MAINE ELDER DEATH ANALYSIS REVIEW TEAM

2007 Annual Report

MAINE ELDER DEATH ANALYSIS REVIEW TEAM
MAINE OFFICE OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

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“ELDER ABUSE IS MORE THAN A VIOLATION OF THE PERSON;
IT IS A VIOLATION OF THE SOUL.”

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MAY 3, 2004

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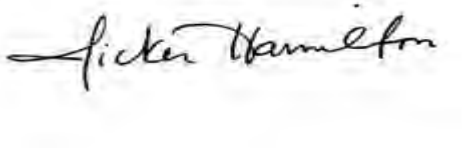
CHAIR REPORT

In 2007, MEDART reviewed six cases, and formulated fifteen recommendations designed to improve assistance to and protection of elderly and vulnerable Maine citizens. As Maine's population continues to grow older and the number of elder abuse victims and persons with disabilities who are victims of crime increase, MEDART provides a strong foundation for addressing the needs of these victims.

Cases may be referred to the Team from any source and in some instances are cases of interest from previous years. During the past year the Team conducted case reviews from referral sources that included law enforcement, victim advocates, Adult Protective Services and the Healthcare Crimes Unit.

As MEDART heads into its fifth year of examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of the elderly and vulnerable adults, the number of cases waiting for review fills the calendar for the next year. Our Mission is to foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART functions because of our dedicated and experienced Team members who donate time, expertise and energy to helping some of Maine's most vulnerable citizens. MEDART exists due to the efforts of Maine Attorney General Steven Rowe. His initiative and guidance resulted in the enabling legislation that created the Team in 2003. The Team wishes to convey its gratitude and acknowledge the leadership, passion and vision that Attorney General Rowe has provided to the Team.



Ricker Hamilton
Chair

2007-01 CASE SUMMARY:

This case focuses on the events surrounding the death of an 81 year old woman, who was a resident of a facility and died as a result of choking. On July 28, 2005, the decedent was eating dinner alone in bed in her room. A Certified Nursing Assistant ("CNA") stated that she removed the decedent's food tray when she was done eating her meal and at that time the decedent was alert and talking. She had checked on the decedent frequently as she ate her meal. The decedent asked the CNA to get her ready for bed. She replied that she was already in bed and because this was unusual behavior for the decedent, the CNA reported her request to the charge nurse. Within five minutes, the charge nurse entered the room. She found the decedent sitting upright in bed, staring straight ahead, with her tongue hanging out of her mouth. The nurse heard gurgling and noted the decedent had shallow breathing. The nurse left the decedent's room to retrieve the suction machine. When the nurse went to get the suction machine, two other staff members went into the room with oxygen. When the nurse returned with the suction machine, the decedent's bed had been lowered and the staff members were giving the decedent oxygen. The nurse attempted to suction the decedent and only got mucus. The nurse felt resistance in the back of the decedent's throat. The obstruction was about one inch into the decedent's throat. The nurse attempted to perform the Heimlich maneuver and tried several times to remove the obstruction in the decedent's throat and clear the airway, but was unsuccessful. When all attempts to clear the decedent's throat failed, she called rescue.

When rescue arrived, the decedent had no pulse and no respirations. Paramedics attempted ventilations with a bag valve mask and were unable to ventilate. The paramedics then used a laryngoscope and removed a whole maraschino cherry from her airway. The decedent had no pulse or respirations at that time. The staff indicated to the paramedics the decedent's down time was approximately ten minutes. The decedent had a DNR (do not resuscitate) Order.

The decedent had a physician's order for a soft pureed diet, with no bread and honey thickened liquids. The decedent fed herself, but had a history of eating extremely

fast. She usually ate her meals in the dining room, but on that night she remained in her room because she had been reported as having loose stools. The decedent's clinical record indicated that she needed extensive assistance of two staff to transfer and that she was not able to walk. The decedent's diagnoses included Mental Retardation with Dementia and Chronic Dysphagia (difficulty swallowing).

The dessert that evening at the facility was pudding with a maraschino cherry garnish. At the time of the decedent's death, the facility procedure was to deliver the desserts separately from the main meal trays after residents consumed their meal. Residents with special desserts had desserts labeled with their names. According to staff at the facility, the dessert trays were "mixed up" that night.

FINDINGS OF FACT:

1. The decedent usually ate her meals in the dining room. On the night that she died, she ate dinner alone in her room. A CNA indicated that he had checked on the decedent frequently while she ate her dinner. When the CNA removed the decedent's meal tray after she was done eating, the decedent was alert and talking.

2. The decedent choked on a maraschino cherry. The dessert that evening at the facility was pudding with a cherry on top. The facility had a physician's order that the decedent was to receive a pureed diet. The decedent should not have received pudding with a cherry on it. The decedent's diagnoses included Chronic Dysphagia or difficulty swallowing.

3. The procedures at the facility called for desserts to be separately delivered from the main meal trays. Residents with "special diet desserts" were labeled with the resident's names. According to staff, the dessert trays were mixed up that night and the decedent received a dessert with a cherry on top.

RECOMMENDATIONS

1. Based upon the decedent's history of eating too fast and having difficulty swallowing, a staff member should have sat with her in her room while she ate her meal and dessert rather than leaving her alone.

2. The facility should conduct more in-service trainings with staff, stressing the importance of being aware of a resident's care plan, including diet restrictions, medications, allergies, likes and dislikes. Facilities may want to review all foods served

to residents and assess whether some foods present a greater hazard for choking. A recommendation was made that a color coded card be placed in the resident's room to remind staff that the resident has a special diet or other specific care needs.

3. Following this incident, the procedure at the facility changed and desserts were no longer separately delivered but rather delivered at the same time as the resident's meal.

2007-02 CASE SUMMARY:

This report focuses on the events surrounding the sudden death of a 27 year old woman, who died as a result of deep vein thrombosis and a pulmonary embolism (blood clot in her lung). The decedent had been in public guardianship for 10 years and resided in a 24 hour supervised group home. Prior to being in DHHS custody the decedent was in foster care for 15 years. The decedent suffered from Bipolar Disorder, Post Traumatic Stress Disorder, Borderline Intellectual Functioning, and had a history of shaken baby syndrome with residual brain damage. The decedent's concentration was very limited and she had difficulty expressing and processing her feelings. Confusion and anxiety contributed to her inability to make decisions that were in her best interest. Recent reports from the decedent's caseworkers and staff at the group home just prior to her death indicated that decedent had been doing well overall.

On 09/18/06, a staff person reported that the decedent had been experiencing ankle pain and went to see a doctor who gave her a prescription for Ibuprofen. The day before the decedent's death, 09/25/06, the decedent had a follow-up doctor's appointment for her ankle. The doctor discontinued the Ibuprofen and stated the ankle appeared fine.

On 09/26/06, the morning of the decedent's death, staff at the group home reported the following:

- The decedent said she woke up at 5:00 and 6:00 a.m. to go to the bathroom and felt dizzy but she did not tell staff at that time.
- The decedent complained about not sleeping, but staff said that the decedent was sleeping when they checked on her at 6:00 a.m.

- At 7:00 a.m. a staff member reported hearing the decedent holler. She had fallen. The staff member requested decedent to sit up and collect herself before standing. The decedent got up and went to her bedroom and fell onto her bed.
- When decedent woke up she stated that she was not breathing well.
- The decedent was not acting like herself; she was not as responsive and appeared in and out of consciousness.
- A staff member took decedent's vital signs and her blood pressure – the lower number was high and her lips were turning blue. She stated that she was having difficulty breathing. An ambulance was called and decedent was given oxygen. The decedent was taken to the Emergency Room and was in cardiac arrest and died shortly thereafter due to a blood clot to her lung.

FINDINGS OF FACT:

1. The decedent wasn't showing any symptoms of a blood clot, i.e. leg pain and swelling. The decedent had not been on a long flight or car trip or sitting in one position for a long period of time. A pulmonary embolism is difficult to diagnose. The decedent's symptoms began suddenly.

2. Typically when an individual suffers a pulmonary embolism the patient dies within 30 minutes of when symptoms begin if the clot is not dissolved.

3. The residents in the group home were having a difficult time understanding and accepting the sudden loss of their friend.

RECOMMENDATIONS:

There are no recommendations for this review, as it was essentially a learning exercise for the team. However, the team would like to note the following:

a. The decedent died because of a blood clot to the lung and the group home staff could not have diagnosed that. The group home staff did an excellent job of responding to the decedent's medical crisis and did everything that they could.

b. The decedent's therapist, group home staff and caseworkers showed a lot of concern and compassion toward the decedent's family, friends, and the group home residents in helping them cope with their loss.

c. The team would also like to acknowledge the expert examination of the Office of the Chief Medical Examiner.

2007-03 CASE SUMMARY:

This review focuses on an elderly resident of a facility that died as a result of the administration of an accidental lethal dose of liquid concentrate morphine. The 86-year old female resident was prescribed a "10" milligram oral dose of morphine on an as needed basis. The Certified Residential Medication Aide (C.R.M.A.) administered a 10 milliliter dose rather than the 10 milligrams prescribed. The dosage given equated to 200 milligrams. It was discovered later that the dropper needed to properly administer the morphine was missing. The CRMA realized her error less than one half hour later and immediately contacted the RN consultant for the facility who instructed her to call her primary care physician, to monitor her vital signs, and to call 911 if her vital signs changed or if she got "sleepy." The physician's office was contacted and the on-call physician said to monitor the resident stating that, "[t]here was no sense in pumping her stomach." At the time that the error was discovered, the resident's condition was treatable with an IV of Nalexone which would act as an antidote to the Morphine and would likely require no more than a one day hospital stay. Thus, the resident might have fully recovered from the potentially lethal morphine overdose if treatment had been sought promptly.

Instead, the resident remained at the facility. Within a few hours the resident became drowsy so an ambulance was called. When the ambulance arrived, the resident refused to go to the hospital. The resident's son and POA was called. He advised that she did not have to go to the hospital if she did not want to. Later in the evening, the resident became unresponsive and was barely breathing. An ambulance was once again called and the resident was taken to the hospital. Attempts were made to treat the resident at the hospital but were unsuccessful. The resident was transferred to hospice care and died four days after receiving the morphine overdose. Her son and POA filed a complaint with the Division of Licensing and Regulatory Services.

The records available in this matter do not reflect exactly what information was given to the on-call physician but indicate that the physician was advised of the actual dosage given to the resident. Similarly, the available records do not indicate whether the resident or her son/POA was informed that the dose given was potentially lethal. For these reasons, the Team is unable to determine whether the resident or her

son/POA had sufficient information in order to give informed consent to refuse life sustaining medical treatment. Due to the medical information contained in the available records, it is postulated that before this event the resident's life expectancy was approximately six months.

FINDINGS OF FACT:

An elderly resident of an Assisted Living Facility died of an accidental lethal morphine overdose that was both preventable and treatable.

RECOMMENDATIONS:

1. Alter CRMA training curriculum to increase the level or amount of instruction related to dosage terminology and conversions for narcotics and other dangerous medications.

2. Improve regulations for Assisted Living Facilities requiring clear documentation of communications and information provided to a resident or that resident's representative or POA to ensure full and accurate information has been provided prior to accepting a resident's decision to forego life sustaining treatment.

2007-04 CASE SUMMARY:

This case focuses on the events surrounding the death of an 87 year old woman from Asphyxia due to suffocation in 1994. Approximately one year earlier, she and her husband had moved to Maine to live with her step-granddaughter and her step-granddaughter's boyfriend. Around the time of their move to Maine, an addition was put onto the step-granddaughter's home. The elderly couple then lived in a section of the house that was separate from but attached to the main house.

The decedent was recently widowed. Three weeks prior to her own death, her husband was transported to the hospital because he was "drooling and shaking." He died a few days later of a subdural hematoma. The decedent had dementia. She had undergone hip replacement surgery several months earlier and used a walker. The step-granddaughter and her boyfriend reported that the decedent's condition deteriorated following her husband's death and she became increasingly agitated and difficult to care for. A Certified Nursing Assistant ("CNA") that provided care to her reported that she "went downhill" after her husband's death and "would not do anything on her own." She would forget that he had died and would become upset when told of

his death. The step-granddaughter had begun making inquiries and applications related to moving the decedent into a nursing facility and may have discovered in the process that the decedent would not qualify for MaineCare.

The step-granddaughter reported that she went to check on the decedent and found her unresponsive lying fully reclined in her living room chair. She called 911. Upon arrival at the residence, the first responders found the outside door to the decedent's residence locked and had to wait for the step-granddaughter to go around and unlock it. The step-granddaughter said that she had checked on her grandmother approximately 30 minutes earlier and she was fine. The step-granddaughter and her boyfriend stated that they had been doing yard work and working on a boat. The responders noted that decedent had numerous bruises, including a fairly recent one on her left eye. When asked about the decedent's black eye, the step-granddaughter stated that the decedent may have fallen. On the table next to the decedent was a handwritten note in her handwriting that said words to the effect "what I have left goes to (step-granddaughter's boyfriend)." The rescue workers noted that the step-granddaughter and her boyfriend exhibited a lack of concern about the grandmother's death.

The decedent's CNA had been with the decedent that morning. The CNA told investigators that she started working at the residence initially caring solely for decedent's husband. Following the decedent's hip surgery, however, the CNA began providing care for her as well. She was paid by the step-granddaughter who was the power of attorney for the decedent and her husband. She stated that the decedent was fine that day and ate a good lunch. She did not notice the bruise on the decedent's eye. That day the CNA got a ride to the residence with her boyfriend and a ride home with the step-granddaughter around noon. She lived about 20 minutes away.

The medical examiner determined that the death was a homicide and was caused by asphyxia from suffocation. The examination revealed that the decedent had broken ribs, numerous bruises and numerous petechiae in her eyes, nose, mouth, and larynx. A lot of old bruises were also discovered on the victim.

Investigators discovered that the step-granddaughter threw out many belongings of the decedent the day after her death. When questioned by police, the step-

granddaughter denied any involvement in the death of her step-grandmother and the boyfriend refused an interview and requested an attorney. Through their statements the step-granddaughter and boyfriend eliminate anyone else being at or visiting the residence on the day of the decedent's death other than the CNA.

A rescue worker who had been to the decedent's residence in the past said each time the decedent or decedent's husband had to be taken to the hospital, no one would go and check on them and that the step-granddaughter and boyfriend seemed to be drinking all the time. Through family members living out of state, investigators learned that all of the decedent's assets were expected to go to the step-granddaughter upon her death. Approximately eight months prior to her death the decedent had granted a power of attorney to her step-granddaughter. The family members estimated the decedent's assets, including stocks, bonds, and cash savings at approximately $300,000.

FINDINGS OF FACT:

1. The decedent required increased care and assistance following the death of her husband.

2. The decedent had dementia and just months prior to her death; the step-granddaughter became the decedent's power of attorney.

3. There appeared to be a significant inheritance to the step-granddaughter.

4. On the table next to where the decedent was found was a handwritten note that said words to the effect "what I have left goes to (step-boyfriend)" and the step-granddaughter said it was her grandmother's handwriting.

RECOMMENDATIONS

1. The Suspicious Death Investigation Protocol should be followed in all relevant cases regardless of the age or mental capacity of the decedent.

****Note the step-granddaughter's boyfriend is now deceased as a result of a drug overdose. This case remains an unsolved homicide in Maine. ****

2007-05 CASE SUMMARY:

This case involves the death of a 27 year old woman who was a facility resident. She was admitted to a hospital on May 5, 2007, then discharged from the hospital and re-admitted to the facility on May 9, 2007. She died as a result of cardiac arrest on May 10, 2007. The decedent was involved in a motor vehicle collision in October 2006, and as a result of the accident suffered from many serious medical problems including: severe traumatic brain injury, splenectomy, removal of a kidney, partial removal of lung, partial removal of liver and fractures. The decedent required total care and was non-verbal but could blink her eyes "yes" or "no" to questions. Of significance to this review is that the decedent had a tracheotomy on her date of admission to the facility. Upon admission in April the decedent's physician's orders for the tracheotomy were: "routine trach care QD (once a day), oral suction PRN (as needed), and routine G tube care QD (once a day)".

On April 27, 2007, the decedent had to be admitted to a nearby hospital for abdominal pain. This was the decedent's first visit to this particular hospital and it was noted that the decedent had methicillin (antibiotic) resistant staphylococcus aureus (MRSA) colonized in sputum. After this visit to the hospital, the decedent was transferred back to the facility and her basic orders for tracheotomy care remained unchanged.

On May 5, 2007, the decedent again had to be admitted to the hospital this time for fever and respiratory distress. While at the hospital, the decedent was found to have thick, green tracheotomy sputum which grew MRSA and was hypoxic. The patient improved dramatically with aggressive pulmonary toileting, aggressive tracheotomy care, and antibiotics. On May 7, 2007, the hospital contacted the facility home and reviewed with them the possible increase in suctioning on return to facility, and that the facility would need to review the patient's care needs to determine whether they could provide needed services. The hospital also spoke with decedent's sister and noted that the sister did not approve of referral to a rehabilitation facility or other facility that provides comprehensive respiratory treatment, and that it was unclear whether the patient would return to the same facility or to another facility.

The administrator of the facility stated that the "hospital was insisting" that the decedent be re-admitted to the facility and that they were getting pressure from the family to re-admit the patient. The administrator said that the decision to re-admit the decedent had to be a nursing decision, and that the facility's nurses need to feel comfortable. The facility's nurses talked to the nurses at the hospital and felt that they could handle the decedent's increased medical needs and level of care.

On May 9, 2007 at 12:00 PM, the decedent was re-admitted to the facility. The decedent's re-admission order to the facility home included more intensive and laborious orders for tracheotomy care requiring the following:

1.) Remove appliance every 6 hours and aggressively clean the appliance and replace;
2.) Aggressive deep tracheal suctioning at least 4 times daily;
3.) Change the tracheotomy tube on a monthly basis; and
4.) Mouth care every 2 hours.

A registered nurse (RN) signed the physician's order record and another RN signed as having reviewed the other RN's transcription of the physician's order record. The order was never transcribed from the physician's order record into the patient's charts which would ensure that the ordered treatment would be carried out by the facility staff. There was no evidence found either on the decedent's medication record or treatment record that the specific order for tracheotomy care had been transcribed as ordered. Also, the registered nurse that re-admitted the patient told the State licensing surveyor that no respiratory assessment had been completed.

The nursing notes indicated that on May 9, 2007 sometime prior to 8 p.m. the decedent was suctioned once. At 11:45 p.m. another nurse discovered that the decedent's humidification for her tracheotomy was not hooked up. On May 10, 2007 at 1:40 a.m. the decedent was suctioned a second time but the decedent's heartbeat had dropped to two beats per minute. Facility staff called 911. The paramedics arrived and found the decedent with no heartbeat. They started CPR and transferred her to the Emergency Room, where she was unresponsive and pronounced dead.

FINDINGS:

1. This decedent suffered from severe respiratory illness and traumatic brain injury due to a motor vehicle accident and required total care. The decedent's

tracheotomy resulted in intensive medical care requirements and therefore she needed to be discharged to a facility that could provide her with that required care. The facility she resided in could not provide the level of care ordered by the physician including frequent tracheal suctioning, and had insufficient staffing to comply with the discharge orders issued upon release from the hospital.

2. The Office of Licensing and Regulatory Services identified as deficiencies the failure to assess the resident's respiratory status, and the failure to meet the special tracheotomy needs of a resident. The actions of three RN's from the facility were reviewed by the State Board of Nursing, and the facility was fined for the deficiencies.

3. The decedent had specific orders for tracheotomy care. Even though an RN transcribed the physician's order from the hospital and another RN reviewed the notes for accuracy, the physician's order did not get transcribed accurately to the patient's record to ensure that the treatment would be carried out as ordered.

RECOMMENDATIONS

1. Nursing Homes need to assess the level of care a person requires and if the level exceeds their abilities and staffing, they should not admit or re-admit the resident.

2. Nursing Homes should have strict protocols stressing the importance of accuracy in transcribing physician's orders when a resident is admitted or re-admitted to their facility from the hospital.

3. Admission/re-admission of a patient should be assessed very thoroughly. In cases where a patient's level of care is questionably elevated above the level of care that can be provided, best practices might demand a pre-admission evaluation at the hospital prior to discharge by qualified facility personnel, such as a nurse, in order to determine the level of care required and whether the facility has adequate staff to meet the resident's needs.