PLR

Tier 3 Report - Early Case Chronology and Analysis

Contents

I. Executive Summary

Ms. N was an elderly but physically quite healthy XX year old widow who lived alone in her own home. She had been noted by a local family friend and by her out of state daughter (by phone and occasional visits) to have progressive dementia, but she remained competent to maintain an immaculate home and yard, to be steady on her feet, and to prepare her food.

One year prior, Ms. N's daughter, on a visit, had removed her car keys because Ms. N no longer had a drivers license or insurance.

Finally, Ms. N was found wandering, miles from home, confused about where she was or how to get home. She was admitted to an acute care facility for a urinary tract infection while social workers reached out to her family.

As her daughter in another state worked on locating memory care for her mom close by, Ms. N was admitted on a temporary basis to a local nursing home. She was evaluated by physical therapy while in the acute care facility, and they had noted Ms. N had poor safety awareness and impulse control and therefore required supervision to prevent falls. She was otherwise healthy, requiring only a blood pressure medication.

When Ms. N's daughter arrived to take her to her new memory care facility, she found her mother confused, combative, refusing medications, refusing to dress, refusing meals, and with a concerning cough. Ms. N's roommate is reported to have told the daughter that Ms. N had fallen that morning. Nursing home staff didn't mention anything about a fall. Ms. N was discharged via wheelchair to the car.

The next morning, Ms. N wouldn't get out of bed and her cough had worsened. Her daughter called an ambulance. Ms. N was admitted to an acute hospital with an intertrochanteric fracture and acute respiratory syncytial virus infection. Ms. N did poorly in surgery to repair her fracture, deteriorated quickly and died while inpatient.

II. CHRONOLOGY

Admission–Discharge	Facility	Admission Reason
February 7 to 11, 20XX	Regional Medical Center – State A	Wandering, dementia, bladder infection, unsteady gait
February 11 to March 5, 20XX	Skilled Nursing Facility – State A	Dementia, wandering, unsteady gait - interim admission pending transfer to Wisconsin facility nearer to family
March 6 to 27, 20XX (expired 3/27)	Acute Care Hospital – State B	Right femur fracture, respiratory syncytial virus infection, possible aspiration

III. Merit Analysis

Injury	Fitchburg HeathCare
Respiratory Syncytial Virus Infection	**Strong Merit** - Resident N showed objective signs of clinical deterioration from March 2 forward, including hallucinations, fixed false ideas, frequent refusals to eat, low oxygen saturation levels (as low as 88%), low grade fever (99 F), and a cough. Taken individually, each would require reassessment, notification of provider and family, and documentation in the record. None of this was done.
Possible Aspiration Pneumonia	**Questionable Merit** - The radiologist read Resident N's initial chest xray as "possible aspiration pneumonia", which the attending physicians at Crouse concurred with. Resident N's daughter related hearing her mother cough and make "gurgling" noises in the hotel the night following her discharge from Fitchburg. It's not clear whether or when she may have aspirated.
Fractured Femur	**Strong Merit** – It's clear that Resident N fell at some time prior at 8:24am March 5, 20XX, while at Skilled Nursing Facility – State A, as evidenced by her sudden need for maximum assist of one staff to walk, the nursing referral to PT, and her refusals of care on March 5, the day of her discharge. Prior to that, Resident N had been "independent" in walking and transferring, despite clear assessments from physical therapy and occupational therapy that she had significant risk for falls.
Death	**Strong Merit** - Resident N was a very active and healthy woman prior to her admission to Fitchburg. She had only hypertension and dementia, and had walked two miles from her residence just prior to her admission to Regional Medical Center – State A. Her infection led to more gait instability which led to her fall and subsequent death.

IV. Therapy Notes Establishing Baseline Function

Note: These evaluations were done just prior to discharge from Regional Medical Center – State A and copies were found in the Skilled Nursing Facility – State A record, indicating that a current skilled assessment of Ms. Resident N's functional status was available for Skilled Nursing Facility - State A staff.

Domain	Physical Therapy	Occupational Therapy	Recommendations	Skilled Nursing Facility – State A reference
Cognition	Confused but cooperative; poor insight and safety awareness.	SLUMS 1/30; severe impairment in memory, orientation, and executive function.	Place in memory care or SNF with 24/7 supervision. **No return to unsupervised home.**	11, 18–19
Mobility	Ambulates 150' under supervision, stairs with rail. No assistive device needed.	Ambulates 25' with contact guard assist; impaired cadence and balance.	**Supervised ambulation only**; evaluate for assistive devices in LTC if endurance or safety worsens.	11, 22
Activities of Daily Living	Not assessed directly.	Requires contact guard to minimum assist with bathing, grooming, toileting, dressing. Fully dependent on IADLs.	**Assign staff to assist with dressing, grooming, bathing, and toileting. Initiate structured ADL retraining program.**	19–21
Transfers	Supervision required for all transfers.	Contact guard assist for bed-chair and toilet transfers.	**Staff supervision and assistance required for all transfers.** Use a gait belt and monitor closely.	14, 22
Fall Risk	Requires supervision due to impulsivity and poor judgment.	Impulsivity and poor insight observed; attempted unsafe behavior during evaluation.	**Implement bed/chair alarms, fall mats, hourly rounding, and assign room near nurses' station.**	11, 22

Aspiration Risk	Not assessed.	Decreased coordination and cognition; feeding requires setup assistance.	Refer to SLP for swallow evaluation; **upright positioning during and after meals; supervise feeding;** maintain oral hygiene.	20
Behavioral Safety	Poor safety awareness noted during mobility tasks.	Attempted to manipulate the hospital bed unsafely; required redirection.	Create a calm environment, use visual cues, and provide close redirection. Document behavior patterns and triggers.	22
Rehabilitation Potential	No further skilled PT needed.	**OT 5x/week for 10 days; focus on ADLs and cognitive training.**	Continue OT in LTC to maintain function; focus on memory aids, safety techniques, and caregiver education.	19

V. TIMELINE RELEVANT TO FALL, INFECTION, POSSIBLE ASPIRATION

DATE	TIME	NOTE	PAGE
February 11, 20XX	none noted	Care plan: "Risk for falls" ... "physical therapy evaluate and treat as needed/ordered", physician orders for PT/OT evaluate and treat as needed.	p. 86
March 1, 20XX	various	Walking independently, no disruptive behaviors, ate >50% of meals	p. 390, 392
March 2, 20XX	Morning	Walking independently, no behaviors, ate 76-100% of breakfast	p. 390, 392
March 2, 20XX	Lunch	Walking independently, no disruptive behaviors, ate >75% of lunch	p. 390, 392
March 2, 20XX	Dinner	Walking independently, **did not eat dinne**r	p. 390, 392
March 2, 20XX	9:00 PM	**Agitated, accusing of others, anxious, restless, disruptive, experiencing something not there, verbalizing persistent false beliefs, wandering, pacin**g - Other than pacing and wandering, these documented behaviors are new. This is clearly a change in status, especially given she didn't eat dinner.	p. 390, 392
March 3, 20XX	Morning	food intake and walking ability not recorded, no behaviors	p. 390, 392
March 3, 20XX	Lunch	Walking independently, no food intake recorded, no behaviors	p. 390, 392
March 3, 20XX	Dinner	Walking independently, ate 51-75% of dinner, no behaviors	p. 390, 392
March 4, 20XX	7:14 AM	NSH Transfer Evaluation - "ambulates independently". **Temperature 99.2, Oxygen saturation 90%**.	p. 343
March 4, 20XX	Morning	Walking independently, **did not eat breakfast**, no behaviors	p. 390, 392
March 4,	10:37 AM	Nurses note "appetite is good"	P. 97

20XX			
March 4, 20XX	Lunch	Walking ability not documented, **did not eat lunch**, no behaviors	p. 390, 392
March 4, 20XX	4:05 PM	Discharge cancelled due to patient refusing medications and **oxygen saturations 88%** despite trying with multiple oximeters. "NP Tiffany aware. Continue to monitor." There is no confirmation in the record that Tiffany received the text message or responded to it in any way.	p. 97
March 4, 20XX	Dinner	Walking independently, ate 51-75% of dinner, no behaviors	p. 390, 392
March 5, 20XX	8:24 AM	NSH Nursing Referral to Therapy - "Change in functional status: "**s/p fall**" (s/p means status post, or any event following the descriptor), **"Reason for referral: falls**" No follow up by therapist as patient was discharged prior to assessment. Completed by C W, RN and S G, Director of Rehab.	p. 349
March 5, 20XX	Morning	**Total dependence with one assist to walk, refused medications, refused toileting, refused hygiene, refused to dress**	p. 390, 392
March 5, 20XX	Lunch	Walking ability not documented, **did not eat lunch,** no behaviors	p. 390, 392
March 5, 20XX	2:29 PM	Discharged via **wheelchair** with daughter.	p. 97
March 6. 20XX	9:48 AM	Admitted to Acute Care Hospital – State B, diagnosis right intertrochanteric femur fracture, respiratory syncytial virus infection, possible aspiration pneumonia.	Crouse, p. 1
March 12, 20XX	not documented	Functional Status assessment - "patient walks 150 feet with supervision/touching assistance" (like a hand on the elbow) Document states it is effective for 3/3-3/5/XX. Document was created 3/12.	p. 368
March 27, 20XX	8:18 AM	Death	Crouse, p. 1

V. F-Tags

F-Tag Number & Title	Facility Failure	What the Facility Should Have Done
F684 – Quality of Care	Failed to recognize and respond to the patient's abrupt behavioral change and sustained refusal of breakfast and lunch for 2.5 days, indicative of possible infection or aspiration.	Assess for infection, delirium, or aspiration; initiate appropriate medical and dietary interventions.
F629 - Transfers and Discharges	The facility failed to address the resident's new inability to walk without assistance and sent her home without a plan for addressing the resident's needs or the cause of the deterioration.	The facility should have cancelled the discharge and sought additional assessment and treatment of the resident's injury and infection.
F689 – Supervision & Hazards	No follow-up/documentation of fall despite 3/5 therapy referral citing "s/p fall."	Investigate and document all potential falls.
F580 – Notify of Changes	No documented notification to physician or family of diminished intake, altered behavior, fall, or oxygen desaturation.	Prompt notification to provider and responsible party.
F842 – Documentation Accuracy	MDS and the record fail to reflect deterioration or fall referral.	Reconcile MDS and record with care events.
F656 – Care Plan	Plan not updated with changes in behavior, appetite, function, or respiratory signs.	Revise care plan to reflect acute changes.

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F-Tag Number & Title	Facility Failure	What the Facility Should Have Done
F657 – Plan Revision	No interdisciplinary review after changes in eating, behavior, or function.	Update care plan and reassess.
F685 – Respiratory Care	No clinical intervention for 88% O2 saturation.	Conduct respiratory assessment and escalate care.
F676 – Activities of Daily Living Care Provided	Total care needs not addressed; discharge occurred despite complete dependence.	Delay discharge and ensure support for ADLs.
F281/282 – Qualified Services	PT/OT not completed after referral; fall not assessed.	Complete ordered services or document rationale.

VI. Defense Arguments

1. There is scant evidence of a fall in the medical record. Defense may try to assert Resident N fell while in the care of her daughter after discharge. It's possible this did happen (she could have fallen AGAIN after discharge), given that Resident N was requiring total assistance to transfer when she was discharged. However, there is sufficient evidence in the chart to support the plaintiff's claim that the patient fell at FHC.

2. Defense may accuse the Plaintiff (the daughter) of neglect, as there is concern for neglect in the Regional Medical Center – State A medical record in several physician's notes.

   The daughter removed Resident N's car keys one year prior to her admission to Regional Medical Center – State A because she wouldn't register her car or pay for insurance, according to one account. In another, her daughter-in-law took the car because Resident N no longer had a license. The medical record notes that Resident N also had an active Adult Protective Services referral and that Resident N wouldn't let the workers into the house.

   The daughter's one year delay and failure to intervene following the APS report could be construed as recognition of Resident N's deteriorating cognitive status while minimizing it.