the restraint hold at 9:25 p.m. After being released from the restraint, the client became agitated once again whereupon the two staff called in a third staff member, to assist in restraining the client. The client was restrained two more times with three staff. Two staff held the client's arms and the third staff held his legs. The client was allegedly in a supine position during all of the restraints. During the third restraint, staff reported that the client suddenly went limp and they noticed that his breathing had become shallow. Staff called 911 and began CPR. EMTs responding to the call stated that it appeared as though the client had suffered a cardiac arrest. Though he was only 30 years of age, the client had been diagnosed with hypertension. The client was pronounced dead at the hospital at 11:50 pm.

Finding: OPA conducted an investigation and substantiated neglect against the DMR and the three DMR staff who initiated the restraints on the client on the evening of the incident. There was no written record (beyond the incident report) describing the timing and restraint procedures which were employed by the three staff. Staffs' statements did not establish a firm timeline of events such as specific times for each restraint and each break in between. Further, the evidence indicated that towards the end of the restraining period and after having called in a third staff to assist, one worker left the facility to go off campus and purchase fast food for himself and his two co-workers. Photographs from the scene indicate that fast food containers were present in the room where the client was restrained. Staff statements indicated that they were engaged in eating between the second and third restraint while the client lay on the living room floor rug. One staff admitted to OPA that he had performed an unapproved restraint, however

briefly, on the client during the third restraint which began while the three staff were eating their food. At various times during that restraint the client was noted to be bleeding from his facial area. One staff indicated there was, "blood everywhere." However, at no point did any of the staff involved decide to call a nurse or seek medical attention for the client as the events unfolded. All of the staff involved indicated that they did not feel that the client's bleeding from the facial area was an unusual circumstance. Yet, a review of incident reports describing previous restraints of the client did not indicate any previous occasion where the client had bled from his nose/facial area during a restraint.

In addition, photographs from the Chief Medical Examiner's Office revealed that the client sustained a relatively large laceration to his nose. The DMR Nursing Supervisor indicated, when interviewed, that as a general rule staff should utilize the on-call nurse system for, "any change in condition." The Nursing Supervisor then indicated that a client bleeding would constitute such a change of condition. Although staff didn't contact the on-call nurse or administrator, they did decide to retrieve the client's bed sheet from his upstairs room. The three staff all represented that the sheet was placed underneath the client's head to prevent him from banging his head onto the floor. There was no approved provision for this procedure or for any use of a bed sheet during a restraint. Eating food, and dispatching one person to travel off grounds to purchase food, during a time when a client who is known to have behavioral episodes is experiencing agitation is also inconsistent with good practice. The only witness to the restraints other than the three staff actors was a client resident, who stated that on that evening, he observed the client to be on the floor wrapped up in the living room rug with one staff sitting on both him and the rug while the two other staff were eating fast food. OPA investigators found what appeared to be blood stains on the underside of the rug that was located in the room where the client was restrained. This case was investigated by the Connecticut State Police. The police investigation did not find the statement of the client witness to be credible, and was unable to establish that the client was either rolled up in carpet or covered with a sheet or blanket while being restrained. The three staff denied doing anything physically abusive to the client on the night of the incident.

OPA determined that there also existed sufficient evidence to substantiate neglect of the client by DMR. The client had a long established history of hypertension. As far back as 1995, the question of how to safely restrain him had been raised. In that year, a physician's concern that the stress of a protective hold could lead to the client having a stroke or heart attack led one facility to discharge the client. DMR was aware of the implications of the client's medical condition with respect to the use of restraints, as it was referred to in his 2005 Individual Plan. Nevertheless, DMR allowed, as relatively common practice, for the client to be repeatedly restrained without any provisions for medical follow-up afterwards and without attempting to make any special modifications to the restraint process that would take into account the client's severe hypertension.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR ensure the decision to utilize physical restraints takes into account any physical or emotional limitations that may place an individual at risk, especially serious physical conditions such as high blood pressure.
2. That the DMR ensure strategies for calming down, identifying risk factors and approved restraint techniques are included in a client's individual treatment plan. All members of the clients team should be aware of individual client needs/risks.

3. That the DMR ensure that repeated incidents in which emergency restraints are administered cause the timely development of an approved plan for restraining to be developed and placed into the client's individual treatment plan consistent with DMR Procedure 1.E.PR.002 (04/06).

26. Age: 46. **Residence:** Private CLA. (**OPA/AID intake:** 02/21/2006).

Nature of Allegation: Reportedly, at 1:00 am, CLA staff called the on-call RN and left a message reporting the client was not feeling well. Staff called the nurse again later (time not recorded) due to no response. First contact with the on-call nurse occurred about 4:30 am, when staff informed her that the client had vomited blood and had a fever. The nurse stated that staff should monitor and call her back if the client experienced more fever or continued vomiting. By 9:00 am the following morning, the client had a fever of 102 degrees and the nurse prescribed Tylenol. The fever came down and the client was able to eat but went back to bed not feeling well.

Progress notes from the first evening in question indicated that client's hands were observed to be blue-tinged and cold. The nurse did not examine the client for two day shifts in a row. On the third day, at 3:00 am CLA staff observed that the client appeared to be sleeping. At 3:30 am that same morning, staff checked and found her to be blue and called 911 then began initiating CPR. The client was pronounced dead upon arrival to the hospital Emergency Room.

Finding: OPA conducted an investigation and substantiated neglect against the on call nurse and three agency staff. It was determined that there was a failure by the on-call nurse to uphold proper standards of care and the above-mentioned direct care staff failed to accurately communicate the client's symptoms to the nurse. There is also concern regarding a lack of consistent standards regarding staff documentation concerning ongoing medical issues. Not all of the CLA staff were aware of the client's symptoms or the course of her illness or her treatment regimen.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency evaluates and corrects the process by which medical issues are managed within the group home. The agency should create a series of checks and balances whereby staff can better monitor illnesses that clients may exhibit. Staff should be educated in regard to the importance of accurate and timely reporting of symptoms when trying to manage a serious illness or even a minor illness. Staff should be informed that it is appropriate to contact the nurse with medical information even if they themselves are not medication certified.
2. That the provider agency ensure all staff involved are in-serviced on signs and symptoms of illness and the importance of communicating this information to the nurse. Staff should also be in-serviced on taking body temperatures and the differences between axillary and oral temperatures.
3. That the provider agency's protocol for on-call nurses is revised to include when and how a client is to be physically assessed by the on-call nurse, when to send a client to the emergency room and when a client should be evaluated by their physician. Specific guidelines should be created to address clients with an elevated body temperature of 102 degrees and or a fever that lasts more than two days. There should also be a protocol established for a back up person to contact in case the on-call nurse is unavailable.
4. That the provider agency re-consider their policy which enables non medication certified staff to work third shift by themselves.

5. Disciplinary action should be considered for those employees who were determined neglectful in their job responsibilities.

27. Age: 45. **Residence:** DMR CLA. (**OPA/AID intake:** 03/02/2006).

Nature of Allegation: Reportedly, the client's program called for him to receive a ground food- only diet. The client also had 15 minute eyes-on checks and at all other times was supposed to be "within earshot" of staff. The client also had a history of trying to "steal" (e.g. take without authorization) and eat food and therefore the refrigerator was kept locked at all times. On the day of the incident at about 5:45 pm, one of three CLA staff went to check on the client and discovered him lying face down. The client was described by that staff as being, "semi-unconscious," but another staff described him as being, "blue." Reportedly, two male and one female staff were on duty at the CLA at the time of the incident. Staff called 911 and tried to perform CPR. EMTs used a forceps/tweezers tool and dislodged a meatball from the client's throat. The meatball was in 2 parts but that may have been a result of the forceps used. The client was taken to the hospital and later pronounced dead.

Finding: OPA conducted an investigation and substantiated neglect against the DMR and the three DMR staff who failed to follow the client's established Level of Supervision Guidelines for ensuring that food was properly secured and failed to properly perform life saving measures in accordance with DMR CPR training. In substantiating neglect relating to the choking incident, OPA noted that the same three staff were involved in a previous choking incident a few years earlier involving the same client, which also resulted in a finding of substantiated neglect.

Upon investigation, the evidence indicated that the client did have a swallowing disorder and also had a history of unauthorized taking of ("stealing") food. On the day of the incident, sometime between 5:10 pm and prior to 5:58 pm, when a call was placed to 911, the client was discovered unresponsive in his bedroom by a male staff. The paramedics determined that the client had a meatball lodged in his throat, that he was not breathing and had no pulse. The results of an autopsy concluded the cause of death was due to occlusion of the airway by a foreign body. The evidence indicated that the meatball that client choked on was left out in the open by CLA staff in violation of established CLA protocols and procedures which required that food be properly secured precisely for the reason that it represented a choking risk to the client.

An investigation was also completed by the Connecticut State Police which did not result in the arrest of any CLA staff. However, the police investigation report stated, "After analyzing the statements and reports, I feel that the staff did not properly supervise (the client) or properly store the food...I have concluded, based upon the evidence, that the staff was 'negligent' in their actions."

OPA also determined that evidence existed sufficient for substantiating neglect by the Department of Mental Retardation in connection with the death of the client. The DMR failed to implement many of the several recommendations that it generated in its own previous investigation that involved the same client choking with the same staff on duty. The recommendations that were not implemented included not having proper food restrictions in place at the CLA on the day of the incident, not having clear CLA staff assignments for monitoring the client's whereabouts, allowing client supervision practices to be substantially at variance with written protocols and CLA log book representations, administrators and supervisors being unaware of the client's supervision requirements and therefore having no way of knowing whether direct care staff were implementing such required supervision.

It was especially troubling to this Office that when interviewed, the DMR Program Manager for the CLA, who himself conducted the previous DMR investigation, was unfamiliar with the client's program and was unable to provide specific information about the implementation of what amounted to his own recommendations for

preventing the client from experiencing another choking incident. Similarly, the DMR Program Supervisor, when interviewed, was also unable to describe any specific measures which were put in place after the first incident to ensure that the client was safe from the risk of choking. Throughout the interview and evidence collection process, it became apparent that there was no consistent response as to the supervision guidelines for the client. In addition, no evidence was found that written protocols were implemented to address the client's behavior of taking food without permission. In addition, the CLA meal time supervision guidelines were not being consistently implemented.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR should take appropriate disciplinary action in regard to the three individuals for whom neglect has been substantiated.
2. That the DMR ensure all supervisors and Program Managers are familiar with any and all recommendations which are generated as a result of a substantiated case of abuse or neglect and that such supervisors and Program Managers are made responsible for ensuring the implementation of any recommendation which might reasonably lead to the reduction of risk for a future similar incident of such abuse or neglect.
3. That the DMR ensure all staff are made aware of the guidelines, protocols, and supervision requirements associated with any implementation of a recommendation which has been generated from a substantiated case of abuse or neglect.
4. That the DMR ensure a concerted effort is made to identify all clients within the system who may be at a higher than normal risk for choking and develop universal strategies for ensuring the ongoing safety of such clients. Such strategies should include regular in-servicing on individual needs and program requirements with Quality Assurance oversight.
5. That the DMR ensure the content of any staff training or in-service is documented with a clear description of what the training entails.
6. That the DMR review the adequacy of CPR instruction and competency testing received by its staff members who are required to be CPR trained and certified. For example, CPR should never be done on a bed (unless there is a board under the person), airways should always be checked, chest should always be monitored for rising, choking should be suspected and the Heimlich maneuver or other airway clearing procedure should be attempted if chest does not rise.

28. Age: 52. **Residence:** Private CLA. (**OPA/AID intake:** 03/13/2006).

Nature of Allegation: Reportedly, the client had an abnormal pap test on an unspecified date in November of 2004. A follow-up biopsy was performed but the results indicated that there were insufficient cells collected for a diagnosis. A second biopsy was not scheduled. Throughout the spring and summer of 2005, the client lost weight and was checked by her primary care physician. In September of 2005, the client became incontinent and was taken to a urologist. The client underwent an ultrasound, which resulted in a report indicating that she had an enlarged prostate. The agency again did not pursue having the test re-evaluated even though the client obviously did not have a prostate due to the fact that she was female. In December 2005, the client was taken for a GYN examination, during which examination she began to bleed and was taken to the hospital. The client was subsequently diagnosed with an inoperable cervical cancer, from which she died.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency, the agency's Primary Care Nurse and the agency APRN. The Primary Care Nurse failed to make follow-up appointments after a lab report dated, 06/18/04 noted, "Small atypical cells, predominantly single, noted in a bloody background," and recommended "GYN F/U." On 9/1/04, the client was seen at a local hospital where, "squamous intraepithelial lesions, high grade" were found. Recommendations noted: "F/U PAP, colposcopy." However, the client did not have a follow-up GYN exam until 12/18/05. Additionally, OPA determined that the agency APRN failed to appropriately review and coordinate medical services with physicians and the primary care nurse as it applied to the client's care and treatment. According to the APRN, the client's initial abnormal PAP (6/18/04) was reviewed by herself and the doctor. The APRN maintained she was, "out of the loop after that." The client had subsequent appointments with other health care providers which were not reviewed by the APRN. The APRN was scheduled to perform a physical exam on the client but noted she was, "uncooperative, cervix not visualized." When asked whether a follow up appointment was scheduled, the APRN replied, "No, I saw what I needed to see, there was no need to do a PAP due to GYN referral already being made to (the OBGYN doctor)." When asked whether she followed up with the doctor to find out the result of the PAP test, the APRN responded, "No, the doctor does that, in this case (the PCP) would." When asked whether she then followed up with the PCP, the APRN replied, "No." The APRN's statement conflicted with the agency's job description for her position.

Additionally, The Department of Public Health, in reviewing this matter found evidence to substantiate several facility deficiencies including: failure to provide or obtain preventive and general medical care, failure to ensure proper coordination and oversight of medical services with gynecologist, failure to follow up with the GYN concerning insufficient material for diagnosis reports, failure to ensure that primary care physician participated in reviewing the abnormal PAP tests on 6/22/04 and 9/1/04, failure to provide accurate information on client's quarterly health care review reports.

Neglect was substantiated against the provider agency.

(NOTE: On 06/15/07, at their request, representatives from the provider agency were allowed to review the investigation report and its recommendations. The representatives expressed concerns regarding the findings of the OPA investigation report. The agency indicated that the results from the 09/01/04 Cytology GYN Report may not have been known at the agency prior to 01/30/06, when the hospital document was faxed from the gynecologist's office with a handwritten recommendation for a follow-up PAP colposcopy. According to the agency representatives, the agency's internal investigation turned up a second copy of the 09/01/04 Cytology GYN Report, on which there was no handwritten instructions for follow-up. This second copy of the report indicated that it was faxed from the gynecologist's office on 11/04/04. The provider agency representatives indicated that the agency found this second copy misfiled and located it along with unrelated non-medical documents pertaining to the client. Both copies of the document indicated that on 09/01/04, the hospital observed the client to have "squamous intraepithelial lesion: high grade." According to the agency representatives, there was no way to determine whether the agency actually received the Cytology report on 11/18/04 and so therefore there was no evidence to indicate that any agency nurse reviewed the document prior to 01/30/06, when the second copy was known to have been faxed.

Agency representatives further stated that the agency had actively attempted to provide the client access to appropriate medical treatment throughout the last years of her life and noted that the agency had received a written notification on 09/20/04 from the OBGYN office that the, "precancerous detection smear was normal." The agency representatives indicated that this same information was made known by them to the Department of Public Health. The agency representatives stated that in light of this information the OPA investigation findings should be amended to reflect that the agency nurses did not receive two notices of abnormal test results and moreover, the agency argued that there existed insufficient evidence to substantiate neglect on either nurse.

In light of the additional information provided to OPA, the conclusions reached in the investigation report were reviewed. Documentation provided by the agency did indicate that two different copies of the 09/03/04 hospital Cytology Report were received by the agency. The evidence indicated that the copy with the handwritten directive for a follow-up was faxed by the gynecologist's office on 01/30/06. The other copy was faxed from the gynecologist's office on 11/18/04 and was subsequently misfiled by the agency. The agency essentially argued that there was no way to demonstrate their receiving notice of the cytology results prior to the second copy dated 1/30/06 being faxed to them. To this end, the agency argued that the individual nurses who were responsible for overseeing the client's medical care and treatment and responsible for reviewing and maintaining the integrity of the client's medical records should not incur a finding of substantiated neglect. This Office disagreed and the findings remained intact notwithstanding the discrepancy regarding the 09/03/04 cytology report. In maintaining this finding OPA also understood that the agency received an erroneous postcard from the gynecologist's office dated 09/20/04, indicating that client's precancer detection was normal and instructing that another PAP test be scheduled in 12 months. However, this postcard did not refer to any date specific test and did not represent itself to be the results of a biopsy. The postcard was also from the beginning inconsistent with the medical history to that point. Neither the agency RN nor the APRN were able to provide any documentation to indicate that they ever undertook to clarify the results of the biopsy as it may have or may not have related to the PAP smear postcard. At some point on or after 11/18/04 the agency received the Cytology GYN Report which indicated that the client had squamous intraepithelial lesion: high grade. This important report and information was misfiled. Neglect remains substantiated against both nurses and the provider agency.)

Status: Closed AID – Neglect substantiated.

Recommendations:

The following recommendations were made by the Department of Public Health:

1. The Nursing Manager will ensure that specific health care requirements are met to include provisions on medical services, maintaining an optimal level of health for each individual, coordination, oversight and documentation of medical services and participation of the Primary Care Physician in the review of medical services.
2. The Nursing Manager will ensure that the Primary Care Nurse investigates and pursues with physicians any subsequent ambiguous clinical data received.
3. (The provider agency) will enhance their current documentation systems through ensuring all recommendations by the APRN are written and that verbal information from the physician that is given to the APRN is also written. In addition, the facility staff, Medical Support Assistant or designee will schedule and complete timely medical appointments. This will be monitored by the Primary Care Nurse through her completion of quarterly audits to ensure accurate completion.
4. The Nurse Manager will review position descriptions with the PCN and APRN to ensure accurate understanding.

It is recommended by this Office that the Department of Mental Retardation Quality Assurance Division and Health Services Division monitor (the provider agency's) progress in coming into compliance with the above recommendations.

Additionally, OPA recommended that the provider agency review its physician communication and accessibility protocols in order to ensure that all consumers are in fact receiving necessary medical appointments within a reasonable time period.

29. Age: 45. **Residence:** Private CLA. (**OPA/AID intake:** 03/23/2006).

Nature of Allegation: Reportedly at 6:40 am the client was checked on by staff and found to be sleeping. Staff then went to use the bathroom and at 6:50 am checked again on the client, who was found to be unresponsive. Cookie wrappers were found either around or on the client's bed. 911 was called and the client was treated by first responders and taken to the hospital, where for a while he was able to have, "shallow breaths on his own." Because he had been determined to present a high risk of choking, the client had a food guideline in place which restricted all food from his room and called for his food to be cut up. The client also had "hands on" supervision guidelines to address behavioral issues. The client never recovered from the choking incident and died five days later.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency. The evidence indicated that at the time of the incident, the client was known by the residential provider agency to have insomnia, aggressive food-seeking behaviors and one to one awake staffing requirements. The client also had had a recent incident of severe choking. The client was not the only resident at the CLA with insomnia. There were a total number of 5 clients in the CLA at the time of the incident. The evidence indicated that the provider agency had cut back third shift staffing for the residence from two regularly scheduled overnight staff to one scheduled overnight staff. The agency provided third shift staff with verbal or informal instructions regarding what to do when the client was awake on third shift. These instructions amounted to requiring the client to follow staff around the CLA as they performed their third shift duties. The agency also knew or should have known that the monitoring/listening device in the client's room which alerted staff when the client was awake, was in fact inoperable.

In addition, it was known that the client also would take food without permission on a regular basis. When interviewed, several staff indicated that the only way this behavior was addressed was the 1:1 assigned to the client would have to try to prevent him from taking food. There was no evidence of any protocol or procedure to keep food out of sight, put food away or otherwise address the client's "high risk choking" potential.

OPA determined that insufficient evidence existed to substantiate neglect on the part of the CLA direct care third shift staff who was working alone with the client and four other CLA residents on the day of the incident. There was no evidence to indicate that the staff person wavered from his prescribed duties and responsibilities. According to the staff person, the client spent most of the evening awake, but late in the third shift finally went to sleep. The staff person stated during his routine bed check at 6:45 am, he noted the client to be sleeping. About ten minutes later, he observed the client to be out of his room, seated at the upstairs window seat and unresponsive. The staff immediately dialed 911 and began performing CPR. OPA found that the third shift responsibilities were practically beyond the ability of one staff person to safely perform.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR ensure that a concerted effort is made to identify all clients within the DMR system who may be at a higher than normal risk for choking and develop universal strategies for ensuring the ongoing safety of such clients. Such strategies should include regular in-servicing on individual needs and program requirements with Quality Assurance oversight.
2. That the DMR ensure clients requiring specific supervision levels "during waking hours" are provided with that supervision without regard for the time of day or night.

3. That the DMR ensure that all monitoring safety devices as medically or behaviorally ordered for clients with choking risk behaviors are regularly checked and maintained in operable condition.

30. Age: 44. **Residence:** Private CLA/Day program. (**OPA/AID intake:** 04/20/2006).

Nature of Allegation: Reportedly, the client fell over in her walker while attending her day program, hitting her head and becoming unresponsive. The client was taken to the hospital where she regained consciousness. When examined by a physician, the client's head was fine, but when the client's blood work came back, it was determined that the client had severe pancreatitis. The client was placed in the hospital's ICU on life support. After a period of maintenance in the ICU without improvement, the client's family decided that she should be taken off life support.

Finding: OPA conducted an investigation and determined there to be insufficient evidence for substantiating neglect. Hospital records indicated that the client died from acute pancreatitis that was determined not to have been caused by a fall or from trauma. The fall appeared to be an unfortunate event which occurred prior to her death. The client gave no indication to any of the staff interviewed that she was in pain or discomfort on the day of, or the week prior to her hospitalization, with the exception of staff observations that she appeared "groggy" or "sleepy" the morning of her fall. When interviewed, the hospital emergency room physician was asked if he felt that the client may have been neglected on the day of the fall to which he responded that that he did not feel she had been neglected based upon his emergency room evaluation.

Status: Closed AID – No substantiation.

Recommendations:

Although neglect was not substantiated, OPA recommended that the DMR closely monitor all clients taking Valproic Acid for signs of pancreatitis. The client died of acute pancreatitis and was taking Valproic Acid. Medical literature reviewed during this investigation indicated there exists a heightened risk for developing acute pancreatitis for people who have Valproic Acid in their system.

31. Age: 49. **Residence:** Private CLA. (**OPA/AID intake:** 07/28/2006)

Nature of Allegation: Reportedly, the client was admitted to the hospital for aspiration pneumonia and was placed on a respirator. Upon admission to the hospital, the client was found to have a serious vaginal infection and doctors obtained permission to run STD tests. All tests returned negative, but the significant skin breakdown in the client's genital area caused a suspicion that the client had received poor hygiene care by CLA staff (diaper changing, etc.). The client later died.

Finding: OPA conducted an investigation and substantiated neglect against the residential provider agency, an agency RN and two residential support staff who were on duty during the events which precipitated the client's experiencing aspiration. In addition to substantiating neglect, OPA found instances of problematic, incomplete, and/or inaccurate agency documentation.

The client was taken to the hospital after experiencing an apparent aspiration incident at her CLA. At the hospital, a Mucinex tablet was suctioned from the client's lung. The CLA records indicated that the client had been administered two Mucinex tablets prior to her aspirating. When interviewed by OPA, a CLA staff worker indicated that he wrote on the Medication Administration Record (MAR) that he had administered the Mucinex to the client that day, but that in fact he had actually given the medicine to the CLA Manager, who subsequently mixed it in with the client's food. The CLA staff was certified to administer medication at the time of the incident. The CLA staff originally represented to OPA that he had crushed the Mucinex tablets prior to their being mixed into the client's

food. The staff person indicated that he also wrote a note to indicate that the administered Mucinex had achieved the, "desired effect," when in fact the client began to exhibit symptoms of respiratory distress only minutes after receiving the Mucinex tablets. When informed that an entire tablet was found in the client's lung, the CLA staff became unclear as to whether he had in fact crushed the medication, but indicated that such was his normal practice.

When interviewed, the CLA manager was unable to recall whether she administered the Mucinex. The manager indicated that she called two agency nurses for advice after she heard the client gurgling and moments later dialed 911 when the client began to turn blue. The manager stated she attempted to pat the client on the back while she waited for the ambulance to respond. However, the manager did not initiate CPR and did not document initiating any attempt to clear the client's airway. She instead documented, "There were no problems or concerns" that morning and further documented that the client had gone to day program. When asked, the CLA manager indicated that she had prematurely completed her shift documentation.

Although both CLA staff were aware that the client had a swallow protocol, neither were able to state how the protocol operated with regard to the administration of tablet medication. The client had a long history of swallowing difficulties which were known to her residential providers. Based on this history, the agency had had an extensive, thorough swallow protocol that was completed by the agency's own speech and language pathologists. However, the swallow protocol did not contemplate the administration of tablet or pill form medication. When interviewed, the client's primary care physician indicated that she was aware the client had a swallowing protocol, but was never presented with the protocol nor made aware that she had difficulty swallowing medication. The doctor indicated that the agency nurse would have been the appropriate person to inform her of any issue the client might have had regarding swallowing medication.

One problem noted was that the medication administered, Mucinex, is an extended-release tablet and, therefore, should not be crushed prior to administration. When Mucinex is crushed, dissolved, or chewed, the time release function is nullified and the recipient receives the full 12 hour dose all at once. In addition, as this medication is used to thin mucous secretions, it is necessary that the patient's fluid intake be increased in order to assist with thinning these secretions. Therefore, the directions for Mucinex are that it be given "with a full glass of water." However, there is no evidence that the client received any water with the Mucinex tablets. To the contrary, it was evident, based on the swallow studies, that the client was incapable of consuming a full glass of water.

Throughout the client's files the diagnosis of dysphagia appeared inconsistently. There was also no consistency on the part of staff with regard to completeness of record keeping. When interviewed, the agency RN was asked if she did regular reviews to ensure that the records were complete, accurate, and up to date. The RN stated that she did not as she saw no reason for doing so. The RN stated during the interview that she was well aware of the client's medical history, including past incidence of choking, and that she had attended all of the client's quarterly meetings. The RN stated that when the client choked it was usually because staff had fed her too fast. The RN was not familiar with the results of the client's last swallow evaluation and indicated that there was no protocol in place to assist her with swallowing medication. The RN indicated that staff basically decided on their own whether and how to give the client the tablet Mucinex or the liquid form of Robitussin. It was also noted, that in several instances, the RN had either changed or augmented the client's doctor's orders after the doctor had signed them, without herself signing or initialing them and without getting the doctor's signature after the change.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency ensures all staff, including the RN receive retraining on proper documentation.
2. That the provider agency ensure that the two CLA direct care staff retake the medication administration course for clarification and reinforcement of proper and legal medication administration practices.
3. That the provider agency take administrative action regarding false documentation as evidenced above in the findings of the investigation.
4. That the provider agency ensure that the RN take a nursing refresher course or is otherwise updated on the current standards and practice of nursing practice, documentation, and doctor's orders.

32. Age: 36. **Residence:** Family Home. (**OPA/AID intake:** 08/03/2006).

Nature of Allegation: Reportedly, the client lived in the family home receiving no services from DMR. The client was also overweight and had diabetes and frequently stayed up all night watching cartoons. The client stayed up all night. The police reported that his mother checked on him during the night and he appeared to be sleeping on the floor, which was normal for him. When his mother later went to check on him, she had concerns and called 911. Client had died on the living room floor.

Finding: OPA conducted an investigation and substantiated that the client was not receiving services necessary to maintain his health and safety while residing at his family residence with his mother and sister. The evidence indicated that the client resided in an extremely rundown structure. The client's residence was noted by police and first responders to be filthy and in substantial disarray. The police took photographs of the residence, which depicted the home to be dilapidated, cluttered and possibly unfit for human habitation. When OPA investigators visited the residence, an accompanying police officer referred to the address as a "bio hazard" even before arriving at the house. OPA investigators noted the residence to have an extremely foul odor upon entry and observed the home to be caked with filth and grime. The client's room was noted to have no furniture of any kind. It was the impression of both the local police and this Office that the home appeared to be in a rundown state which evidenced years of neglect.

Autopsy results indicated that the client had a urine glucose of more than 5000 units on dipstick, which according to the Medical Examiner was consistent with a medical condition known as diabetic acidosis. According to the American Diabetes Association website, diabetic acidosis, or ketoacidosis, is a serious medical condition which can lead to severe illness, diabetic coma or even death. The evidence indicated that the client was not under a doctor's care or being followed by any physician at the time of his death. When interviewed, the client's mother stated that the client did not have diabetes. The mother also indicated that for years the family refused DMR offers for services.

Sadly, the client's mother herself died about four months after the client died. A review of DMR records indicated that the Department did periodically follow the family even though the family refused services and last made contact with the family in April, 2005. A note in the client's DMR file indicated that the home was in deteriorating condition in December, 2001 but that the family at that time still refused services.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DMR ensure reports of suspected neglect in family homes are made to the Office of Protection and Advocacy when so warranted in connection with periodic Case Management family contact to residences, especially in situations where the family is not receiving ongoing service delivery.

2. That the DMR provide Case Managers with ongoing training in order to increase the Department's ability to spot issues such as poor medical oversight, poor hygiene, poor nutrition and/or a neglectful living environment while performing home assessments.
3. That whenever possible the DMR should attempt to ensure continuity of Case Management services by limiting the number of Case Managers assigned to support families and individuals over time. (It was noted that the client had seven Case Managers in a ten year period.)
4. That the DMR should ensure Case Management supervisors accompany Case Managers from time to time when visiting clients who are not receiving any outside services and for whom there may be a question or concern as to the suitability of their living environment or adequacy of their health care.
5. That whenever possible, the DMR should ensure FAPs are completed in person as opposed to over the phone in order to adequately assess the person's living situation and support needs.

33. Age: 54. **Residence:** Private CLA. (**OPA/AID intake:** 09/01/2006).

Nature of Allegation: Reportedly, the client died due to a choking incident, which may have involved the client choking on a chicken bone or piece of chicken. The client was supposed to have a chopped food diet consistency.

Finding: OPA conducted an investigation and substantiated neglect on the private residential provider. The evidence indicated that the client had a history of inappropriate eating behaviors which included aggressing toward and taking food which was not meant for his own consumption. Additionally, at least two nutritional assessments identified the client as being at risk for choking at meal and snack time and the client's meals were ordinarily served to him in a chopped consistency with staff support and supervision. Yet, there was no evidence of a formal protocol or formalized procedure for ensuring the client's ongoing safety with regard to his known behavior of aggressing toward food. The evidence indicated that the residential staff informally followed an unwritten protocol where client would not be left alone in the kitchen when food was out. However, OPA noted confusion among group home staff regarding the purpose for preventing the client from entering the kitchen when food was present. Some staff indicated they thought the procedure was in place to prevent the client from getting into the pots and pans or to prevent him from burning his hands on the stove. Overall, CLA staff were left to interpret on their own how best to supervise the client. Staff were also on their own in deciding how small to cut the client's food pieces. On the day of the incident, the client was able to obtain a piece of uncooked chicken from the kitchen area while staff were out of the room. The client choked on the piece of chicken and subsequently died.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency's clients have clearly written safety and behavioral protocols and that all staff are in serviced in these protocols.
2. That the DMR ensure during client quarterly meetings day program and residential program staff share information relevant to the client's health and safety.
3. That the DMR ensure the safety of another client residing in the CLA with regard to his reported trash and food cabinet rummaging.
4. That the provider agency Behaviorist review all clients and make recommendations that encompass all reported behavioral safety incidents.

5. That the provider agency ensure all staff are complying with recommended safety protocols.

34. Age: 48. **Residence:** DMR Regional Center. (**OPA/AID intake:** 01/25/2007)

Nature of Allegation: Reportedly, the client passed away after having been hospitalized for two days with pneumonia. The client was transported to the hospital at approximately 12:20 pm after exhibiting symptoms of extreme illness throughout the day. The client was noted to have developed a "barking cough" on Monday. Unit staff alerted the Regional Center nursing staff as to the client's condition and recommended that she be examined by a physician throughout the week, as her cough persisted and she eventually developed a low grade fever (99.0° on Friday). However, the Regional Center nursing staff allegedly responded by giving the client some Robutussin cough syrup and little else.

On Wednesday at about 9:30 am, the client was found on the floor, face down by direct care staff. The client was removed from the floor and propped up onto a couch with a pillow. Allegedly, a nursing supervisor RN was then contacted and arrived on the unit a short time later. After listening to the client's lungs, that nurse determined them to be clear and made the decision to have the client continue to rest at the Regional Center even though direct care staff were expressing the opinion that the client was getting worse and should be seen at the hospital. By 11:30 am, the client's temperature was 100.5°. Staff also noted the client to have diarrhea at about 11:30 am. A nurse made the decision to send the client to the hospital for an evaluation after being told that she had developed diarrhea.

Finding: OPA conducted an investigation and determined there was insufficient evidence for substantiating neglect with regard to the actions of the Regional Center nursing staff. The overriding concern from all parties during this investigation was that of a lack of effective communication. There was little, if any, documentation of communication of medical and other concerns by direct care staff to the nurses or to administration. There also appeared to be confusion regarding the way in which direct care staff who have questions or health related concerns communicate them to nursing staff, and also, some confusion as to how such communication of concerns were to be documented. Notwithstanding confusion on these points, facts found by OPA investigators indicated that the client received timely and appropriate nursing care.

Of note was the fact that direct care staff were concerned that an LPN did not do a nursing assessment of the client following her being found on the floor, even though conducting nursing assessments is beyond the scope of practice for LPNs. (Assessments are considered to be within the scope of practice of Registered Nurses under the Nurse Practice Act.) Also, staff were concerned that the RN did not take seriously a rectal temperature reading of 99.1. However, that temperature was considered a normal temperature (a fever with a rectal temperature would be over 100 degrees F).

Status: Closed AID – No substantiation.

Recommendations:

The overriding concern from all parties during this investigation was that of a lack of effective communication. There was little, if any, documentation of communication of medical and other concerns by direct care staff to the nurses or to administration and expectations on the part of direct care does not seem to be clearly defined. The issue seemed to concern the manner in which direct care staff communicated health related concerns and also, some confusion as to how direct care staff concerns were documented.

In addition, each job classification needed to be clearly defined to all staff. Also, roles needed to be clarified as LPNs were not legally allowed to do nursing assessments. It was also recommended that DMR consider refreshing the

training regarding vital signs as staff were concerned that the RN did not take a rectal temperature of 99.1 seriously when in fact this temperature is considered to be a normal reading. Also recommended was that DMR ensure that clients are receiving medications within the allowed time parameters.

35. Age: 63. **Residence:** Private CLA. (**OPA/AID intake:** 02/20/2007).

Nature of Allegation: Reportedly, the client was found unresponsive by third shift during a client check at approximately 11:15 pm. 911 was called and police were dispatched to the scene. The client was declared deceased and the OCME accepted jurisdiction. CLA staff indicated that the client had been vomiting, "all day." When asked how often the client had vomited, CLA staff responded, "I couldn't count, pretty much continuously." CLA staff also indicated that the agency's on-call nurse had not been called and staff had been, "giving her a lot of fluids."

Finding: OPA conducted an investigation and substantiated neglect on the private residential provider, an agency RN and an agency residential support staff. The CLA staff member who found the client to be unresponsive failed to perform CPR. The staff stated she did the initial part of CPR as trained to the extent that after observing the client to be unresponsive, she checked her pulse, performed a finger sweep and called 911. The staff stated she then, "freaked out" and was unable to perform the chest compression and/or rescue breathing. There was no equipment discovered in the house to aid in performing CPR, such as a face mask or mouth shield.

Upon review it was found that the agency nurse RN never carried over the client's previous surgical and hospitalization issue history, which were included on the DMR Transfer Sheet when the client first began receiving services from the provider agency in June, 2003. Noted on the DMR Transfer Sheet were: "1975-ileostomy," "R/O SBO (rule out small bowel obstruction)," and "chronic ileus." These diagnoses were not found on any agency paperwork, medical or otherwise. These diagnoses were significant and related to the cause of the client's death, which was noted on autopsy to be caused by "small intestinal obstruction." A review of the agency's records revealed that the client went upwards of two weeks without a bowel movement and spent the last few weeks of her life vomiting off and on. Although there was a mechanism established for tracking bowel movements, the information did not seem to be of any value as it was not conveyed to anyone nor was the data summarized in any helpful way. In addition, some staff were unaware of the rationale behind the bowel tracking information. Were staff more knowledgeable about the client's medical history of small bowel obstruction and/or ileus, along with the most recent bowel tracking patterns, more timely and appropriate medical care might have been afforded for the client.

The agency RN indicated when interviewed that she had minimal oversight and involvement with the client allowing her move to a supported living arrangement from a CLA on 12/1/2005. The RN stated she was told by an agency administrator that no notes were needed from the nurse for residents in supported living settings. Nevertheless, a review of the American Nurses' Association standards indicated that, "All of the reporting and recording activities in which nurses engage support the goal of ensuring quality patient care and accountability for care delivery. In fact, documenting care is a part of giving quality patient care." Additionally, a review of the DMR nursing advisory indicated, "A licensed nurse shall document all nursing interventions and care provided for each client including telephone communications." The same DMR advisory also indicated, "A licensed nurse shall document an evaluation of identified nursing needs when an individual's health status changes and/or as specified by regulation." The evidence also indicated that the RN changed a doctor's order to have the client continue a medication for an additional two days past the date that it was discontinued by the physician without first consulting with the physician.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency consider administrative action against the CLA staff for failure to perform CPR upon discovering a client unresponsive.
2. That the provider agency ensure each group home has proper equipment to aid in performing CPR, such as a face mask or mouth shield and gloves and that such equipment is maintained in a consistent location.
3. That the provider agency review client documentation and update these records to reflect current and complete medical diagnoses and history.
4. That the provider agency reinforce with agency nurse and medication certified staff that it is their responsibility to know the side effects as well as the rationale for all medications they administer as is part of medication administration training and should also be reinforced during the annual pass and pour by agency nurse.
5. That the provider agency consider retraining all agency direct care staff on policies and expectations regarding complete documentation on any and all legal documents.
6. That the provider agency adopt a more integrated medical model for nursing oversight. The complete autonomy of the agency nurse, without any checks and balances, put other clients at risk and may have contributed to the death of this client.

36. Age: 58. **Residence:** Private SLA. (**OPA/AID intake:** 02/21/2007)

Nature of Allegation: Reportedly, the client had been complaining of abdominal pain and vomiting beginning Thanksgiving Day. The client called EMS after vomiting in the early morning hours of the following Saturday, but refused to be transported to the hospital. The client also called an agency on-call supervisor who spoke with both the client and a paramedic who was then present at the client's SLA. After the paramedics left, the client continued to vomit and had a low grade fever of 100.9. Later, on Saturday, second shift staff stated that the client vomited twice, but also documented that he was given his night time medication with no mention of him vomiting it up. The client was found unresponsive at 7:00 am on Sunday. EMS was called but no attempts at CPR were made by staff. The client was pronounced dead by the EMS.

Finding: OPA conducted an investigation and substantiated neglect on the private residential provider and the support staff person who failed to initiate CPR, failed to document the client's vomiting and failed to call medical support staff for the client's vomiting. Despite having been trained and certified to administer CPR, the staff person did not provide any resuscitative attempts nor did she immediately call 911 in order to obtain emergency assistance when she observed the client to be unresponsive on the floor. The staff person stated that she did not provide CPR because, "I could tell, as far as I could see, he was passed."

The same staff member showed poor judgment by ordering the client pizza and a grinder on Friday night. The client was on a low cholesterol, no added salt diet. The client also vomited twice on that same night (Friday) and the staff person failed to document the vomiting, failed to start an illness log, failed to notify the house manager and most importantly, did not call the on-call nursing coverage despite posted criteria that indicated the need to do so in the event the client experienced a change in health status.

The client also had a medical history of bowel obstruction and resection, which was known to the agency, but poorly documented.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency performs updated training for all direct care staff to ensure that they have a more complete understanding of criteria used for contacting the contracted on-call nursing agency.
2. That the provider agency performs updated training for all direct care staff to ensure that they are able to document shift events, vital signs, medical incidence, and concerns according to nursing standards.
3. That the provider agency performs updated training for all direct care staff to ensure that they have a more complete understanding and importance of ongoing and complete communication from shift to shift.
4. That the provider agency retrain staff regarding performing CPR and calling 911 upon finding a client unresponsive.
5. That the provider agency establishes a contingency plan, as needed, for periods of time in which ill clients may need more oversight, such as overnight coverage, despite being assigned less than 24-hour supervision.
6. That the provider agency performs audits of all medical records to ensure that all pertinent diagnoses, medications, allergies, and other issues are present and consistent throughout the client's files.

37. Ages: 53 & 49. **Residence:** Family home. (**OPA/AID intake:** 02/26/2007).

Nature of Allegation: Reportedly, the clients, who were brother and sister, were killed by gunshot wounds following an apparent murder/suicide incident that took place at the home of their parents. Allegedly, the clients' father shot his wife, both adult children, then contacted the clients' stand-by guardian and directed him to call 911 before hanging up the phone and turning the gun on himself. All four family members were subsequently found dead in the home. It was noted that the father/alleged perpetrator was recovering from recent back surgery at the time of the incident. The clients resided outside of the family home but both visited their parents' home on weekends. The appropriate police agency conducted investigations; OPA investigated alleged abuse on the part of the father, and possible neglect on the part of the brother and sister's respective provider agencies in allowing them to visit their parents' home.

Finding: OPA conducted an investigation and substantiated physical abuse by the deceased father of the two clients. The findings of the Office of the Chief State's Medical Examiner identified the manner and cause of both clients' deaths as homicide. The evidence indicated that the father was acting as their caretaker at the time of their death and that he acted alone in killing his family as evidenced by his leaving a detailed suicide note and his verbalizations to the stand-by guardian which took place just after he shot his wife and two adult children. There was no evidence to implicate the mother of both clients in this incident. The OPA investigation included a review of the police file and an interview with police detectives assigned to the case.

Through interviews and investigation, OPA found no evidence to indicate that the father ever made any statements or took actions prior to the date of the incident, which might have created reasonable concern for the clients' safety prior to the tragic incident of them being shot on that date.

Status: Closed AID – Abuse substantiated; no substantiation of neglect by provider agencies.

Recommendations:

1. That the DMR develop a plan to provide grief counselors, similar to programs used by schools and other community based programs in response to sudden or unexpected death by violent means.

2. That the DMR establish procedures to ensure ongoing support for consumers and line staff in dealing with the stages of the grieving process which are a natural consequence of sudden or unexpected deaths.

38. Age: 34. **Residence:** Private CLA. (**OPA/AID intake:** 02/26/2007).

Nature of Allegation: Reportedly, the client died after several days of deteriorating health. However, agency on-call nursing notes indicated that the residential staff had reported episodes of the client dropping to the floor in November and December 2006. One on-call notation from mid-December indicated that the client dropped to the floor and hit the side of her face. A DMR Medical Desk Review was unable to find documentation to indicate that agency ever developed a behavioral response for dropping incidents. Also there was no documentation that the client ever received a full medical work up to rule out any medical condition which might have been causing the behavior. According to the agency nursing notes, approximately five days before the client's death, she was observed by staff to be sleeping all night and most of the day and "difficult to feed." Her left eye was also observed to be black and blue and she was unable to ambulate. By 7:00 pm on the night of these observations, she was noted to be "crawling on all fours." Nursing notations also indicated that the client had returned from a home visit at the end of December with a bruise. The day after the client was observed "crawling on all fours," she was admitted to the hospital where a CT scan revealed that there was bleeding in the brain. Two days following her hospital admission, the client died.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect prior to the client's death. This finding is based on documentation reviewed and interviews which indicated that the agency and family provided the client with appropriate care and treatment in the weeks and months prior to her death.

Status: Closed AID –No substantiation.

Recommendations: None.

39. Age: 42. **Residence:** Private CLA. (**OPA/AID intake:** 03/20/2007).

Nature of Allegation: The client died at the hospital. Reportedly, prior to dying, he disclosed to two unknown family members that he had been force fed by staff at his CLA. The client was hospitalized due to aspiration pneumonia.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate abuse or neglect prior to the client's death. OPA investigators made an unannounced visit to the CLA where the client resided and where the neglect allegedly occurred. OPA reviewed all of the facility records, interviewed staff and did not find any evidence to corroborate that the client was force fed by staff. There did not appear to be any nexus between the client's feeding protocol and his admission to the hospital. OPA was also unable to substantiate that the client sustained any delay in obtaining necessary medical treatment in the days and weeks prior to his passing. The records indicated that the CLA was consciously attempting to provide the client with better food and feeding options, while respecting his right to consult with his guardian and make decisions about the best course of treatment for his condition of dysphagia.

Status: Closed AID –No substantiation.

Recommendations: None.

40. Age 24. Residence: Private CLA. (**OPA/AID intake:** 05/26/2007).

Nature of Allegation: Reportedly, a 24 year old client of DMR with autism was missing after he was wading in the water of a pond at a public park and suddenly went under. When reported to OPA weekend coverage investigator, at 8:00 pm, rescue workers were on the scene but the client was still under water and had been for at least the 45 minutes. The client's body was later found in the water near where he went under earlier that evening. The client was pronounced dead at the hospital from drowning. The client was visiting the park with a residential staff support worker from his CLA. The client had an unsteady gait and was unable to swim. An off-duty staff person, who had worked at the CLA until a few days prior to the event, and who still worked for the provider agency, was also present at the park.

Finding: OPA conducted an investigation and substantiated neglect on the part of the residential staff assigned to supervise the client on the day of the incident and also on the part of off-duty staff member and the provider agency. The client was known to have a seizure disorder which required that staff support remain within an arm's length distance when he was ambulating, and when out in the community. The client was also known to be attracted to water but unable to swim. The staff person assigned to work with the client on the evening that he died was responsible for providing the client with arm's length support and supervision when he decided to take the client to a public park which had a pond. The staff worker was aware of the client's specific supervision requirements and was also aware that the client was unable to swim. The staff person was himself, unable to swim. Interviews with a number of witnesses, including patrons at a restaurant with a patio overlooking the pond, the police department diver who recovered the client's body, and other members of the public who were present, yielded information that was inconsistent with the stories told by both the on-duty and off-duty staff members. The evidence indicated that notwithstanding the client's supervision requirements and his inability to swim, both of which were known to the staff person caring for him, he twice managed to enter the water from opposite sides of the pond and, after entering it for a second time, subsequently drowned.

Neglect was substantiated against the staff worker for failure to ensure the client's ongoing health and safety by allowing him to enter the water at the south end of the pond and minutes later allowing him to enter the water again at the north end of the pond. Neglect was also substantiated against the off duty staff, who undertook to operate in a caretaker capacity for the client while off duty but later provided inconsistent statements about her interactions with the staff worker at the park while he was responsible for ensuring the client's safety. Neglect was also substantiated against the provider agency, which did not have any system in place by which staff were required to sign off on new or amended client care directives before undertaking to care for such clients. The staff worker had been counseled by his supervisors on the previous day regarding the need to maintain a close distance between himself and the client, but he had not been required to read and sign a similar written directive which was placed in the client's chart. The evidence further indicated that the agency did not have any procedures in place for knowing and monitoring the whereabouts of residents while on outings with staff.

Status: Closed AID –Neglect substantiated.

Recommendations:

1. That the DDS ensure all clients who are unable to swim and have an attraction to water, or have scheduled activities near and around water are accompanied by water safety certified staff.
2. That the provider agency review and make changes as warranted regarding CLA off grounds activities.

3. That the provider agency initiate administrative procedures to ensure that any changes in an individual's staff support and supervision requirements are immediately communicated to direct care staff.

41. Age: 54. **Residence:** Private CLA. (**OPA/AID intake:** 06/05/2007).

Nature of Allegation: Reportedly, the client died after having developed pneumonia. The client had a cough that the staff allegedly ignored, from the time he woke up until the time he went to bed. The House Manager demoted himself after the client's death because of his misjudgment.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate medical neglect in connection with the client's death. The evidence indicated that the client had a chronic cough, which was addressed by the agency through medical oversight by the medical doctor, the speech-language pathologist, direct care staff, and the nursing staff of the ICF/MR group home to which the client was moved specifically to address his ongoing medical concerns. The client had a physical exam conducted by the APRN approximately two months prior to his death. After the exam, the on-call nurse was called and a record of illness was started for coughing, refusing to eat, etc. The next day, the client was seen by the APRN and started on antibiotics. A few days following, the client was admitted to the hospital. Although neglect was not substantiated, OPA did observe that the coordination of archival client records was done poorly and that records were not kept together and in a consistent location. In addition, there were orders from the APRN that did not have a medical assessment or rationale accompanying them. Lastly, there was no health status change documented by any direct care staff that indicated what had changed in the client's condition that necessitated a transfer to the hospital. While these concerns were noted, there was no evidence they resulted in delays in obtaining appropriate care or otherwise contributed to his death.

Status: Closed AID – No substantiation.

Recommendations:

1. That the provider agency maintains current documentation standards and archives client records according to standards and timeframes set and expected by DDS.
2. That the provider agency maintains clear documentation that records the medical rationale for client transfers and treatments.

42. Age: 67. **Residence:** Private CLA. (**OPA/AID intake:** 7/12/2007).

Nature of Allegation: Reportedly, the client did not receive adequate nursing assessments prior to his death. In summary, staff reported that his epidermoid cyst was reddened and inflamed; there was no nursing evaluation until two days had passed. Evaluation by a physician was delayed for about a week, and all subsequent nursing follow-up relied solely upon direct care staff observations. The client died at the hospital, where he had been admitted with a fever and altered mental status on a week prior to his death through the Emergency Room. The ER physician incised and drained an abscess on the client's back. A large amount of purulent drainage came from the wound. The doctor wrote on the history and physical form, "Abscess lanced under sterile conditions. Pus cultured." However, according to the computerized records from the hospital, the wound culture was not ordered or done until a few days after he was admitted to the hospital and after the client had been placed on antibiotics. At this time the culture grew *Proteus mirabilis*, sensitive to Ampicillin, Cefazolin, Ciprofloxacin, Gentamicin, and Bactrim.

Finding: OPA conducted an investigation and determined that there existed insufficient evidence to substantiate neglect on the part of the agency with regard to the nursing care provided to the client prior to his death. The evidence indicated that despite the client's having an epidermoid cyst on the back of his right shoulder, the agency's

RN conducted a nursing assessment in a timely and appropriate manner, resulting in appropriate recommendations to the group home staff and follow-up with the primary care physician. The cyst was documented to have been present for about three years. In late January, CLA staff noted the cyst to be "red." The RN performed an assessment and noted the cyst to be, "slightly pale pink" and not "boggy." When interviewed about this assessment, the RN stated, "There was not a big change noted from my previous observations and documentation of how it has looked over the past few years. Despite what all the notes from the house staff say, I never saw the cyst red or inflamed." One direct care staff also interviewed regarding the client's cyst stated, "Yes, I saw it, but I think they were pretty subtle changes, not big ones." Within a week, the client was examined by a physician, who also noted that the cyst was pink, not "boggy," and appeared intact. The client was started on Keflex 500 mg. four times daily for 10 days with wet to dry compresses twice.

The RN indicated she did not initially seek to prioritize the doctor visit or to send the client to the emergency room due to the minimal nature of the changes noted. These minimal changes were described by the RN to be slightly pink, "like he had been leaning on it in the chair or lying on it." Also, the nursing assessment was completed on a Thursday and the client was seen mid-day on the following Monday. No other symptoms of concern were noted until a week before his death when, despite antibiotic therapy there was only minimal improvement with intermittent pain noted at the site, redness, and continued lethargy. At that point the client was immediately sent to the emergency room.

While at the hospital, based on the X-ray findings a pulmonary consult was requested. While in the hospital, the client was seen by a pulmonologist, who reported, "Impression: 'Sepsis syndrome with unclear primary site. This could represent pneumonia although against this is the fact that his respiratory status is reasonably stable and chest X-ray really is not much different. It could be due to his abscess or urinary tract.'" There was no direct link noting the cyst as the source of the sepsis that led to the client's death. The CLA manager indicated that she had noted other gradual changes in the client's health and that he appeared to be declining over the last year of his life. The manager stated there were also changes in the client's eating habits and that the client had begun to "spit his food out," even things he usually liked. In addition, the client's day program hours had been decreased due to his having lethargy and sleeping more at the program in the months prior to his death. The client also had a protocol in place to be propped up instead of being laid down in order to avoid aspiration. During his hospitalization the client was laid down during a CT scan at the hospital and did aspirate at that time.

Status: Closed AID – Neglect not substantiated.

Recommendations:

1. That the provider agency maintains current documentation standards as expected by DDS policy.
2. That the provider agency considers having the agency RN in-service CLA staff regarding medical issues and documentation standards since.
3. That the provider agency considers allowing the agency Nurse Consultants to have input in team meetings for initial residential placements in order to ensure medical appropriateness and compatibility with other CLA clients' possible medical issues.

43. Age: 80. **Residence:** Private CLA. (**OPA/AID intake:** 7/16/2007).

Nature of Allegation: The client fell at home and was taken to the hospital. Reportedly, there existed concerns regarding the discharge plan from the hospital after the fall, which allegedly did not address the critical nature of the client's condition. There was allegedly no evidence that her condition was monitored post hospital discharge.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect with regard to the coordination of nursing care provided prior to the death of the client by the provider agency and the agency RN.

The concerns reported to OPA were brought to light due to a lack of documentation that these services were provided and that the lack of these services may have contributed to the death of the client. The supporting documentation for these actions was discovered during the course of the investigation, as they had been taken from the client record by the RN, who was contracted by the agency to cover the CLA for only five hours per week. The RN had kept these documents at her home for over two years. Had these documents remained in the record, as standard practice dictates, the concerns that led to an intake through OPA/AID would not have arisen. While the actions of the RN may have violated HIPAA privacy laws, and OPA noted a lack of consistency in the documentation by the primary care physician, once they were located, the records satisfactorily demonstrated that the client received timely and adequate care.

Status: Closed AID – No substantiation.

Recommendations:

1. That the provider agency maintains current documentation standards and practices as expected by DDS policy.
2. That the provider agency retrain the RN regarding proper documentation procedures and practices.
3. That the provider agency retrain the CLA medication certified staff regarding documentation standards, following MD orders and the expiration of medical orders.
4. That the DDS ensure client Individual Plans are done in a timely manner even when case management is being reassigned.
5. That the provider agency instructs staff on the importance of writing timely incident reports.

44. Age: 63. **Residence:** STS Cottage. (**OPA/AID intake:** 07/20/2007).

Nature of Allegation: Reportedly, two unit staff discovered that the client had removed her tracheostomy tube at 5:20 am. Allegedly, this was not considered unusual behavior for the client and the tube was easily reinserted by a nurse. Switchboard records indicated a call was placed to the pager of the nurse who was assigned to cover that shift was placed at 5:26 am. Meanwhile, unit staff continued on their rounds and found another resident who had vomited. Staff cleaned that client and then returned to the first client's room whereupon they found that the client was blue and called 911 (STS' internal 911). The 911 call was logged by the switchboard at 5:55 am, indicating that either staff missed a required 15 minute bed check or the call was made 15 minutes after discovering that the client needed emergency assistance. The campus did not have a specific protocol for staff to follow when a person removes a tracheostomy tube at the time of the incident. Staff performed CPR but provided air through the mouth instead of the stoma. The client was pronounced dead at the hospital that same morning. The campus RN represented she did not receive the page.

Finding: OPA conducted an investigation and substantiated neglect. The evidence indicated that on the morning of the incident, the client's tracheostomy tube came out as it sometimes had in the past. When the two direct care staff on duty discovering the tube was not in place, they followed an unwritten protocol of contacting the campus switchboard and having a nurse paged to come and attend to the client's tracheostomy tube. This initial call was logged in as having been received at 5:26 am, but the call was documented in a unit log note as being made at 5:20 am. Interview statements with the two unit staff indicated that after contacting the switchboard operator, they both checked on another resident who was vomiting and that they jointly attended to that client's needs. In doing so, both staff left the first client alone in her room with her tracheostomy tube out.

Switchboard records indicated that staff placed another call to the switchboard at 5:55 am to report the client was unresponsive and requested 911 emergency response. Both staff represented that this second call to the switchboard occurred immediately after the two had finished attending to the second client who had vomited. One of the staff returned to the client's room and observed to be in her bed and "turning blue." The unit log notes indicated that the second "911 call" occurred at 5:40 am. A State Police investigation was unable to find evidence of any way to track the internal campus switchboard telephone records from the morning of the incident. However, OPA determined that the call was more likely to have been placed closer to 5:55 am, the time noted by the switchboard operator, who recorded the times of all paging requests. Also, the campus EMS, when interviewed, indicated that they were dispatched at 5:56 am, or a minute after the switchboard operator recorded that a 911 call was received.

One of the unit staff on duty (staff #1) indicated on a 15-minute sleep/awake data sheet that she checked on the client at 5:45 am and marked the client's status as "awake." However, upon interview, staff #1 indicated that she did not actually check on the client at that time and that neither she nor the other unit staff worker (staff #2) checked on the client after the first (5:26 am) call to the switchboard until they were finished attending to the resident who had vomited. Therefore, the best evidence indicated that the client was not checked by unit staff from 5:26 am until just moments before the 911 call was placed at 5:55 am, or 29 minutes later.

The third shift nurse, (an LPN) indicated, when interviewed, that she never received any page that may have been issued at 5:26 am. That LPN further indicated that she did not receive an earlier page to the unit that was made at 3:36 am. Interviews with several campus staff and administrators indicated that the on grounds paging system rarely failed and that most of those infrequent failures involved receiving incomplete pages during inclement weather or more rarely, a missed page in a specific campus location. Neither situation applied to the two pages which were issued for the LPN on the morning of the incident. No other person reported missing pages that morning. The only evidence that the paging system did not function that morning was the LPN's own representation that such was the case. Also, no witness was able to recall even seeing the LPN on the campus grounds after 4:00 am. In several statements and interviews given to the State Police and to OPA the LPN's own version of the events differed. Timeframes and reports by the LPN regarding the events of the morning of the incident were not corroborated by any other staff. The evidence indicated that the LPN, as a third shift nurse, failed to answer two switchboard pages on the morning of the incident. By failing to respond to these pages, the LPN deprived the client of services necessary to maintain her ongoing health and safety. Similarly, the two unit staff members failed to properly monitor the client following their initial call to the switchboard at 5:26 am, nor did they perform at least one mandatory 15 minute check during a time when they were aware that the client was in a vulnerable state. Since there was no response from the nurse within a few minutes from the initial call, it was staff #1's responsibility as the building charge to notify the operator again. Although both unit staff were busy attending to another client, one or the other of them should have remained focused on what was or was not occurring to address the client's condition.

First responder records indicated that the client also did not receive appropriate CPR measures. The client was initially given chest compressions on her bed rather than on the floor or other stable surface. Additionally, it became apparent through the interview process that there was confusion regarding where to properly provide ventilatory assistance to the client without losing airflow via the tracheostomy stoma. Several witnesses also indicated that staff were unable to locate an ambu bag used for providing ventilated breaths via the tracheostomy tube. Some staff were not familiar with the item at all.

A campus on-call physician did arrive at the scene at approximately 5:58 am. When interviewed, the physician stated that he did a quick assessment and checked for the carotid pulse which he was unable to obtain, then attempted to obtain an apical pulse. He then replaced the client's entire tracheotomy apparatus which was then used by the ambulance team to begin oxygenation attempts for the client. The client was then transported to the hospital, where she was pronounced dead at 6:52 am. The cause of death listed by the Medical Examiner's office was, "Acute and chronic pneumonia associated with chronic tracheostomy and mental retardation."

Additionally, it was noted for several weeks prior to the client's death that her medical condition was changing. The records indicated the client was making more attempts to pull out her tracheotomy tube, her mucous was changing color, that she had at least one episode of hypoxia and she was reported to have become more agitated. Despite all of these symptoms the client's change in condition was never reported to any campus medical practitioner by the unit RN. The unit RN wrote in the client's quarterly that she was aware that a respiratory therapist had some "tracheotomy tube reinforcer collars" made to be used at the discretion of the nurse when the client was pulling out her tracheostomy tube. This possible intervention should also have been documented on the Nursing Care Plan but was not present on the Care Plan for 2007. In addition, the RN did not document on the Nursing Care Plan what interventions should have taken place when the client pulled out her tracheostomy tube. Neglect was therefore also substantiated against the unit RN.

OPA also substantiated neglect against the campus facility, which routinely assigned staff #1 as the 3rd shift charge, despite the fact that she was the one of the most junior staff members working in the building. The campus facility also did not properly train staff for the general needs of clients with tracheostomy tubes, nor did they train staff specifically about performing CPR on residents with tracheostomy tubes. During the interview process there were complaints from direct care staff regarding a lack of client specific training for what to do with a tracheostomy tube. There was no policy or protocol written in the cottage but was simply staff sharing information with each other. The unit RN was asked who reviews the medical notes and she responded that no one did, other than for quarterlies. Every unit on grounds was assigned a physician or PA. It was the responsibility of the nurse to relay information to the physician and the PA. During the client's autopsy it was concluded that she had had acute and chronic pneumonia. Unit documentation demonstrated that she was showing signs of this in the days prior to her death but that information was never given to the physician's assistant who covered the unit. Throughout the investigation, individuals repeatedly stated that the client removed her tracheostomy tube whenever she was not feeling well in an attempt to improve the quality of her own breathing.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS/STS discontinue the practice of MRW-1s being assigned shift charge responsibilities based on their generally having less experience than MRW-2s and also in order to comply with the MRW-1 job description that indicates MRW-1s are not to work alone more than 50% of their time and are not to supervise.

2. That the DDS ensure that both cottage staff understand the importance of implementing supervision levels as they are written and of accurate data documentation.
3. That the DDS/STS in-service staff regarding signs and symptoms of client-specific needs and initiating appropriate follow-up. This in-service should include a section regarding performing CPR on a client who has a tracheostomy tube.
4. That the DDS/STS ensure medical log documentation adheres to national standards for nursing notes and that general cottage log notes contain entries that have a date/time, are legible, have a signature, and contain the writer's title/credentials.
5. That the DDS ensure that the campus pager system is evaluated and updated as necessary to provide a reliable, on-grounds communication network.

45. Age: 48. **Residence:** Private CLA. (**OPA/AID intake:** 09/13/2007).

Nature of Allegation: Reportedly, the client was wheeling himself out to the van which was in the driveway of his CLA, which he did each morning, when at the same time, a garbage truck was backing into the driveway. The garbage truck allegedly ran over the client, who was in his wheelchair, and killed him. The client was independent with ADLs and did not require one to one or line of sight supervision. The client could, and frequently did wheel himself around independently in the community. Local police initiated an investigation.

Finding: OPA conducted an investigation and found insufficient evidence to substantiate neglect in the death of the client. According to statements obtained and documents reviewed in the course of the investigation, the client was receiving supervision consistent with his identified needs at the time of his death. The driver of the truck was not considered a caretaker as defined by C.G.S. 46a-11a, therefore OPA made no finding concerning his actions regarding backing up the garbage truck on the day of the incident.

Status: Closed AID – No substantiation.

Recommendations:

That the DDS ensure ornamental plantings at program sites are routinely checked and pruned so that they do not provide potential visual obstruction near shared pedestrian/traffic areas.

46. Age: 52. **Residence:** Private CLA. (**OPA/AID intake:** 10/29/2007).

Nature of Allegation: Reportedly, the client had an apparent seizure at his CLA at approximately 4:50 pm. The CLA staff called 911 and the client was transported by EMS personnel to a local hospital where he was diagnosed with a subdural hematoma and arrangements were made for him to be transferred to a medical center for emergency neurosurgery. The client was then transferred to yet a different, out-of-state medical facility neurosurgical ICU, where he subsequently died. The client had a history of exhibiting self-injurious behaviors, which included biting himself, hitting his body, hitting his head and banging his head. Upon autopsy, the cause of death was listed as, "Blunt impact of head with subdural hematoma and brain swelling." The CLA records revealed that there were six incidences of the client hitting his head between 3:00 - 4:00 pm and 4:00 - 5:00 pm on the day 911 was called. There was no documentation of any injury or any indication of the intensity of these events. However, the medical examiner allegedly indicated that the inciting event would likely have occurred close to or on the day of the 911 call. No Self Injurious Behavior (SIB) was documented as having occurred for several days prior to that date and review of

the CLA progress notes or incident reports revealed no reported injuries or falls during the last month of the client's life, up until the 911 call.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect in connection with the client's experiencing a subdural hematoma sometime on or around Saturday, 05/12/07. Based upon the findings and judgments of two state medical examiners from two different states, it appeared likely that the client experienced a subdural hematoma as a result of the self injurious behavior (SIB) he exhibited on the afternoon of the 911 call. The lone staff person working at the CLA on that day noted in the client's behavior chart two separate incidents where he slapped his head three times during her shift. The staff worker's signed statement indicated that the client struck himself in the chin three times sometime after 3:45 pm and that he also exhibited SIB at about 4:43 pm, shortly before he collapsed at 4:45 pm.

Despite the likelihood that the SIB exhibited on the day of the 911 call caused the client to experience a subdural hematoma, OPA found insufficient evidence to substantiate neglect on the part of either the staff worker or the provider agency.

The client often exhibited SIB in the form of him striking the right side of his head with his right hand. Witnesses reported that this behavior ranged from mild slaps to the head to much more forceful head slapping. This Office was unable to find evidence of the client engaging in serious or substantial SIB in the hours just prior to his being taken to the hospital. The evidence indicated that the client had a normal evening and morning prior to the afternoon of the 911 call with no recorded incidents of his engaging in SIB. The CLA staff worker on duty that afternoon stated that she did not consider the client's SIB on the day of the 911 call to be serious incidents and indicated that she intervened by distracting him with tasks and reminders, such as asking him to get up and use the bathroom. Such staff responses were not inconsistent with the provisions of the client's approved behavior program. The staff worker also denied having any knowledge of the client experiencing any other sort of blow to the head or fall on that afternoon. The staff worker's representations about the client's symptoms and the timeline of events following his collapse were consistent with the ambulance run sheet and the statements of other witnesses interviewed during the investigation.

The evidence indicated that the team was actively monitoring the client's self injurious behaviors, including his head slapping behavior. The client's program included a response mechanism for intervening and blocking the client's arms when his head hitting behavior was unable to be abated with reminders and directives. There was also a programmatic provision for staff to complete an incident report whenever the client was restrained in response to engaging in serious SIB. The client's program directed CLA staff to record the number of incidents of SIB which occurred on an hourly basis. Record reviews indicated that the client was prescribed Seroquel in the previous January, and was being followed by a psychiatrist and primary care physician. The team also held quarterly meetings in which the client's SIB was reviewed, although discussions at those meetings apparently did not include consideration of application of protective devices (e.g. protective helmet or padded gloves), or an increase in the frequency of SIB that had occurred during April. Evidence indicated, however, that the program and procedures developed and provided for the client were generally consistent with recognized standards of professional judgment.

After collapsing at the CLA, the client was taken to the hospital and later to a medical center and from there flown to yet a third hospital. The evidence indicated that the provider agency staff followed the client to out of state hospitals and monitored his daily progress until he died a few days later. Whether the client received appropriate medical treatment and follow-up at the out of state hospitals was not a focus of this investigation, but there was no evidence discovered to suggest he did not.

Status: Closed AID – No substantiation.

Recommendations:

1. That the DDS ensure all supported clients who exhibit self injurious behaviors involving the head have programs which monitor behavior intensity as well as behavior frequency.
2. That the DDS ensure all behavior programs designed for clients who exhibit self injurious behavior involving the head include provisions for requiring DDS 255 unusual incident reports to be completed whenever the behavior involving the head becomes severe or potentially dangerous.
3. That the DDS ensure all support teams involved with clients who exhibit self injurious behaviors involving the head regularly consider and deliberate whether external supports such as helmets or mittens are warranted upon review of the most current available information concerning the frequency and intensity of the self injurious behavior.
4. That the DDS ensure all Individualized Programs for clients who exhibit self injurious behaviors involving the head provide for a medical evaluation to be obtained whenever there appears to be significant increases in the frequency and intensity of target behavior involving the head.

47. Age: 37. **Residence:** Private CLA. (**OPA/AID intake:** 04/02/2008).

Nature of Allegation: The client was 37 years old when he died. He was described as non-ambulatory and non-verbal with some vocalizations. Reportedly, his cause of death could not be determined due to the lack of an autopsy. The client was taking multiple anticonvulsant medications for a seizure disorder, but reportedly had not been seen by a neurologist since December 2002. The client's Primary Care Physician (PCP) prescribed the anticonvulsants and had increased blood levels of his medications since at least 06/08/07. The client's records also indicated he had a history of malabsorption syndrome that did not appear to be addressed by the dietician and he had been exhibiting vomiting and decreased oxygen saturation levels, which the reporter thought might have been exacerbated by the increased blood levels of the medications he had been taking. Allegedly, there was no documentation to show that the PCP had addressed the client's high blood levels of Phenobarbital and Carbamazepine.

Finding: OPA conducted an investigation and determined that there was insufficient evidence to substantiate neglect against the PCP, the RN on duty the day of his death, or the provider agency. The evidence indicated that in the morning on the day of his death, the client aspirated, developing respiratory distress and needing resuscitative assistance. The nurse RN on duty performed CPR from the moment of the witnessed aspiration until the arrival of EMS.

However, OPA did note several concerns regarding the agency's medical staffing and communication. Specifically, communication between the CLA nursing and the medical providers, as well as with the agency Director of Health Services was inadequate. The nurse who was noted by all interviewed as the, "Coordinator" of the home was an LPN. While that person performed many duties consistent with the parameters of her LPN license, she admitted when interviewed that she was the conduit for information from the registered nurses who worked at the home to the agency's Director of Health Services. The LPN listened to the nursing assessments of the Registered Nurses and then decide if that information would or would not be conveyed to the Health Services Director. It is inappropriate for an LPN to act as a filter for triaging information between RNs. It was also noted several times during the record review that the LPN filled out forms considered to be patient assessments, such as the Nursing/Medical Assessment form, which again fell outside of the scope of practice of an LPN in the state of Connecticut.

The agency's Director of Health Services was on personal leave for several months during the development of the client's illness and the associated increasing medication blood levels. It did not appear that there was ever any clear

discussions about the RN duties and which ones, if any, needed to be appropriately delegated in her absence. It appeared that instead, assumptions were made that the other nursing staff would pick up some of her duties, even though they were not asked and/or assigned these duties, such as ensuring that pharmacists' charts were reviewed by the physician.

Status: Closed AID – No substantiation.

Recommendations:

1. That the provider agency puts in place appropriate hierarchy for delegation, reporting, and assignment of duties in accordance with the State of Connecticut nurse practice acts.
2. That the provider agency reviews the job duties with each nurse within the home and the agency to ensure that all duties are assigned to an appropriate responsible party and that there be a contingency plan in place should that person be unable to perform that duty for some reason.
3. That the provider agency performs a review of all clients' medical diagnoses to ensure that every diagnosis was generated from an appropriately licensed medical professional.
4. That the provider agency obtain backboards for use during CPR in homes, especially where there may be difficulty with client movement due to the disparity in size and mobility between staff and client.
5. That the provider agency has proper reporting procedure in place to alert management and other agencies to improper practice such as adding diagnoses for billing purposes.
6. That the provider agency ensures that a registered nurse performs regularly scheduled chart audits in which missing information is followed-up and physicians are made aware of all pertinent information such as evaluations made by all other medical professional, including, but not limited to, pharmacists.
7. That the provider agency receives training regarding the State of Connecticut nurse practice acts as it relates to the roles and limitations of both registered nurses and licensed practical nurses.

48. Age: 63. **Residence:** Private CLA. (**OPA/AID intake:** 04/11/2008).

Nature of Allegation: The cause of death noted on the client's death certificate was, "Failure to Thrive, Cerebral Palsy, Bedbound, Nothing by Mouth." Reportedly, the client had a weight loss of 28 pounds with no documentation of related treatment or oversight prior to his death. A speech language pathologist order stated, "Continue to monitor weights every two weeks and report any abnormal increase or decrease to nurse (+ or - 5 pounds in two weeks or a steady loss or gain)."

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect. Based on the timeline, and the supporting documentation, the weight loss that led to the OPA/AID intake occurred during a period when the client was an in-patient in a hospital and, later, a SNF and was not present at the CLA. The evidence further indicated that the client's weight loss was a result of a small bowel obstruction and surgery which also occurred during his time away from the group home, and for which he was being treated in those medical facilities.

Status: Closed AID – No substantiation.

Recommendations:

That the provider agency maintain client specific and date specific documentation. Such documentation should be reflective of current timeframes rather than be regenerated information which is no longer current.

49. Age: 57. **Residence:** Private CLA. (**OPA/AID intake:** 04/28/2008).

Nature of Allegation: The client, who resided in CLA, was shopping with residential staff support approximately one month prior to her death, when she suddenly passed out. Taken to a hospital ED that was close to the store, she was diagnosed with possible dehydration. (EKG and lab values were within normal limits.) She was discharged with instructions to keep well hydrated and follow up with her PCP in 3 days. The client was allegedly also limping during this hospital ER visit, but the limping was not addressed in her hospital evaluation. However, the next day, the client was taken to a different hospital (closer to her home) to have her leg examined whereupon it was discovered that she had sustained two broken bones to her right ankle. The client was discharged with plans to see an orthopedic doctor the next day. The client did see an orthopedist, her foot was casted and the provider agency determined that she should receive 1 to 1 staffing.

That same evening, the client began to experience a fever (100.9 degrees). Staff contacted the team nurse and, because the client seemed flushed, gave her 3 glasses of water along with Tylenol. By 11:30 pm, her temperature was 102.2 degrees. An on-call nurse was contacted, but she was informed that the client's temperature was 101.6 degrees. The on-call nurse believed the Tylenol was working and directed the CLA staff to keep the client hydrated. Over the next several days, the client's temperature continued to fluctuate between 99.4 and 102 degrees. She was brought to see her PCP, who diagnosed an upper respiratory infection. The following day, the client refused lunch. At 1:41 pm her temperature was 99.6 degrees. She suddenly went pale, breathing became labored. 911 was called. The client was taken to the hospital and admitted into the critical care unit in respiratory distress. She was diagnosed with acute respiratory failure and pneumonia. Despite intensive care and treatment in the hospital over a period of nearly three weeks, the client died.

The specific allegations of neglect reported to OPA were that when the client first began to exhibit elevated temperatures, there were no on-site nursing visits to clinically assess the client. Also, the physician who examined the client during this time period did not receive sufficient information regarding her fever patterns. Also, the agency's vital signs log for this time period was incomplete.

Finding: OPA conducted an investigation and determined sufficient evidence existed to substantiate neglect. However, OPA determined that there existed insufficient evidence to substantiate that such neglect operated to cause the death of the client. In the days prior to the client's hospital admission, the client was provided access to medical care. After the incident where the client passed out while shopping, she was taken to hospital #1's emergency room. The following day, the client was provided access to medical treatment at hospital #2's emergency room for a broken ankle. The client was provided access to medical treatment to cast her broken ankle. The client was also provided access to medical treatment after CLA staff reported coughing and fevers. Each medical provider treated the client based on their direct observations and reports of symptoms presented by CLA staff.

Nevertheless, OPA did find sufficient evidence to substantiate neglect with regard to the client not receiving several services which were necessary for her ongoing health and safety. Evidence obtained during the investigation documented a lack of coordination of care and a failure of the provider agency nursing staff and on-call agency nursing staff to follow accepted nursing procedures and practices. Additionally, CLA staff did not follow DDS

documentation standards. Neglect was substantiated on the provider agency and several individual nurses and support staff.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS should develop appropriate training and regulatory oversight to ensure that timely communication occurs between the on call nursing service and the provider agency nurse regarding any resident who has experienced a recent change in health status.
2. That the provider agency implements procedures for ensuring that accurate and timely communications occur between doctors, nurses and residential staff, especially as such communications relate to a resident who has experienced a recent change in health status.
3. That the provider agency ensures CLA staff are re-in serviced regarding medication administration regulations, policies, procedures, and advisories.
4. That the provider agency ensures CLA staff are re-in serviced regarding emergency procedures such as when and under what circumstances staff should call 911.
5. That the provider agency ensures CLA staff are re-in serviced regarding appropriate communication and documentation procedures for all client health related issues, such as recording doctor's orders, recording client vital signs and documenting telephone contact with nursing staff.
6. That the provider agency implements procedures for ensuring that appropriate staffing level changes are administered in a timely way when circumstances, such as a change in a client's medical condition, operate to warrant such staffing changes.

50. Age: 44. **Residence:** Private CLA. (**OPA/AID intake:** 07/01/2008).

Nature of Allegation: The client died after an ambulance responded to a call which indicated that the client had a low oxygen saturation level and had fluids coming out of his tracheostomy tube. The ambulance report allegedly indicated the CLA nursing staff had stated she would not suction the client's tracheotomy tube because she did not want to occlude his airway. The client had recently been discharged following a month's stay in a hospital for surgical repair of a ruptured bowel.

Finding: OPA conducted an investigation and substantiated neglect on the part of the CLA's LPN. Authority for best practice was consulted as part of the investigation. As noted in Nursing Procedures & Protocols (2003, Lippincott, Williams & Wilkins, p. 383), "In addition to removing secretions, tracheal suctioning also stimulates cough reflex. This procedure helps maintain a patent airway to promote optimal exchange of oxygen and carbon dioxide and to prevent pneumonia that results from pooling secretions." Although the LPN was not able to be interviewed by OPA, she did state to Department of Public Health Surveyors that she did not suction the client's tracheostomy as ordered by the physician. The LPN also stated that she, "did not want to occlude his airway." The DPH cited deficiencies regarding this incident. Neglect was substantiated.

Status: Closed AID – Neglect substantiated.

Recommendations: None.

51. Age: 64. **Residence:** CTH. (**OPA/AID intake:** 08/22/2008).

Nature of Allegation: The client was a 64-year-old female who resided in a DDS licensed Community Training Home (CTH). The client was also blind and edentulous (without teeth). Her program directed that her food be served in cut-up form and that the pace of her food intake be monitored. The client was rushed to the hospital following an incident that occurred in her CTH where she choked on a corn muffin. The client's paid caretaker was present during the incident. A local police report indicated that some of the muffin was observed to be on the table when first responders came onto the scene. The EMT run sheet indicated that a food bolus made of corn muffin was suctioned from the client. The client did not recover from the choking incident and died six days later.

Finding: OPA conducted an investigation and substantiated neglect against the CTH operator and DDS. The evidence indicated that a corn muffin was served to the client in its entirety by the CTH operator. The client's most recent Level of Need form identified that she required her food consistency to be "cut-up," which is defined by DDS as:

"The individual requires a cut-up food consistency because he/ she cannot cut his/her own food or must have the size of the food pieces monitored. All foods must be cut into pieces no larger than 1/2" x 1/2" x 1/2" or roughly the size of a dime x 1/2" high. (Note: Individuals known to have swallowing disorders may have a food consistency order that allows for other sized or combination consistencies, depending on the results of individual evaluations. Individuals who require cut-up food consistencies may have an above-normal risk for choking.)

The CTH operator, when interviewed, stated that she did not know that the client's food should be consistently cut into dime-sized pieces, even though she herself helped to develop the client's Level of Need assessment that directed her food to be cut-up. The operator indicated she was aware that at times some foods were to be cut up due to the client's having no teeth, but was unable to state what her understanding was regarding exactly which foods should be cut for the client and how they should be cut up. Similarly, the client's day program was also unaware that her food should have been cut into dime-sized pieces.

The investigation revealed a general confusion and a distinct lack of coordination around the development and implementation of individual client services and supports relating to the client. As stated above, neither the CTH operator nor the day program were aware of the client's specific food requirements even though they were both responsible for assisting her during her meals. The evidence indicated that a DDS licensing citation was issued in 2006 due to the client's Individual Plan having been developed in a way which omitted the previously documented need for her to receive food consistency oversight. Following this citation, the client's 2007 Level of Need Assessment and Screening Tool Summary Report did include a provision for her to receive food consistency oversight. However, no clear or reliable mechanism was ever in place to ensure that caretakers were familiarized with this provision. The 2007 screening tool indicated by check marks that the, "Strategies to Address (the) Identified Risk" associated with the client's food consistency requirement would be shared by Clinical Services, Nursing Care Plan, and Staffing/Supervision Supports." Yet, OPA was unable to find evidence to support that such a coordinated delivery of support ever occurred.

When interviewed by OPA investigators, the DDS Regional CTH Coordinator demonstrated confusion regarding what DDS division or department was responsible for ensuring that CTH operators and day programs are familiarized and properly trained regarding client specific Level of Need Assessment and Screening Tool Summary Reports, which identified the need for food to be of a particular consistency. The CTH Coordinator indicated that he believed such training was the responsibility of the DDS nursing staff, but was unable to articulate how the nursing system operated

to provide such oversight and moreover, was unable to provide any information to indicate that such nursing guidance ever occurred as it applied to the client.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS ensure food consistency guidelines, including specific size requirements and other pertinent instructions are spelled out in the client’s IP and that appropriate oversight is provided to ensure that such guidelines are made familiar to caretakers who are ultimately responsible for their implementation.
2. That the DDS ensure that an internal review regarding Regional CTH program is conducted to ensure that CTH operators, CTH administration, CTH case management and CTH nursing are working in a coordinated manner, especially regarding the development and implementation of individual client supports and services.
3. That the DDS review its own, "Connecticut DMR Level of Need Assessment and Screening Tool Summary Report (Case Manager)" form and amend it as necessary for ensuring that specific, coordinated supports are developed to address identified individual risks.
4. That the DDS ensure the CTH operator receives training and support regarding food consistency and consumption requirements, especially as they may relate to any individual who may be presently under her care.

52. Age: 48. **Residence:** Private CLA. (**OPA/AID intake:** 08/28/2008).

Nature of Allegation: Two days prior to her death, the client had a seizure. Reportedly, despite a seizure protocol to call EMS for repeated seizures or any seizure lasting longer than 10 minutes, an agency RN was telephoned by CLA staff after the seizure was ongoing for over 15 minutes. The RN then informed staff that she would be right over and arrived at the CLA approximately 2 minutes later. EMS was not called until at least 18 minutes after the onset of the seizure. Upon arrival to the hospital, brain damage was noted. The client died after 2 days of decline during hospitalization. The cause of death was listed as Cardiorespiratory Arrest, Seizure Disorder, Alzheimer's Dementia.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency, the agency RN and the support staff who worked with the client on the morning of her seizure. The evidence reviewed indicated that on the morning of the incident, the client exhibited seizure activity for a period of at least 27 minutes before 911 was called despite her having in place a “Seizure Response Protocol” which required 911 to be called, “if a seizure lasts longer than 10 minutes.” The direct care staff on duty failed to follow the agency protocol and instead of dialing 911, called the agency nurse RN, who drove over from the office to perform an assessment rather than immediately requesting staff to follow the client’s protocol, which the RN herself had written.

During the course of the investigation, the agency and its staff defended their failure to follow the established protocol by explaining they were unsure whether the client was experiencing a seizure or “myoclonic jerks”, which were described as “twitching episodes” or “body jerks”. OPA was unable to find any documentation or evidence of training on what was considered to be a seizure, which would have triggered the protocol versus what was considered to be seizure-like “myoclonic jerks,” which the agency and its staff asserted did not trigger the protocol response. (Allegedly, it was this very confusion that led to a delay in staff and nursing seeking assistance from 911 on the morning of her seizure.) The agency’s Incident Report form concerning the events of that day noted, “Staff observed client having an unusual seizure. Nurse called to group home. Notified EMT 911. Administered Ativan, sent to ER. Admitted for unknown seizure activity.” This form was completed by an agency administrator who was not present during the incident. While this incident report demonstrated the agency believed that the client experienced a

seizure, it did not accurately correspond to an EMS run sheet time frames to the extent that it represented the client received treatment at 8:30 am, whereas the EMS run sheet indicated EMS did not arrive on the scene until 8:39 am.

The client's MD neurologist was interviewed by OPA, who stated it was very difficult even for neurologists to differentiate between seizures and "myoclonic jerks" and that frequently the only clue for differentiation was whether or not the patient's pupils were reactive. There was no evidence by way of documentation or interview statements that such an assessment was undertaken, observed or measured by any agency employee or nurse prior to such an assessment being performed by EMS on the day of her seizure. The neurologist also stated that myoclonus is more of a quick movement, like a twitch or shudder and should, "not be lasting 10 minutes." The neurologist also stated, "Any activity like a seizure or the myoclonus, lasting more than 10 minutes, should have 911 called. So, the staff following the seizure protocol as written certainly would seem reasonable."

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency develop client specific protocols as to the nature of illnesses, behaviors, and/or treatment needs.
2. That the provider agency update documents by formal process rather than have forms where dates are left unchanged yet information is hand-written onto the form and then photocopied.
3. That the provider agency in-service staff on the importance of following protocols exactly as written without exceptions of individual staff interpretation.
4. That the provider agency in-service nursing staff to ensure that Nursing Quarterly Reports contain all medical and mental health diagnoses for each client.

53. Age: 49. **Residence:** Public CLA on grounds of a Regional Center. (**OPA/AID intake:** 9/9/2008).

Nature of Allegation: The client allegedly required line-of-sight supervision at all times and was not to be on stairs without staff assistance at any time. Reportedly, the client suffered multiple fractures to her head and fractures to her facial area after falling down the basement stairwell at her CLA. The client was taken to the hospital and received staples to her head and subsequently experienced swelling inside of her skull. The client died due to the injuries she sustained during the fall.

Finding: OPA conducted an investigation and substantiated neglect against DDS. However, it was determined that insufficient evidence existed to substantiate neglect against the staff worker who was on duty the day the client fell down the stairwell at her CLA, because that staff member had not been made aware of the client's needs.

A review of the evidence collected from document reviews and staff interviews suggested that the client had at least a ten-year history of experiencing intermittent problems with her balance. Within a three-year period of the client's life, residential staff documented eight falls. In 1998 and again in 2005, residential staff were concerned enough that they shared their concerns with medical staff. Although no apparent follow-up occurred in 1998, two specialists were consulted in 2005. However, follow-up subsequent to the 2005 consults was not evident in the record. There was no evidence that the client's caregivers were instructed at any time to afford her any special supervision to prevent additional falls.

OPA interviewed thirteen staff who had direct care experience with the client, all of whom agreed that she was frequently unsteady on her feet. Concerning her risk of instability on stairs, ten of these staff agreed that the client

required close supervision to ensure her safety. Unfortunately, this apparent understanding among most of the staff was not effectively communicated to the staff worker who was working with the client on the day of her fall, who had worked only three months at the CLA. Neither was this common concern about stairs reflected in any of the client's routine assessments (medical/residential/vocational) completed over the last few years of the client's life. To the contrary, the client's ambulation skills, including the use of stairs, were consistently assessed as being unremarkable.

Although a preponderance of the evidence established the client as having a history of difficulty with balance – whether in motion, on a narrow base of support or standing still – and many staff working in her residence followed an informal protocol involving close support and supervision, the issue was never formally identified by her caregivers as a need to be addressed through enhanced supervision or additional evaluation.

Status: Closed AID –Neglect substantiated.

Recommendations:

1. That the DDS ensure that in contemplation of periodic IP reviews, direct care staff familiar with the respective client are consulted about any perceived changes in the client's level of need or general functioning.
2. That the DDS ensure a representative of the non-supervisory direct care staff attend and participate in each client's IP reviews.
3. That the DDS ensure direct care staff are provided with a means of recording, in a separate client-specific record (not the unit log), concerns that may arise during their day-to-day involvement with the individual. This information should be reviewed by clinical staff in preparation for the individual's IP or other relevant review.
4. That the DDS ensure that all Regional Center clients who present with ambulation or stability of gait issues are assessed to determine their need for supervision when using stairs or other irregular surfaces. Staff working directly with identified clients should also be instructed regarding such necessary supervision.

54. Age: 74. **Residence:** Private CLA. (**OPA/AID intake:** 12/12/2008).

Nature of Allegation: The client was a 74-year-old woman who died in a hospital ten days after an ambulance was called to her CLA in the early morning hours. Reportedly, the timeline of events that occurred at the CLA which caused the client to be taken to the hospital were not fully known. It was also not known whether and at what time the on-call nurse was notified of the client's declining medical condition during the early morning hours, or whether any documentation generated by the CLA relating to that morning was altered after the fact.

Finding: OPA conducted an investigation and substantiated neglect against the provider agency and the CLA staff worker on duty during the morning of the incident. The evidence indicated that on that morning, the client began to exhibit signs of illness. Despite protocols to the contrary, the direct care staff did not call the on-call nursing service. Instead, the staff worker called the CLA manager. Witness accounts vary as to the time of the phone call but both the staff worker and the manager described the call as occurring somewhere between 4:00 am and 6:00 am, and both stated it occurred prior to the on-call nurse being called. The purpose of the call was to discuss the client's current medical symptoms, which were concerning to the staff worker. OPA noted certain progress note times appeared to be altered and written notes were also inconsistent with time frames given during witness interviews.

When interviewed, the staff worker indicated that she did not call the on-call nursing system that morning. Instead, she called to notify the CLA manager of the client's condition at around 4:00 or 4:30 am but there was no answer, so she hung up and called her back a short time later. The staff worker was asked if she thought that the short time later

could have been around 6:00 or 7:00 am, to which she responded, "It was not that late." The staff worker later stated she called the agency nurse at 7:15 am, which was also verified by the agency RN, who stated she advised the staff worker to call 911. However, the EMS dispatch time was noted to be 7:46 am. The progress notes generated by the staff worker relating to that morning appeared to have been altered, with the time of 7:15 am being written over what appeared to have been originally written as a time of 6:15 am. The staff worker stated she wound up calling one of her own agency's nurses instead of the on-call nursing agency because the CLA manager had said that she did not think the on-call agency "was responsive to our clients' needs." Concerning this comment, the CLA manager stated in her interview, "I might have thought that but I don't know if I recall saying that to anyone." The CLA manager also stated she was first contacted by the staff worker at about 6:00 am.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency in-services all staff who are regularly scheduled to work in a CLA, on the medical history of all clients overseen on their shifts.
2. That the provider agency in-service staff on the importance of proper documentation standards for making changes, proper maintenance of timelines, and accuracy in all documentation.
3. That the provider agency in-services all staff regarding the importance of following protocols as written without the exception of individual staff interpretation.
4. That the provider agency reinforce with staff the proper protocols for who should be called at what times and for what circumstances.
5. That the provider agency DDS ensures proper nursing oversight during vacation times and actual site visits occur when necessary for client evaluations.

55. Age: 52. **Residence:** SNF. (**OPA/AID intake:** 01/22/2009).

Nature of Allegation: The client lived in a skilled nursing facility (SNF) when he died. Reportedly, the SNF demonstrated a lack of supervision necessary around food based upon the client's having a diagnosis of Prader-Willi Syndrome. Allegedly, the client's death was attributable to a "Massive weight gain."

Finding: An investigation conducted by the Department of Public Health and monitored by OPA substantiated neglect. DPH found, "Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy whereby corrections are required." The client carried a diagnosis of Prader-Willi which was known to the skilled nursing facility. The DPH investigation report contained information to indicate that in November, the client weighed 282 pounds and that the following January, he weighed 315 pounds. This represented an increase of 33 pounds in 69 days. The facility records indicated that the physician was called in mid-January and that the client's diuretics were increased. The client died six days later. Although there was no autopsy, the DPH investigation report indicated that a physician identified the cause of death as cardiac arrest. The physician further identified that the client's weight gain was attributed to worsening congestive heart failure and non-compliance with his diet.

The client also attended a work program outside of the SNF. However, the participants of this program all brought their own lunches with them when attending the program. OPA reviewed the conditions of the client's supported employment work enclave and found all foods to be secured away from consumer access, in a locked refrigerator.

The work enclave served several individuals with Prader-Willi and closely monitored all food intake. Witnesses recalled discussing what appeared to be the client's gaining weight during the last months of his life, consistent with the documentation reviewed by the DPH. The day program supervisor stated that she contacted a supervisor at the SNF and was told that his weight had not changed.

Neglect was substantiated against the SNF for failing to adequately oversee the client's food intake. The client experienced a significant weight gain during the last two months of his life while under the care and custody of the facility. It was not determined whether or to what degree this weight gain contributed to the client's death. The SNF in question has since closed.

Status: Closed monitor – Neglect substantiated.

Recommendations:

That the DDS ensure clients with Prader-Willi Syndrome residing in skilled nursing facilities have appropriate supports in place to maintain and monitor weight and food intake as warranted for their ongoing health and safety.

56. Age: 87. **Residence:** Private CLA. (**OPA/AID intake:** 1/30/2009).

Nature of Allegation: Client passed away days after his left ear was observed by direct care staff to be swollen by staff, who notified the RN. Reportedly, the RN instructed staff to apply Bacitracin after cleaning the client's ear. However, the client had non-insulin dependent diabetes mellitus and a history of cellulitis. Staff noted that the client's left ear was red and swollen for two days in early June. The CLA RN did not document an assessment of the client's left ear in June. The client was seen by PCP, who diagnosed an abscess of the left ear with cellulitis and directed staff to take client to the ED for incision and drainage and possible admission. The client was admitted to the hospital with a diagnosis of malignant otitis externa and cellulitis extending into the left neck and left jaw. His white blood cell count was 13.7 (normal 4.5-11.5), ear drainage was cultured, and he was treated with antibiotics. The client developed respiratory distress, hypotension and hypoxemia. He was transferred to the critical care unit and lab work confirmed an acute MI (myocardial infarction; commonly called heart attack). The client's condition deteriorated despite anticoagulant therapy and noninvasive mechanical ventilation.

Finding: An investigation completed by DPH and monitored by OPA did not substantiate neglect on the part of the agency RN or provider agency. The DPH investigation report indicated that the client's physician order sheet indicated the fragility of his skin due to Prednisone use and stated, "There is no need to notify the physician for routine skin tears or bruises." The DPH investigation further found that the treatment prescribed was consistent with standing orders, and that the staff communication log contained no additional record of the injury from the initial entry date up to the client's hospital admission. As a result, DPH concluded that "Based upon the information she (the RN) was given there was no indication that she should have taken any an action beyond what she did."

Status: Closed monitor – No substantiation.

Recommendations: None.

57. Ages: 54 and 57. **Residence:** Family Home. (**OPA/AID intake:** 02/25/2009).

Nature of Allegation: A newspaper article appeared in the Norwalk Hour regarding the deaths of two clients in a condominium. The article read in part, “. . . fire marshal called in state police detectives to investigate the fire that trapped and killed two mentally handicapped residents of a condominium . . . Saturday at around 7:55 a.m.” The

article went on to read, "The detectives would investigate the possibility of arson and help . . . determine the origin of the blaze."

According to the newspaper account, of the fire, "One of the two had passed out in a stairway outside of apartment . . . but died at (the hospital) a short time later. The other was pronounced dead at the scene after being located near the bedroom doorway."

Finding: A follow up to this article by OPA included conversations with the client's support provider agency and the local fire department. The condominium had been inspected in February 2008 and that it was found to require only the addition of dead bolt locks. The support agency also indicated that the smoke detectors were periodically checked to ensure that they remained operable. The cause of the fire appeared to have been electrical in nature. It was not known whether the stove was involved due to its proximity to the electrical panel and the damage found to both. One of the deceased residents required assistance when cooking, which he reportedly did receive. It was also unclear, due to the fire damage, whether all of the smoke detectors were operating properly at the time of the fire. However, it was known that the detectors in the common hallway were operating at the time and that at least one neighbor was successfully alerted to the fire by such a detector. The OPA AID determined further investigation to be unwarranted.

Status: Closed DNT – No substantiation.

Recommendations: None.

58. Age 29. Residence: Family home. (**OPA/AID intake:** 3/10/2009).

Nature of Allegation: The client lived at home with his sister and her two children at the time of his death, which at first was thought to have been due to a massive heart attack. However, jurisdiction was asserted by the OCME. The client had history of diabetes, but no other known health issues. An in home health agency assisted the client in monitoring his diabetes and coordinated his medical appointments. The client also received assistance through DDS family support staff. (*NOTE: In 2005, OPA/AID conducted an investigation concerning the alleged neglect of the client which found that his, "ability to manage his diabetic condition was lacking" and protective services from DDS were recommended.*)

Reportedly, just prior to his death, the client had a cold, or some congestion, and was seen and treated at a local Walk-In Clinic, where Sudafed was prescribed. According to the OCME autopsy report, the client's cause of death was listed as Combined Amitriptyline (Elavil) and Tramadol Toxicity. The manner of death was listed as Accident.

During the course of the OPA investigation, the OCME pathologist reported that in light of the client's most recent medication history and based upon the levels of Amitriptyline (Elavil) and Tramadol found in the toxicology screen, the client would have had to have taken eighty-two 50 mg tablets of Amitriptyline (Elavil) and sixty-four 100 mg tablets of Tramadol to reach the levels obtained in the post mortem samples taken by the OCME. The medical examiner indicated that either, "(the client) took potentially dozens of pills at once or lots of pills over a long period of time."

Finding: OPA conducted an investigation and was unable to substantiate abuse or neglect in connection with the untimely death of the client due to a high toxicity of Amitriptyline and Tramadol. The client's records indicated he was prescribed both of these medications and had both prescriptions filled during the few weeks prior to his dying. The evidence indicated the client had several doctor's appointments during that time period for back pain. Also, the autopsy conducted by the Office of the Chief Medical Examiner concluded the client's death was accidental.

The only known witness who was with or around the client on the date of his death was his sister, who was unable to be fully interviewed by this Office on the advice of a family attorney. The client's sister did indicate to OPA

investigators during a short preliminary interview that she had an argument with the client on the morning of his death in their home and that he went to his room for a while, but that they later made up. OPA investigators did view the inside of the client's home and his room and found no evidence to indicate that anything suspicious had recently occurred. The client's sister was quite willing to speak with OPA investigators until one point early in the interview when her mother spoke with her on the telephone and advised her to consult with the family attorney before continuing. The client's sister did not provide OPA with any other information concerning the events that occurred on the date of the client's death after this phone call, nor did she provide any information about the administration of his medications.

Although the client was receiving nursing oversight from DDS and a home health care agency with regard to managing his diabetes, there was no evidence to indicate that he received any nursing assistance or other daily assistance in managing both medications which were prescribed for his back pain in 2008 and which were found to be above toxic levels in his system upon autopsy. OPA was unable to determine the manner in which he ingested those toxic levels.

Status: Closed AID – No substantiation.

Recommendations:

That the DDS ensure clients receiving specific nursing follow-up for diet, diabetes or medication administration issues are periodically assessed (between Level of Need assessments) for any additional health related issues which might develop and require similar or additional support management.

59. Age: 59. **Residence:** Private CLA. (**OPA/AID intake:** 3/12/2009).

Nature of Allegation: Reportedly, after contacting nursing about the client's having diarrhea, CLA staff were instructed to give her only Jell-O. It was alleged the client received only Jell-O with no additional liquids for the next three days until her admission to the hospital. The client continued to have diarrhea during this time period.

An established diarrhea protocol, which required CLA staff to alert nursing should diarrhea continue so that other dietary or medical interventions could be implemented, was not followed after the client's having diarrhea was originally reported to the CLA nurse. It was suspected that neither the communications with nursing nor subsequent interventions occurred.

Finding: OPA conducted an investigation and substantiated neglect in connection with the care and treatment the client received at her CLA relative to the incidents that took place over the course of her illness, and continuing until her hospitalization. Neglect was substantiated against one residential staff worker and the residential provider agency responsible for overseeing the client's nursing care.

The evidence indicated that the client developed symptoms of diarrhea and that during this same time period the regularly scheduled nurse LPN assigned to the CLA was away on vacation. There was no formal or informal nursing coverage for the CLA residence set up in the LPN's absence, other than an agency-wide on call system. Record reviews indicated that there were no nursing notes recorded during a ten-day period prior to the client's death. There were inconsistent notes from direct care staff and OPA interviews conducted with agency staff were at times conflicting. In fact, communication concerning the client's symptoms, both written and verbal, appeared to be lacking in several areas. An agency on-call LPN and stated that if she had been given all the information documented in the staff log book and on the I&O sheet, she would have made different recommendation for the care of the client during the week of her illness

There was an order to increase the client's fluid intake by giving Jell-O and a directive to follow the "Diarrhea Protocol." The evidence indicated that due to poor communication the "increased fluids" order was misinterpreted by the CLA staff worker as a diet plan to give Jell-O only. This misinformation was then passed along on to several subsequent shifts until the client was eventually admitted to the hospital with signs of dehydration which may have contributed to her acute renal failure and death. The staff worker admitted that she did not read the log book at the start of her shift and also did not review the MAR, the physician's orders, or the diarrhea protocol for proper diet and treatment.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency in-services staff on the importance of following protocols as written without exception of individual staff interpretation.
2. That the provider agency in-services staff on the importance of proper documentation standards for proper use of times and timelines and thoroughness in all documentation.
3. That the provider agency reinforces with staff the proper protocols for when and how the on-call process should be utilized, what information should be shared, and how to fully document the nursing directives so that subsequent shifts can follow the directives to the same standards.
4. That the provider agency review client charts to assure they all contain all relevant information and that diagnoses and plans are consistent throughout the various documents within.
5. That the provider agency ensures on-call nursing staff are provided with access to full and accurate medical histories of clients for whom they are providing oversight.
6. That the provider agency nursing staff ensure follow-up for medical issues is done either by themselves, the regularly scheduled CLA nurse, or the agency RN.
7. That the provider agency provide adequate time at shift change for the exchange or pertinent information and time to read the log book and other pertinent documentation.
8. That the provider agency ensures continuity of proper nursing oversight during vacation times and that actual site visits occur when necessary for client evaluations.
9. That the provider also incorporates these recommendations into the training provisions for new employees.

60. Age: 24. **Residence:** Family Home. **(OPA/AID intake:** 4/3/2009).

Nature of Allegation: Prior to the client's death, it had been reported to OPA that the client's overall health was becoming progressively worse due both to her having a congenital heart condition, and to her living in a state of neglect in the family home. The client's oxygen saturation levels (expressed as a percentage fraction of 100), was recorded to be in the low 70s and even in the 60s. (Normal values for most people are in mid-to-high 90s.) The client had significant breathing problems and sleep apnea and had been taking antibiotics for six months, causing her to have chronic diarrhea. The client slept on a mattress which smelled of urine and was stained and soiled. The family home was reportedly unclean and smelled of cigarette smoke and urine. A pulmonary specialist had recently examined the client and referred her to an ENT, but the appointment was not scheduled to occur for another 26

days. A previous OPA investigation of the family home two years earlier substantiated neglect and requested protective services from DDS.

In response to the allegations, OPA conducted an investigation and substantiated neglect by the client's parents and the Department of Developmental Services (DDS). Statements provided and documents reviewed by OPA demonstrated that the client was substantially unable to care for herself and that her caretakers did not, or were unable to provide her with services necessary for ensuring her physical health and safety as defined by C.G.S. § 46a-11a (2). In 2007, OPA completed a previous investigation which substantiated neglect on the part of a family caregiver. At that time, OPA found the family residence to be extremely dirty with a pungent odor and in need of serious repairs. The client's bed mattress was observed to be urine-soaked. In addition, the client herself was noted at that time to be, "unclean...with blackened feet and greasy hair." As a result of the 2007 investigation, protective services were requested from DDS to address the client's home environment. The client was subsequently placed on "Emergency" or "E" placement status by DDS in July, 2007.

The most recent referral to OPA indicated that the client's overall health had been in decline and that her living environment was a significant contributing factor to this decline. Documents and statements reviewed by OPA demonstrated that the client's family was unable to provide a home setting that would not be harmful to the client's well being. Witness statements and DDS records indicated that the client did not receive necessary dental, GYN, cardiology and other medical appointments. In the last month of her life, the parents declined a DDS offer to have that agency's services provided to the client in the family home.

Although the client was deemed an "E" (emergency) placement status, and notwithstanding a 2005 court settlement agreement on the part of DDS which committed that agency to providing more timely placements for clients having such "E" status, the client had not received residential placement support services as of the most recent referral to OPA of suspected neglect.

Upon receiving a referral that the client had several ongoing health issues and was doing poorly in the family home, OPA requested an Immediate Protective Service Plan (IPSP) from DDS, and specifically requested that the client be placed in a setting that would not further jeopardize her health and safety. An initial response to the IPSP from DDS was received by OPA, which indicated only that the client would remain on emergency placement status and that two unnamed private provider agencies were considering providing residential supports for her. In early April, the client was seen by a physician who recommended that she be placed in a group home environment and that she lose weight. Following that recommendation, OPA faxed an additional request to the DDS administration asking that the client be placed in an alternative residential setting in order to ensure her ongoing health and safety, especially in light of her exhibiting symptoms of having poor oxygen saturation, as had been reported.

The second week of April, OPA received a second IPSP response from the DDS region, which indicated that DDS was awaiting clarification from the client's physicians regarding her current health status and diagnoses. The response, which apparently reflected the views of the DDS region's Director of Health Services as well as regional administrators, speculated that the client might have adapted, over time, to lower than normal oxygen saturation levels, and referred to the fact that none of the physicians who had been treating the client had deemed her condition sufficiently serious to warrant immediate hospitalization or placement in a SNF. The response also indicated that there were no appropriate vacancies in DDS supported residences within the region, and that attempts to interest providers in developing a residential placement for the client had been unsuccessful due to their perceptions about her "medical risk". The response concluded by stating that the client would remain on the emergency waiting list for placement.

Finding: Neglect was substantiated with respect to both family caregivers and DDS. In failing to develop adequate immediate protective services plans, including an alternative placement, DDS ignored the provisions of a 2005 court settlement agreement which placed a legal duty upon the Department to secure placements for individuals designated as "E," which the client was so designated for almost two years. DDS also ignored the provisions of its own departmental policies and procedures, particularly Policy Number I.C.P.O. 001 and Procedure Number I.C.P.R. 001, which mapped out procedures for regional and state utilization review. The department also overlooked a provision in Procedure Number I.B.P.R. 001, which allowed for emergencies to be, "dealt with outside of (the PRAT) process due to special circumstances." The department also ignored repeated internal pleas for placement on the part of at least two DDS workers who were familiar with the client's compromised health status and unhealthy living situation. The department also did not initiate appropriate and timely action in response to either IPSP request for placement made by OPA in connection with this investigation, in violation of the 2008 DDS/OPA Interagency Agreement and C.G.S. Sec. 46a - 11e. (c) (2009), both of which directed that DDS not delay in initiating immediate protective services pending the outcome of an OPA investigation. Neglect was substantiated against the DDS up to and including individuals in high administrative levels. Senior level administrators were either uninformed about the immediacy of the risk facing the client, or were dismissive in responding to it. None took responsibility for ensuring an effective response to the client's situation. Senior administrators ignored repeated correspondence addressed to them regarding the need for Immediate Protective Services. The DDS administration also approved an inadequate IPSP response that minimized the risk facing the client.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS Central Office consider initiating disciplinary action in response to senior level regional administrators who failed to ensure timely and appropriate oversight regarding responses to two OPA requests for the client to receive Immediate Protective Services, as outlined in the body and findings of this investigation report.
2. That the DDS Central Office ensure that the senior level regional administrators are retrained with regard to DDS obligations under the DDS/OPA 2008 Interagency Agreement, as well as DDS obligations under C.G.S. 46a-11e. (c) (2009).
3. That the DDS Central Office ensure regional practices regarding immediate protective service responses substantially conform to the provisions of the 2008 DDS/OPA Interagency Agreement.
4. That the DDS ensure IPSP placement options are not limited by regional boundaries.
5. That the DDS should ensure IPSP placement options are not limited to private provider only settings but also consider DDS residential placements when a client has Emergency Placement Status and an IPSP or PSP has been requested.
6. That the DDS ensure all Regional Directors are required to become actively involved whenever their region receives an IPSP request for alternative placement involving a client having both an Emergency placement status and an open protective service plan stemming from a previously substantiated OPA investigation.
7. That the DDS ensure medically fragile clients who are on the Emergency Placement list receive ongoing medical oversight from Utilization and Resource Review, which oversight should include a DDS representative familiar with the client's medical history. In this case, the client's medical condition and staffing support needs appear to have

warranted Utilization and Resource Review. However, the evidence indicates that she did not receive URC consideration.

8. That the DDS ensure regional Planning and Resource Allocation Team (PRAT) establishes practices to consider any and all updated information relating to medically fragile clients with an Emergency placement status. DDS should also ensure that PRAT reviews involving such medically fragile individuals with "E" placement status have in attendance a medical professional who is familiar with the individuals' medical issues.

61. Age: 43. **Residence:** Private CLA. (**OPA/AID intake:** 4/17/2009).

Nature of Allegation: Reportedly, the client was found unresponsive at his CLA, just prior to his scheduled transport to his vocational program. Staff contacted 911 and the client was brought to the hospital. Two days prior to his death, the hospital issued a DNR Order due to the fact that the client was void of brain function and was on artificial life supports. The hospital removed life supports and the client was pronounced dead two days later. An autopsy revealed the cause of death to be "blunt head trauma," however; there was no known knowledge of the client experiencing recent trauma to the head.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiated abuse or neglect in connection with the client's death. Interviews were conducted with all group home staff and vocational staff. None of the staff indicated that they witnessed anything, or had any knowledge about anything that might have contributed to the injuries which were apparently sustained by the client. OPA was also unable to find and physical or documentary evidence that might have explained such an injury to the client's head.

However, there were concerns that were generated from the interviews of staff and document reviews. One of the staff who routinely cared for the client stated that he routinely strapped the client to the toilet seat based on his own concerns and fears of the client falling off the seat. This was no protocol or guideline for doing this, and it was not an authorized procedure. The staff member had not brought his concerns about the client being unsteady while on the toilet seat to his supervisors in order to have the concern addressed. It was also of concern that one staff support worker, who worked third shift had never been trained regarding any protocols, guidelines or anything else related to the client's care prior to working with and being assigned responsibility for his care. The staff worker stated that the morning of the incident leading to the 911 call was the one and only time that she had worked with and been assigned direct responsibility for the client. The client also had a physical in February of 2009 in which the physician documented that he had abnormal motor activity which he categorized as an unsteady gait. There is no evidence that the group home nurse or anyone else ever followed up on this diagnosis and referred the client to be re-evaluated by the physical therapist. These concerns were communicated to the provider agency and DDS, but could not be causally linked to the client's death.

Status: Closed AID – No substantiation.

Recommendations:

1. That the provider agency ensure all out of house staff are trained on client specific routines and protocols prior to working with or being assigned direct responsibility for a client who requires close supervision while ambulating.
2. That the provider agency ensure all in home regular staff are trained regarding client specific routines and guidelines including clients who require close supervision while ambulating.

3. That the DDS ensure licensing and quality assurance inspection occur at the CLA and that such inspection includes a review of the facility's records relating to following through on any concerns or problems that are identified by the clients' general practitioner or other medical professional.

62. Age: 81. **Residence:** Hospital. (**OPA/AID intake:** 10/2/2009).

Nature of Allegation: Reportedly, the client died as a result of multiple fractures that she sustained when she fell off of a hospital X-ray table. Following the fall, a CT scan was requested for the client but the hospital allegedly refused and stated that they did not provide head-to-toe CT scans. The hospital allegedly stated that they did not treat non-ambulatory fractures, even though the leg fractures sustained by the client were attributed to being the direct result of her falling off the hospital's own X-ray table. The hospital also allegedly refused an overnight observation request for the client following her fall.

The client's health deteriorated and continued to decline following the falling incident. The day after the fall, the client had low blood pressure and the hospital refused a request for further X-rays. Three days after the fall, the client had grey skin and was diagnosed with having fractures to both legs and a low blood count. The client was admitted to the same hospital where she had fallen off of the X-ray table three days earlier. The client allegedly did not have her oxygen on nor was her pain being properly managed when visited at the hospital by CLA staff. A week later, the client received a full body scan which revealed two broken legs and a lumbar fracture. The client needed to be tube-fed which required her being upright but she could not be put upright due to her being immobilized for fractures.

Finding: An investigation completed by DPH and monitored by OPA substantiated neglect against the hospital. In mid-July, the client, an 81-year-old woman with a non-verbal intellectual disability, entered the hospital's Interventional Radiology Department in order to undergo a scheduled feeding tube replacement procedure. In preparation for this procedure, the client was taken to the Radiology Department where X-rays were to be taken regarding the positioning of her feeding tube. While in Radiology, the client was left unattended and unsecured on the X-ray table whereupon she experienced a fall to the floor from the table, resulting in her sustaining multiple fractures. Eighteen days later, the client died as a result of complications from the injuries she sustained during the fall. The events that occurred between the time of her fall and her death raised additional and serious concerns about the quality of care the client received at the hospital. Findings from the DPH investigation included improper safety practices by the hospital's Interventional Radiology staff. There was also a significant delay in diagnosing and treating the client's injuries post fall. In addition, physical and pain assessments were not completed on the client by the Emergency Department nursing staff. There was also a lack of communicating important information between the Emergency Department staff.

The client's fall from the X-ray table in the Interventional Radiology department was a preventable incident. The Department of Public Health (DPH) investigation report revealed that the hospital X-ray table which the client was placed on was equipped with operable safety straps. However, these safety straps were not utilized by the Interventional Radiology staff in order to secure the client to the table. As a result, the client slid from the X-table, fell approximately two feet to the floor, whereupon she sustained multiple bone fractures.

The DPH Investigation Report also revealed that the Interventional Radiology staff did not follow the hospital's post fall policy. Immediately following the fall, radiology staff moved the client by placing her back on the X-ray table prior to notifying hospital nursing staff of the incident. The hospital's post fall policy directs that an RN should immediately assess any patient that sustains any fall. Moving the client prior to her receiving such an assessment

placed her at risk for sustaining further injuries. The evidence indicates that these two improper safety practices by the hospital's radiology staff operated to the client's detriment at the time of her fall.

Additionally, hospital documentation and the residential provider agency's documentation indicated there was a three-day delay in the diagnosing and treating of the client for bilateral leg fractures. This delay in diagnosis and treatment occurred despite the fact that the client made two intervening visits to the hospital's Emergency Department following her fall off of the hospital x-ray table. Additionally, there was a seven-day delay in the hospital diagnosing the client as having an L2 spinal fracture.

The hospital's Emergency Department (ED) records reported that following her fall in the Interventional Radiology Department, the client was taken to the ED for evaluation. While in the ED, X-rays of the client's pelvis and left shoulder, as well as a head CT scan, were ordered and performed. The results of the head CT scan were not of diagnostic quality and a repeat head CT scan was recommended by the radiologist. However, the ED physician did not order another head CT scan as recommended. Instead, the ED physician documented that the client should be sent back to the CLA (group home) with standard head injury precautions, however, there was no order for such standard head injury precautions or monitoring on the ED's discharge instructions. In addition, the ED physician's physical examination from the day of the fall listed several body areas as having been assessed following the client's fall from the X-ray table, but there was no mention of her extremities being assessed. As a result, the client was discharged from the ED back to the CLA without a full body examination. Had an examination of her extremities been performed, it is likely that the leg fractures would have been discovered at that time. Importantly, the client was also repeatedly taken back to the hospital by agency staff after experiencing the fall from the X-ray table due to her being in obvious discomfort. The CLA nursing documentation indicates that the group home nurse also spoke with the ED physician and requested that the client undergo a full body and head scan in order to check for fractures and also requested that she receive an in-patient overnight observation. The CLA nurse stated the ED physician denied these requests.

There were also other concerns noted during the client's initial evaluation in the ED following her fall. Documentation indicated the client was in the ED from 1:48 pm until 8:35 pm, a period of almost seven hours. Her temperature was recorded as being 98.5 degrees at 1:54 pm, which represented the only recorded temperature during the seven hour visit. Although other vital signs are listed, there was no temperature recorded at the time of discharge. CLA documentation indicated that the client arrived back at the CLA at 9:40 pm with an elevated temperature of 102.2 degrees. It was also noted that the client's pain/discomfort level was not assessed and no pain medication was provided to her during this seven hour ED visit, despite her having just experienced a traumatic fall. The DPH Investigation Report found that the ED nursing staff did not perform comprehensive pain assessments to determine the client's discomfort level at any time during this hospital visit. A review of the ED nursing documentation indicated sedation medications were administered only prior to the client's undergoing the head CT scan. No pain medication was administered to the client while in the ED.

The day after the fall, the client returned to the ED at the same hospital for further evaluation. CLA documentation indicated that although non-verbal, the client was in obvious discomfort when repositioned and her left leg was edematous and slightly internally rotated. CLA documentation indicated that the client was sent back to the hospital by ambulance due to her having fever, low blood pressure, bruising to the left side of the face and arm, and a flaccid lower extremity. The CLA nurse stated that the ED Triage nurse was called and notified of the above signs and symptoms. The DPH Investigation Report revealed that a note written by the ED nurse stated she received a call from the group home nurse reporting increased bruising and a flaccid left leg. However, this information was not communicated to the ED's physician assistant (PA) assigned to the client. Documentation from the ED indicated that

the client's chief complaint was, "Fall." However, a comprehensive physical assessment was not performed by the PA upon her returning to the hospital. The client's lower extremities were also again not assessed by the ED staff during this second ED visit and no further X-rays were taken. Had an examination of the client's extremities been performed at that time, it is likely that her multiple leg fractures would have been discovered. Instead, she was diagnosed with a urinary tract infection (UTI) and discharged back to the CLA with a prescription for antibiotics. It also appeared that UTI was in itself an incorrect diagnosis. An MD progress note written following the client's eventual hospital admission stated, "There is documentation that the patient may have been diagnosed with a urinary tract infection recently, although the urinalysis from this presentation is not indicative of infection." The ED nursing staff also again did not perform any pain assessments during the client's second visit to the hospital the day after the fall.

Two days later, the client returned by ambulance for her third ED visit since her fall off the hospital's X-ray table. By this time, the client's medical condition had significantly worsened. The hospital's documentation revealed low blood pressure, fever, pale/gray skin color, and obvious signs of discomfort. Blood work performed indicated severe anemia requiring blood transfusions. Hospital documentation also indicated there was much confusion between the ED physician, admitting physician, radiology, and orthopedics regarding which leg to X-ray and immobilize. In part because of this confusion, X-rays of both legs were performed, which results revealed that the client had sustained displaced fractures to both femurs and a fracture to the right tibia. By this time the client had gone three days without any immobilization/casting/ setting/treatment for fractures to her legs.

Later that day, the client was admitted to the hospital from the ED for treatment of her injuries and anemia. The hospital's documentation indicated her admitting diagnoses were acute anemia and right knee fracture. Although evident at the time of her hospital admission, the femur fractures were not listed in the admitting diagnoses. The full extent of the client's injuries from the fall off the X-ray table were not found until a full body bone scan was performed a full week after the incident. The results of this scan revealed that in addition to having three leg fractures, the client also had a fracture of her L2 spine.

The client's hospitalization lasted 15 days. Hospital documentation indicated that surgical intervention for her fractures was not performed due to the nature of these femur fractures and her identified co-morbidities. Treatment included immobilization of her legs with splints. The leg splints led to skin problems in areas under the splints. Also, the immobilization of her femurs made it difficult for the client to remain upright in bed as she had been able to in the past, a position which facilitated her tube feedings and helped her to avoid aspiration. By the end of July, the client's condition significantly worsened. She was noted to have increased secretions and more difficulty coughing up secretions and she remained unable to sit upright as she had been able to before the fall. A chest X-ray during this time revealed, "bibasilar atelectasis or infiltrate. Small pleural effusion." Eventually, the client was transitioned to inpatient hospice. The principal diagnosis listed on the Hospice Certification and Plan of Care was aspiration pneumonia. However, it was noted that hospice was first discussed in the hospital records two days prior by the assigned APRN. Her documentation, in consultation with the MD, stated a different rationale for hospice; "The patient has been on hospice in the past and it seems that hospice would in fact be the best avenue for the patient at this time given the degree of pain and the probable skin breakdown that will take place going forward." The APRN also wrote, "Again, hospice may be in the patient's best interest given the fact that she has non-operable bilateral femur fractures and is in leg immobilizer which will precipitate many complications going forward." There was no mention of aspiration pneumonia at that time and it appeared that the APRN's note was written prior to the client's undergoing a chest X-ray as she also wrote in this note, "We will order a chest X-ray to evaluate for possible pneumonia."

The client continued to steadily deteriorate. She died at the hospital 18 days after falling from the same hospital's X-ray table. An external postmortem examination was performed at the Office of the Chief Medical Examiner. The OCME postmortem report indicated the cause of death was, "multiple fractures." The manner of death was listed as accident.

In conclusion, the evidence indicated that although advanced in age, the client's death was untimely, resulting from traumatic injuries she sustained after falling from a hospital X-ray table. The evidence also indicated that this fall was entirely preventable and occurred due to hospital staff's failure to utilize appropriate and available safety straps to secure the client to the X-ray table. The evidence further indicated that after the fall, there was a significant delay on the part of the hospital in properly diagnosing and treating the client's injuries. It took the hospital a full week to discover the full extent of her injuries, despite multiple visits to the Emergency Department. In addition, as noted in the DPH investigation report, the hospital ED physicians failed to perform adequate physical examinations on the client in assessing her for injuries during her first two ED visits. Also, pain and discomfort level were not properly assessed or treated by the ED nursing staff, despite the client having suffered a significant fall while under the hospital's facility and care. The client did not receive services necessary to maintain her health and safety. Neglect was substantiated.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS follow up with the Department of Public Health to confirm that the Plans of Corrections stated in their investigation report have been implemented by the hospital.
2. That the DDS ensure its Health Services Division is aware of the findings from this investigation.

63. Age: 57. **Residence:** Private CLA. (**OPA/AID intake:** 10/19/2009).

Nature of Allegation: Reportedly, the client died after being taken to the hospital early in the morning, when she was observed by two CLA third shift staff to be unresponsive. One of the CLA staff was supposed to remain awake all night and perform 15 minute bed checks on the client while the other staff was allowed to sleep. The awake staff represented that the client had been up at about 1:15 am and was slightly agitated, so the staff worker had the client sleep in a recliner chair in the living room, which allegedly was not an unusual event. The awake staff indicated that the client was still breathing and resting at 3:00 am but allegedly also stated, "When I got up after 5:00 (the client) wasn't breathing." The awake staff woke up the sleeping staff, who dialed 911 and then they then began two-person CPR with rescue breathing. EMTs arrived at 6:40 am and took over. Although the client was supposed to be checked every 15 minutes, there was no documentation to support that the bed checks took place.

Finding: OPA conducted an investigation and determined that there existed sufficient evidence to substantiate neglect on the part of the third shift awake staff, who failed to provide an immediate response to the client's medical condition on the morning of the incident, when she observed the client having trouble breathing at about 5:00 am, but waited until about 6:20 am to call 911. OPA also substantiated neglect on the part of the provider agency for failing to provide sufficient oversight concerning the performance and documentation of the client's 15 minute checks.

When interviewed, the awake staff stated that she noticed the client was in a state of distress at 5:00 am, and that she responded at that time by alerting the asleep overnight staff, initiating CPR and calling 911. However, the worker was unable to account for what she did between the time that she stated she noticed the client to be in distress and the

time that she woke up the other staff person, who herself indicated that she was awakened by the awake staff when the alarm on her cell phone went off at 6:10 am. First responder records indicated a dispatch time of 6:20 am. The awake worker was unable to provide any explanation for the over one hour delay which apparently occurred from her first observing the client to be in obvious need of assistance and her alerting the other staff and actually calling for such assistance.

The client also had a requirement for 15 minute checks which were to be logged on a data collection chart. The client's death took place on the first day of a new charting cycle and no data was maintained for the night prior to her death. While it was presented to OPA by supervisory staff that the expectation was for this data to be recorded in real time, a review of the data sheet demonstrated that staff frequently recorded the data by drawing a line through an entire night from a point where sleep started to a point the next morning. Agency administrators were unable to state who was responsible for providing direct oversight of the staff practice and line staff interviewed were inconsistent in their view of the agency's expectations for data collection. The asleep overnight staff indicated she was told during her orientation that documenting the 15 minute checks was part of her morning responsibilities. However, the data collection process, if properly implemented, would have required at least three occasions for checking the client between the time the awake staff stated she initially noted distress and the eventual initiation of assistance.

Status: Closed AID –Neglect substantiated.

Recommendations:

1. That the provider agency ensure staff are adequately trained in data collection requirements, and that there is a supervisory mechanism to ensure ongoing compliance with these requirements.
2. That the provider agency consider initiating disciplinary action as may be warranted with regard to the staff's lack of timely response and improper documentation on the morning of the incident.

64. Age: 57. **Residence:** Private CLA. (**OPA/AID intake:** 10/27/2009).

Nature of Allegation: The client died following a brief hospitalization. The cause of death was attributed to respiratory failure and septic shock. The client allegedly experienced delay in treatment on two separate occasions, one of which was during the hours immediately preceding her hospital admission. The CLA RN on-call, did not properly undertake to perform a nursing assessment of the client or otherwise initiate, cause or enable her to receive timely, appropriate and necessary medical treatment as was required for ensuring her ongoing health and safety. The RN was allegedly notified four or more times on two successive dates prior to the client's hospital admission by CLA staff regarding the client's symptoms, such as ongoing vomiting, fever over 100 degrees, low blood pressure, high respiration, pursed lip breathing and agitation. The client's blood pressure was recorded as being 79/43 and 85/53 on the second of these dates. Yet, the client was neither assessed nor sent to the hospital until 12:10 am in the early morning hours on the date of her death, when her oxygen saturation level was 84, respiration 40 and her blood pressure was difficult to obtain.

Finding: An investigation completed by DPH and monitored by OPA substantiated neglect against the agency RN, who according to the DPH documentation, "may not have conformed to the standard of care for (her) profession (and) failed to ensure that the LPN nursing staff was appropriately checking residuals before administering gastrostomy feedings." The DPH also determined that the RN, "failed to perform a nursing assessment in order to gather additional data in order to determine a plan of care. The Department understands that at all times (she) relied upon the knowledge, experience and observations of the LPNs who worked with the client on a daily basis.

However, (an) LPN scope of practice does not include patient assessment." Based on this finding by the practitioner's (LPN) licensing authority (DPH), OPA substantiated neglect.

Status: Closed monitor – Neglect substantiated.

Recommendations:

That the provider agency ensure only RN or APRN level staff (or above) perform nursing assessments and that no delegation occurs to practitioners whose scope of practice does not include patient assessment.

65. Age: 57. **Residence:** Private CLA. (**OPA/AID intake:** 10/28/2009).

Nature of Allegation: The client died after collapsing in front of residential support staff and experiencing a cardiac event. Reportedly, staff failed to properly initiate CPR after dialing 911.

Finding: OPA conducted an investigation and determined there to be insufficient evidence to substantiate neglect in connection with the residential staff's responses on the date of the incident. Despite appearances to the initial responder, a police officer, the CLA staff were consistent in representing that the client was breathing on his own up until the moment the officer arrived on the scene. A review of the American Red Cross guidelines for initiating CPR indicated that CPR initiation was recommended when the victim was not breathing and had no pulse. OPA was unable to establish that the client was in fact not breathing just prior to the first responder's arrival. The 911 tape from the date of the incident indicated that staff called for emergency assistance twice and answered in the affirmative when asked by the 911 operator whether the client was still breathing. As a result, neglect could not be substantiated for staff's failing to initiate CPR.

Status: Closed AID – No substantiation.

Recommendations: none.

66. Age: 62 & 73. **Residence:** STS. (**OPA/AID intake:** 01/26/2010).

Nature of Allegation: Falls from Hoyer lifts during transports reportedly resulting in the deaths of two clients. Both falls occurred in the clients' respective residential cottages at STS.

Findings: OPA conducted an investigation and determined there existed sufficient evidence to substantiate neglect with regard to the fall Client # 1 experienced from a Hoyer lift at his STS Cottage. This finding was based on a review of the STS investigation report and reviews of medical records and interviews with STS medical staff. The internal STS investigation substantiated neglect on the part of a direct care staff member for failing to follow procedures which required that two staff operate a Hoyer lift. The staff member attempted to lift Client # 1 from his bed by way of the Hoyer lift without another staff present to assist in the lift. Client # 1 fell from the lift to the floor and immediately exhibited signs of cardiac arrest.

This Office's review of the available records indicated that at 7:25 am, Client # 1 fell head first from the Hoyer lift to the floor striking the occipital portion of his head. Within five minutes of the fall, CPR was initiated by nursing staff and Client # 1 was observed by a responding Physician Assistant (PA-C) to be lying on the floor pulse-less and breathless. First responders attached an AED to Client # 1's chest which indicated: "no shock," whereupon a weak pulse and respiration were noted. Client # 1 was placed on a hard board with neck support and was noted to be ashen and grey in color. He was taken to Waterbury Hospital where he was noted to have a large laceration to the back of the head. Client # 1 was given ventilation and underwent a CT scan which revealed a stable C-1 fracture

(either "minimally displaced" or "non-displaced" according to the CT Cervical Spine scan report). The CT scan also revealed "no acute intracranial process." Several chest X-Rays were taken while Client # 1 was in the hospital, which revealed rapidly developing bibasilar infiltrates, from the right lower lobe.

Dr. Vincent Waters, MD, JD, STS Medical Director, stated to OPA during an interview that he was not able to say with medical certainty that the fall from the Hoyer lift was the proximate cause of Client # 1's death. Dr. Waters indicated that there was no evidence of brain swell and that he was not certain that Client # 1 actually experienced cardiac arrest on the day he fell from the lift. Dr. Waters indicated that in his experience, which included experience as an ER attending physician, he would have expected Client # 1's pCO₂ levels to decrease while on ventilation after the trauma to his system occurred. However, since the pCO₂ levels remained elevated, Dr. Waters wondered whether Client # 1 may have silently aspirated or perhaps even had developed sepsis either before during or after the traumatic event. Nevertheless, Dr. Waters also stated that subjectively he believed there to be a link between the fall from the Hoyer lift and Client # 1's death, which occurred four days later.

Dr. Kirsten Bechtel, MD, a consultant to OPA's Fatality Review Board with extensive experience in both emergency medicine and healthcare facility mortality review processes, also reviewed the records associated with Client # 1's fall from the Hoyer lift and his subsequent demise at Waterbury hospital. Dr. Bechtel indicated that she believed there existed sufficient medical evidence to link Client # 1's death to his fall from the Hoyer lift.

Based on the information obtained and reviewed, The Office of Protection and Advocacy concurred with the STS internal investigation in finding that there existed sufficient evidence to substantiate neglect on the part of the staff member who failed to ensure Client # 1's safety while operating the Hoyer lift at the time he fell from it. OPA further determined that that fall was a substantial contributing factor in Client # 1's death four days later at Waterbury Hospital.

This Office also reviewed the circumstances surrounding the death of Client # 2, age 73, who like Client # 1, fell from an STS Hoyer lift and sustained a significant injury. Two STS staff members were executing a Hoyer lift with Client # 2 when the lift suddenly tipped over and Client # 2 fell to the ground, fracturing her hip. Client # 2 was taken to the hospital but hip replacement surgery was ruled out due primarily to concerns about the risks associated with anesthesia. Client # 2 passed away over two months later.

An investigation conducted by STS substantiated neglect on the part of the two staff members operating the Hoyer lift due to their failure to properly open the lift spreader bars before transporting Client # 2. However, Client # 2 survived the fall by a period of over two months, during which time some healing appeared to be evident around the area of her hip fracture. Client # 2 returned to STS two days later and passed away in her cottage. According to her death certificate, the cause of Client # 2's death was Cardio-pulmonary arrest, pulmonary fibrosis, recurrent aspiration pneumonias and COPD/emphysema. When asked about Client # 2's case, neither Dr. Waters, STS Medical Director, nor Dr. Bechtel, OPA's independent consultant, were able to state with medical certainty that the fall from the Hoyer lift was sufficiently closely connected to Client # 2's death to consider it to be the cause. As such, the Office of Protection and Advocacy concurred with the results of the internal STS investigation which substantiated neglect on the parts of two staff members who failed to ensure Client # 2's safety when using a Hoyer lift to transport her. However, OPA determined that there existed insufficient evidence to substantiate a causal relationship between the injuries Client # 2 experienced as a result of that neglect and her eventual death.

Recommendations: As the STS undertook to retrain all campus staff with regard to Hoyer lift protocols and general transfer safety strategies, no recommendations are being made at this time.

67. Age: 49. **Residence:** Private CLA. (**OPA/AID intake:** 02/01/2010).

Nature of Allegation: The client had Down syndrome and a cardiac history of mitral valve murmur and endocardial cushion defect. Reportedly, during the last ten to fourteen days of her life, the client was noted by her CLA staff to have had, “a bad cold.” On Thanksgiving Day, the client was noted to be coughing throughout first shift. At about 2:30 pm that same day she visited the home of a staff person, where she watched football and ate Thanksgiving dinner. The staff person noticed the client’s lips were blue and that she wasn’t breathing normally. The staff person documented her concerns about the client’s blue lips and breathing problem in the CLA log book. An on-call nurse was called regarding the client’s condition at about 6:40 pm, but the client was neither assessed nor sent for additional medical follow-up either Thursday or Friday. On Saturday morning, 3rd shift staff became concerned when the client refused to eat her breakfast. Sometime after 9:00 am, the client’s lips were observed to be “black.” CLA staff then attempted to take the client to a walk-in clinic but she refused and began screaming. 911 was then called and the client was taken to the hospital. She passed away two days later.

Finding: An investigation completed by The Fatality Review Board (FRB) and monitored by AID substantiated neglect against the client’s residential support provider. The residential provider was responsible for scheduling, coordinating and overseeing virtually all of the client’s ongoing medical needs and appointments. As such, the primary responsibility for ensuring that the client received appropriate and timely medical care rested with their provider agency. For this particular client, fulfilling this responsibility was complicated by her fear of medical visits and associated avoidant behaviors. However, responses to the signs of distress she exhibited in the days prior to her death reflected confusion about decision-making protocols and inadequate communication between caregivers that operated to delay access to effective medical treatment.

On Thanksgiving Day the client attended a holiday gathering hosted by the family of one of the client’s residential support staff. At this gathering, the client had difficulty breathing and it was also observed that her lips were blue. For over a week prior to Thanksgiving, she had been exhibiting signs of a “bad cold.” Upon returning to her CLA, at least some of the client’s symptoms were reported to an on-call nurse (RN) who was employed by an agency that was contracted to provide on-call nursing services for the residential provider. CLA staff maintained that the on-call nurse was informed that the client was wheezing and also that her lips had been blue. The on-call nurse stated that staff never said anything about the client’s lips being blue, but only that she had cold symptoms and was stuffy. The on-call nurse indicated that she recommended the administering of Tylenol and for the group home to keep an eye on the client and call her back if the symptoms persisted. The on-call nurse further stated she never received another call throughout the weekend regarding the client. This was corroborated through staff interviews. Although a review of the CLA documentation indicated different residential staff were concerned with the client’s symptoms and health status at different times throughout the Thanksgiving weekend, it was Saturday before a decision was made to have her medically evaluated.

The decision to obtain medical intervention was apparently made by a residential support manager, with no input from any nursing staff. This may have been due to the fact that the agency’s regular nurse (an agency employee) was on a leave of absence, and the nurse who had been hired to cover the agency had only begun work nine days prior to the first report of the client having blue lips. As stated above, the agency did have a contracted, on-call nursing service available that weekend to field medical questions and give over-the-phone advice. However, neither the on-call service nor the newly hired agency nurse were familiar with either the client’s congenital heart condition or her anxiety and avoidant behaviors with respect to medical interventions. Moreover, the provider agency did not have any protocol or plan of response in place for direct care staff to follow in the event that the client’s known heart condition became more pronounced. Even the agency’s regular nurse indicated when interviewed that she did not

know what the client's endocardial cushion defect entailed. She also stated that when she came to the organization in 2005, she never saw or reviewed the report from the client's 2002 cardiology consult because she did not review that far back into client records. There were no specific instructions regarding what staff needed to look for regarding the client's cardiac issues. Thus, when the client appeared to be in declining health before, on and after Thanksgiving there was no coordinated approach or response in place to address her changes in condition.

Although it is not possible to determine with certainty whether these deficiencies contributed to the agency's delay in seeking medical evaluation and care, or even if that delay contributed to the client's death, for an agency undertaking to care for an individual with a significant health concern, they are significant.

Status: Closed monitor – Neglect substantiated.

Recommendations:

The Recommendations made by OPA were generated by the FRB (and AID) as follows:

1. That the DDS ensure any "alerts" relating to an individual's diagnoses are carried forward from year-to-year and maintained in the individual's most current medical record. These alerts should be noted with the individual's current diagnoses and highlighted/emphasized in active records where the current diagnoses appear. For example, doctors' order sheets, appointment consult sheets and/or Medication Administration Records.
2. That the DDS ensure that all provider staff have accurate information regarding the nature and extent of their clients' medical conditions and health care needs. This information should include any precautionary measures which need to be taken in the event their clients experience changes in condition and/or exhibit symptoms requiring immediate medical attention.
3. That the DDS ensure all providers make arrangements for nursing support services to be consistently and adequately maintained during periods of nursing staff turnover. In the event providers are required to temporarily utilize nursing services through a home health care agency, DDS should ensure that the services provided by the home health care agency are equivalent to those typically made available by the provider. DDS should also ensure that provider staff are instructed to access the services of the home health care agency in the same manner they would their own nursing services.
4. That the DDS ensure all newly hired provider nursing staff complete a full review of the medical files for individuals in their care in order to be fully informed of their individual medical histories and health care needs.
5. That the DDS ensure all providers develop methods to support clients who are reluctant or afraid to attend medical appointments. These methods should include the development of desensitization techniques, which are based upon the needs of the individual, in addition to the use of sedating medications and/or physical holding techniques.
6. That the DDS ensure all provider plans requiring the use of sedating medications and/or physical holding techniques for medical appointments have the approval of the appropriate Program Review and Human Rights Committees.
7. That the DDS encourage providers to involve residential staff members having knowledge of clients' health care need in individual planning meetings and reviews. This includes individuals accompanying clients to medical appointments as well as individuals acting as liaisons between doctors' offices and residential programs.

8. That the DDS ensure non-licensed staff persons who are functioning in the role of “medical liaison” are not performing the duties of licensed medical personnel.
9. That the private provider take disciplinary action against, or provide appropriate training to, the staff persons who worked with the client over the Thanksgiving weekend and failed to report changes in her condition (bluish/blue/black lips, difficulty breathing, not “looking good”) to the nurse on-call.
10. That the private provider encourage residential staff to report any unusual changes in a client’s behavior to the appropriate supervisory and/or nursing staff for follow-up. In this case three residential staff members noted in interviews with FRB staff that the client had begun sleeping sitting up on her futon, rather than lying down in her bed.

68. Age: 29. **Residence:** Hospital. (**OPA/AID intake:** 3/12/2010).

Nature of Allegation: Reportedly, the client died after having been transported from an acute-care hospital to an inpatient psychiatric hospital/facility. Allegedly, the client was in restraints upon arrival at the second hospital (a psychiatric hospital) and died shortly after being removed from restraints. The client was allegedly in hospital #1’s Emergency Department in four-point restraints for five days prior to his being transported.

Finding: OPA conducted an investigation and determined there existed sufficient evidence to substantiate neglect against the hospital from which the client was discharged (hospital #1). The client died after arriving at hospital #2 and collapsing upon being transferred from hospital #1. Upon autopsy, the Office of the Chief State Medical Examiner (OCME) found the client’s death to have been caused by a pulmonary embolism. The OCME also found it significant that the client had experienced immobilization due to his having psychiatric illness prior to his death. (One of the known risks associated with long-term immobilization, including from restraints, is the development of emboli.) The Department of Public Health (DPH) conducted an investigation following the client’s death which resulted in hospital #1 being cited with several violations in connection with the care and treatment that the client received for the five days he was a patient in hospital #1. The DPH citations included: failure to develop a comprehensive care plan for use of restraints; failure to obtain physicians’ orders for the continuation of restraints; failure to consistently monitor the client while he was in restraints; failure to ensure that a face to face re-evaluation of restraint use occurred every eight hours; and failure to ensure that the client received timely psychiatric evaluations and appropriate medical management while he was in hospital #1’s Emergency Department.

In addition to having an intellectual disability, the client was also diagnosed with having Williams Syndrome and was known to have challenging behaviors which from time to time required him having to be restrained. According to interviews conducted with his CLA (group home) staff, the client’s aggressive behaviors began to increase both in frequency and intensity during the last year of his life and by the time of his hospitalization he was being manually restrained on a daily or semi-daily basis. There was no evidence that the client was ever placed in four-point restraints at his group home.

The client was taken via ambulance to hospital #1’s Emergency Department (ED) after exhibiting aggressive and out of control behaviors at his CLA. The client’s arrival that morning represented the third time in eight days that he was taken to the hospital by ambulance in restraints. During the prior month, the client received a police escort to hospital #1’s ED following a behavioral incident at the group home in which he had sustained a laceration to his head. The client was also sent back to hospital #1’s ED after the police requested an ambulance in the wake of another behavioral incident that occurred at the CLA.

Hospital #1's Administrator of Psychiatric Services (APS) indicated when interviewed that during the first two visits to the hospital the client was eventually able to calm down and return to his CLA. However, according to the APS on the third visit, after initially appearing as though he would become more calm, the client suddenly again became very agitated. The APS stated that the client did not wish to return to his CLA and instead indicated both verbally and behaviorally that he wanted to remain in restraints. The APS indicated that he and others determined fairly early on that the client would not be an appropriate candidate for hospital #1's inpatient psychiatric unit due to the client's having specialized needs as someone with a developmental disability and his exhibiting behavioral dyscontrol. According to the APS, he and others called several inpatient facilities in the hope of transferring the client to a more specialized program. The hospital was also aware that the client was already scheduled to be evaluated at an out of state medical center in the next few days. The APS stated that he also personally contacted the Department of Developmental Services (DDS) and the Department of Mental Health and Addiction Services (DMHAS) and was eventually able to secure a bed at hospital #2.

The evidence indicated that the client then remained in the hospital #1 ED for 83 hours, in four-and/or three-point restraints the entire time. Although the client was evaluated by at least one physician and several clinicians during this time period, he did not receive a psychiatric evaluation until Wednesday, when he was seen by a psychiatrist upon being transferred to hospital #1's inpatient psychiatric unit. Records reviewed indicated that while in the ED, hospital restraint procedures calling for range of motion and skin care examinations every two hours (four hours when sleeping) were not properly followed. As stated above, the client was transferred to hospital #1's inpatient psychiatric unit on Wednesday, three days following his ED admission and only after the placement at hospital #2 had been secured. Once transferred to the psychiatric unit, the client appeared to become more cooperative, but remained in restraints up to and including his being discharged from the hospital on Friday. Hospital records indicated that the client was provided with a sitter the entire time he remained at hospital #1 and that he was periodically and regularly assessed by nursing staff. Hospital notes also demonstrated that several attempts were initiated to remove the client from restraints but that in each instance, he became assaultive and threatening. The documentation also indicated that the client verbalized several times throughout his hospital stay that he preferred to be in restraints. However, as noted in the DPH investigation and a DDS Medical Desk Review, hospital documentation also indicated that on the evening prior to his being discharged, a physician who attempted a physical examination of the client wrote a note indicating that the client had kidney stones and may have also had a urinary tract infection. Although a urine culture was ordered, there is no record of it ever being received.

Hospital #1 was aware that there were risks associated with the client's remaining immobile for a long period of time. One of the hospital's own MD pulmonologists, stated when interviewed by OPA investigators that immobility such like the client experienced while in hospital restraints is one of the main risk factors for developing deep vein thrombosis (DVT). The MD pulmonologist further stated that pulmonary embolism (which the OCME listed as the client's cause of death) is a manifestation of someone's having deep vein thrombosis. The client's medical records indicated that the hospital did perform a risk assessment for venous thromboembolism (VTE), at which time the client's risk for developing deep vein thrombosis was determined to be low. However, the risk factor of immobility due to being restrained, which the MD pulmonologist spoke about, did not appear to have been properly considered as part of the VTE evaluation. Instead, the documentation merely had a check mark placed next to the "Low" risk category. That category stated as a matter of document form, "Ambulatory patients without risk factors or expected LOS (length of stay) (less than) 2 days: Recommend early ambulation." This same form document contained a check box option for introducing prophylaxis medication to help prevent the development of venous thrombosis.

However, none of the medications were checked off as being warranted for the client even though by that time he had been substantially immobile for over four days by virtue of his having been in hospital restraints for that entire

time period. Instead of properly identifying the client to be at risk of developing VTE, the document incorrectly evaluated that he should receive no prophylaxis medication due to his being a low risk category for developing thrombosis. Importantly, the VTE document also did not anywhere indicate whether the client received a physical assessment as part of the evaluation even though the form itself appeared to have a designated space for recording such assessment notations. There was no evidence that the client received any other VTE evaluation while at hospital #1.

When interviewed, the two EMTs who transported the client from hospital #1 to hospital #2 on Friday, stated that the client was observed by them to have redness and swelling in his right leg at the time he was placed onto the ambulance at hospital #1. However, as the client had been given medical clearance to leave the hospital, the EMTs did not question the appropriateness of the transport at that time. Hospital #2 records documented that the client arrived at hospital #2 at approximately 9:30 am, whereupon he was released from the restraints. The client stood and had just begun to walk when he suddenly stooped over and required assistance into a wheelchair. The client then slumped out of the wheelchair and a full code was initiated. The client was taken to Hospital #3 where he arrived intubated, pulseless and receiving ambu-bag respirations. He was pronounced dead at 10:05 am.

Neglect was substantiated against hospital #1, which knew or should have known the risks associated with a patient remaining substantially immobile for a five-day period. The client was not considered at risk for developing VTE and deemed to be not a candidate for prophylaxis medication even though he did present with having at least one risk factor for VTE, which was his being immobile due to his having been put into restraints by the hospital itself for an extended period of time. Additionally, the hospital delayed appropriate treatment for the client by not having a psychiatrist evaluate him until his third day in hospital restraints, after he was transferred to the hospital's inpatient psychiatric unit. Hospital #1 further delayed appropriate treatment by not considering the client to be appropriate for admission to its own specialized inpatient psychiatric unit until after an outside hospital bed at hospital #2 had been secured. Hospital #1 also failed to initiate follow-up procedures to address the client's possible urinary tract infection. Additionally, as stated above, the Department of Public Health found several violations on the part of hospital #1 in association with the care and treatment of the client.

Since the client's death, hospital #1 has revised its policy regarding patient restraints and VTE assessments as part of a plan of correction in response to the DPH investigation. The hospital also entered into a Consent Agreement with the Department of Public Health, which called for the hospital to pay a fine and consider least restrictive measures when considering restraints.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the DDS canvas licensed providers to determine the prevalence of difficulty that may exist in securing appropriate psychiatric services for DDS clients with acute behavioral issues.
2. That the DDS also determine whether there are specific facilities in which securing appropriate psychiatric services for clients appears to be a reoccurring problem. Upon identifying such facilities, the Department should initiate advocacy and education strategies to assist that psychiatric facility in better meeting the needs of individuals with developmental disabilities.

69. Age: 71. **Residence:** Private CLA. (**OPA/AID intake:** 4/1/2010).

Nature of Allegation: Reportedly, the client was being prepped for a colonoscopy at her CLA when at about 7:30 pm, she began to vomit profusely. Two direct care staff were working at the group home at the time of the incident noticed the client to be in a distressed state and called 911. The client was taken to the hospital and placed on life support, but she died three days later. It was reported that there appeared to be no evidence that the direct care staff initiated CPR when they noticed the client to be vomiting and unresponsive. There also appeared to be unexplained discrepancies between the time that the direct care staff observed the client to be unresponsive and/or vomiting significantly and the time that 911 was contacted. This discrepancy appeared to represent a 15 to 30 minute delay in calling for help. There appeared to be a question as to whether the colonoscopy prep that the client was receiving was properly administered and whether she inappropriately consumed Jell-O or broth along with preparation mixture. There was also a question as to whether the residential support agency provided appropriate medical supervision to ensure that the client received the level of assistance that an elderly person who uses a wheelchair required when preparing for a colonoscopy.

Finding: OPA conducted an investigation and substantiated neglect on the part of two direct support staff and the residential provider agency. Neither of the two direct care staff workers provided the client with CPR when she was observed to be vomiting and unresponsive. Also, the provider agency did not ensure appropriate medical oversight for the client during a five-day intensive colonoscopy preparation.

When interviewed, both staff acknowledged that upon observing the client to be unresponsive, neither administered CPR nor attempted to lift or slide the client from her wheelchair to the ground in order to administer CPR. Both staff concurred that staff #1 administered back blows to the client while she was seated in her wheelchair. 911 was dialed at 7:55 pm and emergency responders arrived at the CLA at 8:01 pm, whereupon they observed the client to be unresponsive and pulseless. CPR was administered by the EMTs and the client was transported to the hospital, where she was placed on a ventilator. It was believed that the client had experienced a severe anoxic brain injury as a result of respiratory failure. The client died three days later. An autopsy was completed by the Office of the Chief Medical Examiner which listed the cause of death as, "Cerebral Hypoxia; Due to: Cardiac Arrhythmia; Due to Concentric Coronary Atherosclerotic Disease."

The CLA staff appeared to have administered the client's colonoscopy preparation according to the instructions recorded in the CLA Kardex. The CLA LPN, Nurse's Note stated that these same instructions were, "reviewed with MD and call placed to (the doctor) for additional confirmation." However, the instructions recorded in the Kardex by the LPN, omitted a portion of instructions, which stated, "during and after the period of taking preparation drink, please be active. This will assist in producing multiple bowel movements. Please attempt a bowel movement after 3-4 glasses of preparation." CLA staff did not note any bowel movements between the hours of 5:00 pm and 7:45 pm and staff #1 stated that the client did not use the bathroom during her colonoscopy preparation. Neither staff attempted to assist the client with getting to the bathroom after her third or fourth glass of preparation.

The client's colonoscopy preparation was especially significant not only due to her being someone with a developmental disability who used a wheelchair, but also because her gastroenterologist had ordered a five-day preparation procedure instead of the normal one day preparation. The client was seen by the gastroenterologist due to her having difficulties during the previous few weeks of passing blood clots. The client was known to have a diagnosis of hyponatremia (abnormally low blood sodium levels). She had also undergone a previous colonoscopy where the preparation was determined to have been insufficient. During the course of the investigation, OPA learned that when a 5-day colonoscopy preparation is initiated, greater medical oversight and monitoring should be

provided. Such oversight should have included monitoring the client's fluids, checking her electrolytes, potassium and magnesium levels, etc. According to the CLA LPN, extra staff were scheduled to work the day of the incident. However, there was no evidence to indicate that any plan was ever put in place for the client to receive enhanced monitoring and oversight during her preparation.

Agency records indicated that staff #1 completed the American Red Cross CPR–Adult and Child Certification in September 2009 and that staff #2 completed the this training in June 2009. The CPR training materials provided by the provider agency included a section titled, “CPR and Unconscious Choking. Agency training records indicated that staff #2 (3/19/09) and staff #1 (12/01/09) received training on how to conduct a 2-Person Lift that was specific to the client’s needs. Yet, when the client began to vomit on the evening of 01/24/10 and then turned blue and became unresponsive, neither staff initiated CPR, nor lifted the client out of her wheel chair.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency ensure involved staff repeat CPR training.
2. That the DDS ensure a medical advisory regarding five day colonoscopy preparations and the need for close monitoring is made known to all residential providers.

70. Age: 48. **Residence:** Private CLA. (**OPA/AID intake:** 6/10/2010).

Nature of Allegation: Reportedly, the CLA RN evaluated the client sometime during second shift and found swelling to her right leg and left foot. Allegedly the symptoms which the RN observed were indicative of a blood clot and should have resulted in the client being sent to a hospital Emergency Room. Instead, the client remained at the CLA and no further treatment or evaluation was provided to her that evening. At approximately 5:30 am the next morning, the client became weak. CLA staff lowered her to the floor and called 911. The client died a short time later. The family declined an autopsy.

Finding: OPA determined that insufficient evidence existed to support an allegation of medical neglect on part of the CLA RN. Although the client’s death was untimely, it appeared that the care she received during the evening prior to her death was appropriate. Records indicated that the nurse observed that the client had some bilateral edema. (If the edema had been unilateral there would be more basis for concern about a possible clot.) The client was assessed by a RN on the evening of the incident and was scheduled to see her physician on the following day.

Status: Closed AID – No substantiation.

Recommendations: None.

71. Age: 76. **Residence:** Private CLA; Site of Alleged Neglect: Hospital. (**OPA/AID intake:** 07/19/2010).

Nature of Allegation: Reportedly, the client was admitted to the hospital for treatment of cellulitis with MRSA. While in the hospital he developed aspiration pneumonia, severe sepsis, hypotension and respiratory failure. He was admitted to the ICU, intubated and placed on mechanical ventilation. The client had underlying cardiac conditions (CHF, atrial septal defect and mitral valve insufficiencies) and Alzheimer's dementia. He met the DDS criteria for a DNR Order, which was implemented. Allegedly, the client was provided the wrong food consistency during the hospitalization which preceded his death and there was concern that this improper food consistency may have contributed to the client developing the aspiration pneumonia which led to his eventual death.

Finding: An investigation completed by DPH and monitored by OPA did not find sufficient evidence to issue a citation concerning the food consistency provided to the client while in the hospital. However the investigation did find the hospital in violation because, "the hospital failed to ensure that a positive radiological result (aspiration pneumonia) was addressed by a physician in a timely manner and or failed to ensure that a comprehensive assessment was completed by a physician following confirmation of aspiration pneumonia." Based upon the violation identified in the DPH investigation report, OPA determined that sufficient evidence existed to substantiate neglect on the part of the hospital for failing to ensure that the client received timely treatment following his having X-rays which identified him as being positive for pneumonia.

Status: Closed monitor – Neglect substantiated.

Recommendations: None.

72. Age: 76. **Residence:** Private CLA; Locations of Alleged Neglect: CLA & Hospital. (**OPA/AID intake:** 9/15/2010).

Nature of Allegation: The client died after experiencing a fall in her CLA and fracturing her right hip. Reportedly, there were questions as to whether the client's injurious fall could have been prevented. Also, there were concerns regarding the post-operative nursing care given to the client at the hospital, in that the hospital did not follow physician orders to provide critical monitoring, and thereby put her at risk for serious complications.

Finding: OPA conducted an investigation and determined that there was insufficient evidence to substantiate neglect on the part of the residential provider agency in association with the falls the client experienced in 2010, the last of which occurred at 11:30 pm and resulted in her sustaining a fractured right hip, a condition from which she proceeded to decline rapidly until she died. The client was supplied with a walker and was consistently counseled by staff to use it while ambulating. The client also had a bell next to her bed which she was instructed to use if she had to get up at night and did not want to use her walker. The client had an accessible bathroom attached to her bedroom and close to her bed. CLA staff completed one hour checks during the night. Documentation and interviews indicated that staff at the group home responded immediately and appropriately when she called for help after she fell. A residential report generated in contemplation of the client's annual meeting mentioned her falling two times. Nevertheless, it was determined by the Team that OT and PT services were not warranted.

However, based on the findings of a Department of Health (DPH) investigation, OPA substantiated neglect with regard to the hospital's failure to ensure appropriate pain management measures occurred in connection with the client's hospitalization following the fall in which she fractured her hip. The DPH investigation included an action plan and three month review to address the hospital's pain management procedures. The DPH investigation report did not mention any evidence of poor post-operative critical care monitoring, as suspected and reported to this office.

Status: Closed AID – Neglect substantiated.

Recommendations:

That the DDS ensure risk of fall assessments are conducted as part of an individual's annual assessment whenever the individual is elderly uses a walker and has experienced multiple falls since the last annual assessment.

73. Age: 50. **Residence:** Private CLA. (**OPA/AID intake:** 11/29/2010).

Nature of Allegation: The client died following a choking incident which occurred at his day program. Reportedly, client had had an earlier choking incident which occurred at his CLA a month earlier. It was alleged that

the residential provider initiated food consistency guidelines as a result of the first incident but that the day program was never informed about the first incident nor were they informed about the changes client's food consistency requirements.

Finding: OPA conducted an investigation and substantiated neglect on the part of the client's residential provider, the CLA RN and a residential manager. Upon investigation, the evidence indicated that the residential provider failed to notify the client's vocational program of a choking incident that took place at the CLA. The residential provider also failed to notify the vocational program of a physician's order to cut the client's food into small pieces. The residential provider agency also failed to notify the client's vocational program regarding dining/eating guidelines created by a residential manager in response to the physician's recommendation's and about specific directives given by the CLA RN to increase supervision and monitoring of the client while eating. The provider agency also did not undertake to hold or initiate an IDT review (which would have included a representative from the vocational program) following the client's choking incident and his subsequent evaluation by his physician. The investigation also found that the CLA's RN did not consider the physician's recommendation for cutting food into small pieces did not amount to a doctor's "order" even though it was written on a doctor's order form and even though the CLA had developed eating guidelines in response to the incident which were consistent with this order. All such physician's orders relating to eating guidelines should be communicated to appropriate caretakers, such as vocational programs.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency managers and supervisors are trained to notify vocational programs anytime there is a significant medical incident or change in a client's condition.
2. That the provider agency conducts emergency IDTs anytime a client experiences a choking incident.
3. That the DDS ensure all choking incidents are reviewed by nursing with the client's primary care physician and that follow-up with specialist occurs if deemed necessary.
4. That the day program staff receive updated CPR certification.

74. Age: 56. **Residence:** CLA (**OPA/AID intake:** 12/22/2010).

Nature of Allegation: The cause of the client's death was listed as a brain stem bleed. Reportedly, while in her CLA the client experienced a sudden change in behavior which included screaming. The client was taken to the hospital at 10:27 pm where it was determined that she was experiencing a brain hemorrhage. It was not known at the time whether the brain hemorrhage that the client experienced was trauma-related.

Finding: OPA conducted an investigation which determined there existed insufficient evidence to substantiate abuse or neglect in connection with the death of the client. The cause of the client's death, which occurred on 8/3/10, was determined to be an Intracranial Hemorrhage. A review of the record strongly suggested that the hemorrhage she suffered was associated with a pre-existing medical condition (cerebral amyloid angiopathy -CCA) which predisposed her to having such an event. However, the record also showed that the client was at increased risk of injury from falling and had in fact fallen on six recent previous occasions. Injuries to various body parts resulted from each of these falls with three of these resulting in injury to her head area.

Subsequent to one of these falls, the client was hospitalized and diagnosed with an intracranial bleed. She was also diagnosed with CCA at that time. The record did not establish that the bleed resulted from trauma related to the fall.

She was discharged with service recommendations to lower her risk for future falls (PT, increased supervision, bed alarm, custom wheelchair for outings). The record also indicated that the residential provider did provide the client with these additional supports subsequent to the hospitalization, although enhanced staffing was discontinued in February of 2010.

The intracranial hemorrhage that caused the client's death was not suspected to have resulted from head trauma related to a fall.

Status: Closed AID – No substantiation.

Recommendations: None.

75. Age: 76. **Residence:** Private CLA. (**OPA/AID intake:** 4/8/2011).

Nature of Allegation: The client was a 76-year-old gentleman who resided in a CLA and died due to his experiencing an Acute Myocardial Infarction. Reportedly, at about 7:30 am on that morning, the client was noted by direct support staff (staff worker #1) to be moaning and complaining of pain on his left side. The client was also noted to be yelling, "help me" from 8:15 to 9:00 am. The client was given one Acetaminophen 325 mg tab for pain at 8:00 am. Direct care staff did not call the RN but instead a call was placed to the program manager who then stopped by and visited the client. The client also stated to the program manager that his left side hurt. The client was helped to the bathroom and given root beer to drink. The manager's note stated that the client felt better after having a bowel movement.

Staff worker #2 noted that the client refused to eat breakfast and tossed soda across his room at 10:00 am. The client also refused to eat his lunch. He received Acetaminophen 650 mg at noon and went back to bed at 1:00 pm. At 2:00 pm, the client indicated that he felt better, and had two large bowel movements. At 3:15 pm, the client, "began kicking the foot of his bed and ripping off his side-rail pads," stating that his head hurt. At 4:45 pm he was still complaining that his head hurt.

At 5:24 pm the agency RN was called and informed that the client was complaining of a headache and that he felt "ice cold" with a low temperature of 95.2 degrees. The RN instructed that 911 be called. The client was taken to the hospital where it was determined that he was experiencing left-sided chest pain measured as a 10 on a scale of 10. The client received cardiopulmonary resuscitation and an EKG indicated evidence of an acute anterior wall injury. The client continued to decline and was pronounced dead at 7:37 pm.

Finding: OPA conducted an investigation and substantiated neglect in connection with the client's death. Neglect was substantiated against the provider agency and also substantiated against four agency employees, including the program manager. The evidence indicated that on Thanksgiving Day, the client complained of left-sided pain. His complaint of pain continued throughout the day. When interviewed, several CLA staff represented that they had interpreted the client's symptoms as behavioral rather than medical in nature. They stated that the client had frequent episodes of agitation and that on the day of his death, he demonstrated the kinds of behaviors and/or complaints that were for him not considered to be extraordinary. Nevertheless, the client also experienced a change in his vital signs and a decreased appetite. Despite the client's medical complaints and change in condition, and despite DDS protocols that call for doing so, staff did not report his symptoms to the on call nurse until 5:24 pm, almost 10 hours from the time his symptoms first appeared. By that time, the client's condition had significantly declined, requiring activation of EMS and immediate medical attention in the hospital Emergency Department (ED).

In the ED it was determined that the client had experienced an acute myocardial infarction. While in the ED the client went into cardiac arrest twice. CPR and ACLS measures were initiated with both cardiac arrests. However, due to the extensive damage to his heart from the myocardial infarction and his grim prognosis, resuscitative measures were deemed futile. The client was pronounced dead at 7:37 pm. His immediate cause of death (per Death Certificate) was Acute Myocardial Infarction and Sepsis. Profound Anemia was also listed as a contributing condition.

The OPA investigation was unable to determine with certainty whether the failure by CLA staff to follow agency protocol for contacting the on call nurse, or whether the subsequent 10 hour delay in seeking medical treatment directly caused the death of the client. However, research indicated that a delay in seeking treatment for a heart attack or stroke can be a major factor in survival rates and “a shorter interval between symptom onset and treatment is associated with better cardiac function.” (Circulation, 2006). It was noted that the client appeared to demonstrate a slow onset of symptoms of a myocardial infarction. There was an on call system in place to report any medical concerns to qualified nurses, but it was not utilized for the client until almost 10 hours had passed after his first symptoms presented themselves. When staff finally did contact the nurse and report his symptoms, they were directed by the nurse to immediately activate EMS. The failure of at least four staff members to follow agency protocols for ensuring the resident's ongoing health and safety and the fact that these staff were operating at various levels of organizational responsibility up to and including the CLA Manager, warranted a finding of substantiated neglect against the agency as well as the individuals involved.

Status: Closed AID –Neglect substantiated.

Recommendations:

1. That the provider agency ensure CLA staff, including management staff, are trained in the RN on call system, including the types of medical and/or other types of complaints that are to be reported to nursing, the responsibilities of both the CLA staff and the Nurse on call, as well as appropriate communication and documentation procedures. Refer to DDS Procedure No: I.E. PR.008, RN On Call System. This training should also clarify for staff that only a licensed RN is qualified to assess a client who may be experiencing a medical problem.
2. The CLA staff reported that there was a policy in place at the time of the client's death that allowed the medication certified CLA staff to administer PRN medications to clients without first notifying the nurse. The CLA staff reported that this policy changed soon after the client's death and that the new policy directs the medication certified staff to notify the nurse before administering any PRN medication. The provider agency should ensure that the CLA staff continue to utilize this new policy.
3. That the provider agency ensure CLA staff follow the clients' Health Safety Plans and Physician Orders even when they may have reason to interpret symptoms as being behavioral in nature, particularly in instances when the individuals have multiple health and or medical issues.
4. That the provider agency ensure all nursing documentation is complete and timely. The CLA nursing staff should follow the guidelines of the DDS Nursing Standard 96.3 Nursing Documentation. It was noted during the investigation that nursing documentation for the CLA was lacking and incomplete. For the almost 8 months that the client resided at the CLA, there was little nursing documentation. Quarterly reviews were conducted, however monthly health reviews were only conducted for 2 of the 8 months. There was only one nursing narrative note in the record. There were no ongoing nursing notes reflecting the client's current health status. Also, communication between the client's primary care physician and the CLA nurse appeared to be in email form. There were several

email entries, most of these emails were between the physician and an LPN. However, there were no coinciding nursing notes or other nursing documentation regarding the client's symptoms, orders received, actions taken, or response to treatment. There was also a lack of documentation to demonstrate RN oversight.

76. Age: 63. **Residence:** Private CLA. (**OPA/AID intake:** 10/21/2011).

Nature of Allegation: The cause of death listed on the client's death certificate was myocardial infarction. Reportedly, at about 10:40 pm an ambulance was dispatched to the CLA after staff found her in her room unresponsive. However, it was noted that there appeared to be a discrepancy regarding the time that CLA direct care staff reported last observing the client to be alive and alert (10:00 pm) and what the first responders recorded the CLA staff as representing in the run sheet ("last seen 2 hours prior").

Finding: OPA conducted an investigation and substantiated neglect against the two direct care staff who were working with the client at the CLA on the evening of the incident. The client was supposed to be checked by CLA staff every fifteen minutes when sleeping due to her having a history of falling out of bed. The client also had an Asleep/Awake chart ("Sleep Pattern" form) which required one assigned staff to mark whether she was sleeping or awake at half hour intervals. On the evening of the incident, a 911 call was placed by the CLA at about 10:38 pm, after the client was observed by both staff to be unresponsive. No other staff were working at the residence at this time. Documentation generated by both workers on that evening represented that the client was asleep earlier early in the evening but awake at 10:00 pm when she was checked on by staff. Then, at about 10:35 pm, she was observed to be unresponsive by staff worker #1, who called staff worker #2 into the client's bedroom.

However, the CLA documentation was at variance with the documentation and interview statements of the 911 first responders to the CLA, all of which indicated that the client's body had evidence of rigor mortis and lividity when emergency services arrived, indicating the client had been dead for quite some time prior to their arrival. Paramedics stated that when they arrived, the group home staff was performing CPR on the client. However their assessment identified that rigor mortis had already set in to the client's jaw. Because of this, they were unable to establish an airway or intubate the client.

The evidence found by OPA indicated that between the time the client went to bed and the time EMS was called (10:38 pm), she was not properly monitored by either staff worker on duty that night. Although the client was supposed to be monitored every 15 minutes while in bed, it remains unclear what time she was last seen alive. Interview statements given by the two staff on duty regarding the timeline of events which occurred on the evening of the incident were inconsistent, conflicting and ever evolving. Documentation generated by both staff on that evening was purposefully falsely recorded. Neither staff ever undertook to correct the record even during this investigation unless or until they were confronted with evidence which demonstrated the false nature of their previous representations. It was also not clear from the evidence which staff person was in fact assigned to monitor the client. Both staff stated when interviewed that staff worker #1 was assigned this responsibility. However, the client's Asleep/Awake chart indicates on its face that staff worker #2 represented that she checked on her that evening and observed her to be awake at 10:00 pm. Two experienced paramedics reported that, upon their arrival, the client's body already had the presence of post-mortem changes, indicating that the time of death was much earlier in the evening.

The investigation was unable to determine whether the failure of the two CLA staff to appropriately monitor the client led directly to the death. However, had the 15 minute health and safety checks been performed correctly by either staff worker, they might have noted the client showing physical signs and symptoms of an acute cardiac event and promptly alerted EMS prior to her cardiac arrest. The failure by staff to appropriately monitor the client may

have operated to lessen her chances for surviving the myocardial infarction she experienced. Neglect was substantiated.

Status: Closed AID – Neglect substantiated.

Recommendations:

1. That the provider agency initiate disciplinary action and/or retraining of staff, as deemed appropriate.
 2. That the provider agency ensure the CLA is appropriately staffed at all times. The staff interviewed in this investigation stated that on some evenings there were 3 staff assigned, however, on the night of the client's death, only 2 staff were assigned.
 3. That the provider agency ensure CLA staff is appropriately trained in the policy of 15 minute checks for health and safety. This training should specifically include what health and safety measures the staff should be monitoring as part of such checks.
 4. That the provider agency ensure CLA staff documentation is complete and timely. The CLA provided OPA with documentation to indicate that an in-service on proper documentation was completed during a staff meeting on 11/8/10. This in-service included: proper documentation, complete documentation, proper timing of documentation in relationship to end of shift, proper signature on documentation, and the proper way to document addendums, late entries, and errors. An annual review and/or in-service of proper documentation for staff would also be effective.
 5. The client was taking Avandia daily for Type 2 Diabetes Mellitus. Her records indicated she had been taking this medication for almost 8 years (11/12/02-8/26/10). On September 23, 2010 (approximately one month after her untimely death), the U.S. Food and Drug Administration (FDA) issued the following safety alert: "FDA notified healthcare professionals and patients that it will significantly restrict the use of the diabetes drug Avandia (rosiglitazone) to patients with Type 2 diabetes who cannot control their diabetes on other medications. These new restrictions are in response to data that suggest an elevated risk of cardiovascular events, such as heart attack or stroke, in patients treated with Avandia."
- (<http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm226994.htm>). The client's physician completed a Med Watch Reporting form for Avandia and sent it to the FDA on 4/11/11, at the request of the IMRB. Med Watch is the voluntary FDA Safety Information and Adverse Event Reporting Program. The DDS should ensure clients taking the medication Avandia, are appropriately monitored by their health care providers per the FDA guidelines for Avandia.

Deaths of DDS Clients Referred to DPH for Investigation of Actions of Facilities or Practitioners

1) **Age:** 59 **Residence:** Private CLA (**Referral Date:** 7/1/04)

A review completed by DDS determined that the client's death was sudden and untimely due to a sigmoid volvulus, which resulted in sepsis and multi-system organ failure. When the client first presented with symptoms of a possible intestinal blockage, she was taken to the ED by group home staff. Following an evaluation and CT scan in the ED, which were positive for a urinary tract infection and colonic distention, the client was discharged home with antibiotics and soaps suds enema instructions for abdominal distention. The client remained without a fever, but enemas brought no relief, and abdominal distention increased. The client only drank liquids at home, but two days later, began to vomit. The group home nurse contacted the client's primary care physician and informed him of the client's continuing symptoms, asking if he wanted to see the client. He said no, and to begin the client on a laxative. The following day, the nurse went to the group home and after assessing the client, whose condition had not improved and was now vomiting, called an ambulance to transport the client to the hospital. DDS, after review of this case, referred it to DPH due to a possible failure of the hospital ED physician and primary care physician to properly identify and treat the client's illness.

DPH cited a violation against the hospital as there was documentation lacking, which identified what time the nursing assessment was conducted and/or that the client's pain was addressed, and/or that additional pain assessments were conducted over an approximate 7-hour period prior to the client's discharge from the ED. The cases against the hospital practitioners in this case were dismissed.

2) **Age:** 43 **Residence:** Public CLA (**Referral Date:** 7/26/04)

A review completed by DDS found reasonable cause to suspect that the client had been neglected. There was a physician's order in place for a straight catheter to be used to obtain a urine culture. There was not a physician's order for a Foley catheter to be used for the same purpose. The group home RN inserted a Foley catheter, with balloon, which was left in place for several hours and taped in place to a sterile, closed specimen container. The client sustained a traumatic urethral injury from the Foley catheter insertion. The client died of sepsis as a consequence of urethral injury during bladder catheterization. The group home RN was referred to DPH, as an unapproved technique had been utilized to catheterize the client.

DPH pursued the case against the RN and the respondent signed a Consent Order, which provided for re-education and quarterly employer reports; however, the Board of Examiners for Nursing denied the Consent Order and ultimately dismissed the case.

3) **Age:** 58 **Residence:** Nursing Home (**Referral Date:** 8/13/04)

A review completed by DDS found reason to suspect that the care provided to the client at the nursing home and by his treating physician was not appropriate, as there were delays in treatment when the client was first diagnosed with osteomyelitis.

DPH made a determination not to accept this case for investigation, as there were too many variables associated with the client's care to single out one practitioner.

4) **Age:** 57 **Residence:** Private CLA (**Referral Date:** 9/30/04)

A review completed by DDS surfaced concerns regarding the nursing oversight the client received prior to her death. There was no documented nursing assessment regarding the client's status in the weeks prior to her death in response to group home staffs' concerns. DDS reported that when the client was finally taken to see a physician, the "reason for visit" was determined by a group home staff member. The DDS review was unable to determine how much information was provided to the physician regarding the client's condition. For example, it was not possible to know whether the physician was told that the client had been vomiting off and on for weeks and had lost weight. The group home staff informed the client's DDS Case Manager that there were no bowel records kept on the client in the group home unless specifically ordered by a physician. Therefore, it was unknown when this particular client had last had a bowel movement. The client's death was determined to be due to aspiration pneumonia, most likely secondary to gastroparesis. It was noted that client was experiencing symptoms of a small bowel obstruction, and that there were no documented nursing assessments done regarding the client's status in the weeks prior to her death in response to the staffs' concerns. A referral was made to the DPH Practitioner Unit for review of the nurse's actions.

DPH made a determination not to accept this case for investigation as there were too many issues associated with the overall nursing services delivery system to single out one practitioner.

5) **Age:** 44 **Residence:** CTH (**Referral Date:** 2/1/05)

A review completed by DDS noted that the client was hospitalized for pneumonia, and that upon discharge, was noted to have a Stage II decubitus ulcer. The client's residential provider reported the hospital to DPH due to the fact that the client had had no skin breakdown prior to his hospital admission.

DPH cited the hospital for failing to implement preventive skin protocols.

6) **Age:** 52 **Residence:** Private CLA (**Referral Date:** 3/8/05)

A review was completed by DDS, which noted that the client had a diagnosis which may have precipitated his having an unusual reaction to standard dosages of medications and anesthetic agents. The client had an elective colonoscopy and endoscopy at the hospital. During the endoscopy, the client's blood pressure dropped. The client was given vaso-constriction and pressor drugs and was discharged back to his group home that same day. Group home staff were not comfortable with the client's condition and the client was subsequently sent back to the hospital and admitted to the ICU with a diagnosis of hypothermia and septic shock. DDS questioned if the physician and anesthesiologist were aware of the client's diagnosis. DDS also questioned whether the necessary precautions had been taken when administering anesthetic medications and performing the procedures. The case was referred to DPH for review by DDS/IMRB.

DPH cited the hospital for failing to appropriately assess and/or evaluate the client for hypothermia while in the outpatient department prior to, during, or after the procedure, or prior to discharge from the department; for failing to ensure that the medical record for the client was accurate and/or complete; and for failing to provide appropriate communication between outpatient staff and the group home staff prior to the client's discharge. The physician in this case was issued an advisory letter, which pointed out where he/she might have failed to provide adequate care.

7) **Age:** 78 **Residence:** Nursing Home (**Referral Date:** 11/7/05)

The FRB reviewed this case and questioned whether the nursing home properly monitored or responded to abnormal levels of the client's seizure medication, which may have caused her to fall and break her hip, an event which led to

the client's hospitalization and ultimate death. The FRB referred the nursing home in this case to DPH for investigation, as the client had a seizure disorder that required medication dosage adjustments, and was prone to developing Dilantin toxicity, which made her prone to falls. The client was admitted to the nursing home for short-term rehabilitation following a fall in her apartment. Her placement occurred three months after DPH had placed the facility on probation. While at the nursing home, the client fell and fractured her hip. She subsequently died following a complicated post-operative course.

DPH cited the facility for failing to provide a care plan and supervision to a resident with observed unsafe behaviors and a history of falls prior to admission. There were also a number of documentation inconsistencies identified throughout the facility investigation.

8) Age: 74 Residence: Private CLA (Referral Date: 5/22/06)

DDS completed a review and referred this case to DPH because there were numerous discrepancies in the hospital medical records regarding the client's feeding apparatus (g-tube versus j-tube); there was no mention in the records of the client's previous history of aspiration pneumonia when the client had a j-tube; and no explanation of why a change was made to a g-tube from a j-tube. In addition, the DDS review surfaced significant concerns regarding the lack of a timely diagnosis and medical intervention for documented symptoms of an acute medical condition requiring emergent treatment when the client was first seen in the ED.

DPH cited the hospital for failing to ensure that a comprehensive assessment of the client's symptoms was completed when the client was seen in the ED.

9) Age: 84 Residence: Private CLA (Referral Date: 6/16/06)

A review completed by DDS noted that the client was hospitalized for an acute myocardial infarction, and an angioplasty was performed for one of two blocked arteries. The procedure for removing the blockage in the second artery was unsuccessful. The client had a history of atrial fibrillation and a pacemaker. The client was diagnosed with irreversible cardiac and respiratory failure stemming from the acute myocardial infarction. The DDS review noted that the client had recently been seen at the hospital for a routine pacemaker check. The cardiology note stated that the client had been feeling somewhat fatigued over the past 24 hours, and had vomited once that same morning. Upon walking into the device clinic at the hospital, the client tripped on a rug and fell. The client was asked if she was experiencing any chest pain, and the client said no, as well as no other symptoms. She was then taken to the same hospital's ED, where x-rays were negative for an elbow fracture. However, the hospital's cardiac service noted that the EKG showed some evidence of a cardiac abnormality indicating a "possible acute inferior wall myocardial infarction." The client was sent back to her CLA from the ED. The client's discharge instructions only made reference to the cut on the client's elbow. There was no evidence that the client had been evaluated by the cardiology team and ED staff for acute EKG changes. The CLA staff had no knowledge that the EKG completed that same day was abnormal. The client began experiencing nausea and vomiting at home following his/her discharge. He/she was also dizzy, pale and clammy, per the CLA staff notes. 911 was called and the client was transported back to the hospital, where EKG changes were consistent with an acute myocardial infarction. The client died six days later. DDS had concerns regarding the lack of coordination of care at the hospital and a resulting possible delay in treatment, and referred this case to DPH for review.

DPH issued a Consent Order against the hospital physician for deviating from the standard of care by misreading an EKG that showed changes of an acute myocardial infarction. The facility was not cited.

10) Age: 36 Residence: Family Home (Referral Date: 9/29/06)

DDS contacted the FRB to report that the client's DDS Case Manager had raised concerns regarding the client's physical condition prior to her being hospitalized some months prior to the client's death. According to the DDS Case Manager, there had been a protocol in place for years, which called for a home care agency primary care nurse to go to the client's home every week to check on the client's physical condition in an effort to prevent the development of bedsores, as the client had a history of chronic bedsores. If concerns arose during the home care agency primary care nurse's visits, the protocol in place called for him/her to contact the home care agency's wound care specialist for further follow-up. The DDS Case Manager reported that two months prior to the client's death, the client was admitted to the hospital with a bedsore, which exposed bone. The client required a partial hip removal due to the condition of the bedsore. Both the home care agency and the primary care nurse were referred to DPH for review and investigation.

DPH cited the home care agency and primary care nurse for failing to re-assess and measure the client's wounds on a weekly basis and/or to re-assess the progress of the wounds and the effectiveness of the treatment regimen, and/or to consistently update and coordinate the treatment regimen with the client's primary care physician, clinical wound consultant and primary caregiver. Although DPH gave consideration to referring the primary care nurse to the DPH Practitioner's Unit, a decision was made by DPH not to do this because the home care agency was the responsible party and ultimately, the agency itself needed to be held accountable.

11) Age: 25 Residence: Private CLA (Referral Date: 10/27/06)

A review completed by DDS noted that the client spent the last eight months of her life hospitalized in four different hospitals. She had seven different admissions back and forth between facilities as her condition improved and declined until her death from abdominal sepsis due to ileostomy perforation. The DDS review surfaced issues regarding the timeframe of events, which occurred at one hospital, such as the possible lack of coordination of care throughout the client's diagnostic work-up, possibly leading to lengthening the time before surgery was performed and the outcome of a gangrenous bowel and rectum. The DDS review also noted a significant delay prior to surgery being performed, which may have contributed to the client's morbidity, and recommended a referral to DPH.

DPH completed an investigation regarding the medical care provided to the client in the hospital ED and determined that there was a significant delay in bringing the client to the OR for surgical intervention; that the client was given pain medications which may have masked the acuity of her medical condition and the need for emergent treatment.

12) Age: 77 Residence: STS (Referral Date: 2/9/07)

DDS completed a review and found no reasonable cause to suspect abuse/neglect surrounding the circumstances of the client's death. However, when the FRB reviewed the client's medical records pertaining to her most recent hospital stay, the Board had concerns about the use of wrist restraints by the hospital; questions about how the client was able to get out of bed and her being found alone in a hospital hallway; and concerns about the client not being assessed properly after she was found alone in the hallway with a neck injury that was bleeding. In addition, while the client was determined to be at risk for falls, there were no fall prevention measures put into place by the hospital; and there was no incident report or review completed by the hospital after the client was discovered in the hallway. There was also no review surrounding the client's subsequent unexpected death the following day.

DPH contacted the FRB to report that because the incidents surrounding this case occurred some time ago, and DPH already had outstanding citations against the hospital, DPH made a decision to re-visit the hospital and investigate the

allegations cited by the FRB in this case, sample other records for care and services, and issue another violation letter to the hospital based upon their findings in this case.

13) Age: 49 Residence: Nursing Home (Referral Date: 2/16/07)

This case was reviewed by DDS and the FRB. It was noted that the client's diagnosis was unclear, and that there didn't seem to be a coordinated plan of care. It was also noted that there was no weight or nutrition monitoring and a cause was never identified for the client's behavioral issues and changes in level of functioning. It was also unclear if the physician, with whom the nursing should have had a collaborative relationship, was involved in the client's care. A decision was made to refer this case to DPH regarding coordination of care and treatment issues.

DPH cited the facility for failing to have the client evaluated by an endocrinologist, despite her having wide variations in serum sodium levels and electrolyte imbalances; for no documented evidence of physician collaboration with the APRN; for a poorly defined diagnosis of a medical condition; for not adequately evaluating changes in the client's health status/condition; and for not submitting documentation that the client's weight was monitored and her status evaluated by a dietician.

14) Age: 71 Residence: Nursing Home (Referral Date: 6/8/07)

According to the initial information provided to the FRB by DDS, the client was found unresponsive at the nursing home following a choking incident. The client's guardian was told by medical staff at the local hospital where the client had been transferred following the incident that the client's cause of death was due to the accumulation of food in both of the client's lungs. The FRB reviewed the client's medical records and interviewed staff at the nursing facility as part of its review. As a result of the FRB's review, a complaint was filed with DPH. FRB staff questioned whether the nursing home staff properly monitored the client during her evening meal. One nursing home staff member who was present at the time of the incident indicated to FRB staff that the client had been "force-fed." The staff member reported that the client did not want to eat that day, and as the client was reluctant to get up out of bed and come to the dining area for dinner.

The DPH findings in this case were "unsubstantiated – lack of evidence." Board members met with representatives from DPH to discuss the DPH findings and to gain a better understanding of their investigative process and the scope of their authority. According to DPH, the exhibits included in their investigation noted that the client had periods of lethargy, a history of being up at night and sleeping during the day. DPH identified no issues with the certified nurses' aide (CNA) who fed the client and indicated that DPH would not expect the nursing home to institute a monitoring program for this same CNA, even though this same CNA was completely unable to recall the incident when interviewed by investigators representing DPH, the FRB and State's Attorney's Office. Upon further inquiry by the FRB, DPH indicated that they could not flatly say that the client should not have been assessed for lethargy; however they could also not state that the client was experiencing a change in status prior to her being fed.

The FRB referred this case to the Chief State's Attorney's Office for investigation. As a result of their investigation, the State's Attorney determined that there was no criminal aspect to this case.

15) Age: 61 Residence: Private CLA (Referral Date: 7/2/07)

DDS completed a review and determined that the client's death was not sudden or untimely, as the client had been very ill and was hospitalized three times in the last three months of her life. However, the DDS review did find reasonable cause to believe that there may have been neglect in the client's medical care because she was kept on the anti-seizure drug, Depakote, in the presence of a diagnosis of pancreatitis. (Depakote has been found to be linked to

pancreatitis, which can quickly become a life threatening condition.) DDS/IMRB reviewed this case and a decision was made to refer to DPH regarding the medical care provided to the client during her last hospitalization. The FRB chose to monitor the results.

Although there were findings related to other complaints investigated by DPH with respect to the hospital during the same time period, there were no findings related to this particular complaint. Medical records reflected awareness of the risk associated with Depakote for someone evidencing signs of pancreatic problems, but the client's history of significant grand mal seizures, her known allergies to other anti-seizure medications, and her responsiveness to Depakote resulted in a well documented, informed medical judgment to continue to use the Depakote.

16) Age: 73 Residence: Nursing Home (Referral Date: (9/28/07)

The client died of cancer of the thoracic cavity. He had surgery, but it was noted that he did not cooperate with radiation therapy. The FRB reviewed the client's DDS records as well as his records from the nursing home. This review surfaced a number of concerns regarding the care and treatment provided to the client at the nursing home, including evidence that he experienced considerable unnecessary discomfort during the final weeks of his life. The FRB agreed to refer this case to DPH.

DPH cited the facility for failing to promptly implement the oncologist's recommendation for a soft diet; for failing to provide evidence that comprehensive pain assessments were completed and/or that assessments were completed following pain medication intervention; for failing to administer alternative treatments related to pain management, such as ice packs, etc.; for failing to promptly follow-up on a APRN recommendation for a Hospice evaluation, even though the client had a terminal illness and continued to cry out due to pain.

17) Age: 27 Residence: Independent Living (Referral Date: (3/7/08)

When the client failed to arrive at work one morning, DDS staff went to his apartment and found him facedown in his bed, unresponsive without pulse or respirations. The client had recent hospitalizations for shunt revision. This case was reviewed by DDS. It was noted that a few months prior to the client's death, he had presented to the ED with complaints of a headache for one day and nausea, requesting that his "head shunt be checked to make sure it was alright." The client had a head CT scan that was interpreted as inconclusive, and was discharged home with instructions to follow-up with neurosurgery. A subsequent review of the radiology results identified that the client had moderate hydrocephalus, a condition that could evidence a shunt malfunction. DDS referred this case to DPH, due to concerns about the treatment the client received at the ED some months prior to his death.

DPH cited the facility for failing to ensure that a timely referral was made for a neurology consult by the ED.

18) Age: 64 Residence: Nursing Home (Referral Date: (8/28/08)

DDS reviewed this case and found reasonable cause to suspect that the client may have been neglected while a resident of the nursing home because her medical and nursing care did not include proper monitoring, reporting and treating of the client's hyperglycemia; and referred this case to DPH.

DPH cited the facility for failing to follow standards of practice with regard to the monitoring of the client's blood sugar levels.

19) Age: 86 Residence: Nursing Home (Referral Date: (10/31/08))

This case was reviewed by DDS. The client's records noted a notation from urology surgery, which was copied to the physician at the SNF which stated, "I got a STAT alert call from the Radiology Department about the kidney, ureter, bladder x-ray or CT scan showing a potential larger bowel dilation, secondary to volvulus. I then called the nursing home and spoke to the client's nurse. The nurse wrote down the information and said that he/she would be passing it on to the client's clinicians and supervisor of his care. I explained to them that I'm not a colon surgeon and cannot evaluate the client for this problem and that he would need to be sent to the ED if he did have an acute problem in that regard." DDS also noted a notation from the nursing home that same day which stated, "Urology called in regards to appointment today. X-ray for kidney stones negative, but x-rays showed critical condition of bowel distention with questionable volvulus. Physician recommends that the client see a GI doctor to further evaluate bowels." DDS noted that the client should have been sent immediately to the ED, however, somehow the urgency of the situation dissipated. It appeared as if the hospital physician left it to the nursing home nurse to decide if the client was experiencing an acute problem. DDS questioned whether the hospital physician should have directly contacted the client's PCP. DDS noted that hospital radiology physician clearly knew what a volvulus was and that he/she had an obligation to make sure the client was evaluated in the ED. DDS noted that the client was also not evaluated properly by the nursing home once the client's x-ray findings had been communicated to them. DDS decided to refer the nursing home and the hospital physician to DPH for investigation.

DPH completed an investigation and noted that the hospital urologist called the nursing home to report that the client's x-ray did show bowel distension with a questionable volvulus; however the nursing home failed to ensure that the client's change in condition and positive x-ray was reported to the nursing home physician.

After consultation with the DPH MD Consultant, DPH decided not to pursue any further investigation concerning the hospital physician.

20) Age: 52 Residence: Private CLA (Referral Date: (11/21/08))

DDS completed a review and noted that the client had been ill for a number of months. He had been hospitalized five times with a series of illnesses, including C-difficile. The client had also spent approximately one month in a nursing home receiving IV treatment for the C-difficile. This case was reported to DPH by the client's guardian, who had a number of concerns regarding the client's care at the nursing home.

DPH cited that facility as documentation was lacking to reflect that the client's 24-hour intake and output totals were monitored. In addition, documentation was lacking to reflect that the client was offered alternative fluid options to encourage fluid consumption to assist the client in meeting his fluid needs.

21) Age: 70 Residence: Nursing Home (Referral Date: (3/6/09))

According to information provided by DDS, the client was placed in the nursing home by his family. Although the client died in January, the DDS Case Manager was not notified of the client's death until March. The Death Certificate listed Manner of Death as Accident, and Cause of Death as due to "Injury, Fell, Struck Head." The OCME did not accept jurisdiction in this case and an autopsy was not performed. The OCME released this case to an Assistant Medical Examiner at a local hospital, who was supposed to complete an investigation and release a report; however this information was not corroborated by the Assistant Medical Examiner, who had no additional information to offer. Due to the accidental nature of the client's death, DDS completed a review of this case, even though the client was placed in the nursing home by his family. Following the DDS review, a number of concerns

surfaced regarding the care the client received at the nursing home. Due to the nature of the concerns, DDS sent a Nurse Consultant to the facility to check on the other DDS residents living there. This case was referred to DPH for investigation due to an apparent lack of safety precautions, medication monitoring and psychiatric oversight of the client by the nursing home.

DPH cited the facility for failing to perform an assessment before discontinuing 15-minute checks, given that the client's diagnoses included seizure disorder, a history of behavioral disturbances and a post-subdural hematoma related to a fall; and for failing to ensure that the client's clinical record was complete.

22) Age: 72 Residence: Nursing Home (Referral Date: (9/18/09)

The FRB reviewed this case and had concerns about the care the client received at the nursing home prior to his death. Specifically, the records ("consultation form") which accompanied the client to a cardiology appointment a month prior to his death, did not reference recent complaints of chest pain. In addition, the client was sent to an orthopedic appointment on a stretcher. When the client arrived for the appointment on a stretcher, he was told that he could not be seen. The orthopedist's office noted that the office did not have a Hoyer lift as they were not an acute care facility but a private physician's office; and it would not have been safe to transfer the client to an examining table without such device. In addition, the orthopedist's office noted that the size of the stretcher would have caused unsafe conditions in the examination room in the event of an emergency. The Board referred this case to DPH.

DPH cited the facility for failing to notify the consulting cardiologist concerning a change in the client's condition. A Report of Consultation to the cardiologist did not include a listing of the client's recent episodes of chest pain, heartburn and recent medication changes.

23) Age: 49 Residence: Nursing Home (Referral Date: (1/22/10)

DDS did not complete a review in this case as the client was placed in the nursing home by her family. According to the initial information provided by the FRB by DDS, the client's cause of death was listed as pneumonia. It was noted that the client was admitted to the hospital from the nursing home approximately two weeks prior to her death with a diagnosis of sepsis. The FRB reviewed the hospital and nursing home records and had concerns regarding the care provided to the client at the nursing home. Specifically, the Board was concerned regarding the level of monitoring provided to the client following his/her having a grand mal seizure. The FRB referred this case to DPH.

DPH was not able to validate non-compliance with the federal/state laws within its jurisdiction.

24) Age: 66 Residence: Private CLA (Referral Date: (2/11/10)

According to the initial report received by OPA, the client was sent to the hospital at 10:30 am via ambulance after an episode of vomiting and fainting at her group home (CLA). The client was discharged from the hospital Emergency Department and sent back to her home at 6:00 pm that same day with a diagnosis of UTI and low blood pressure. The hospital's recommendation was for the client to stay home in bed and follow-up with her doctor the following Monday. At approximately 8:00 pm that same evening, the client vomited a green-colored substance and was noted to have abdominal distention. She was sent back to the hospital and was admitted to the ICU in critical condition with a distended abdomen, and died the following day of septic shock. This case was referred to DPH for review.

DPH cited the facility for failing to complete a re-assessment of the client's vital signs prior to her discharge from the ED; for failing to provide evidence that the client's pain was addressed; and for failing to provide evidence of the client's cardiac rhythm while she was on the cardiac monitor.

25) Age: 69 **Residence:** Nursing Home (**Referral Date:** (10/1/10)

There was a delay in the reporting of this death because the DDS Case Manager neglected to complete a Death Report Form. During the course of the DDS review of this case, a greater concern was noted regarding an apparent delay in sending the client to the hospital for treatment of an acute medical condition. The records reviewed showed that the client had a three-day history of ongoing issues, including vomiting, abdominal distention, and grimacing in pain and looking uncomfortable. After three days of abdominal issues, including vomiting blood, the client was sent to the hospital for an evaluation. It was noted that although the nursing home physician was made aware of the client's issues and discomfort beginning on day one, no action on his/her part to refer the client for an outside evaluation was taken. The FRB reviewed this information and referred both the nursing home and the nursing home physician to DPH for review.

There were no DPH facility findings against the nursing home in this case; however DPH completed a medical review concerning the care provided to the client by the nursing home physician, which resulted in him/her being referred to the DPH Practitioner's Unit for investigation.

The complaint against the practitioner was dismissed.