Bakas & Associates

REPORT TYPE: Narrative – Moderate Length
Case: Fall Resulting in Death
SAMPLE

TO: George Scott, Esq.
Scott and Scott Attorneys at Law

DATE: 11/20/2023

RE: Death from fall: Margaret Bigley

Dear Mr. Scott:

I have prepared this report at your request to review the medical history, diagnosis, treatment and clinical course of Margaret Bigley, specifically the frequent falls she sustained while under the care of Eagle Nursing Home.

I will discuss Ms. Bigley's risk factors (medication, nutrition, wound, skin and diabetes mellitus) and how these risk factors played a significant part in her falls. I will compare the nursing care Ms. Bigley received to the nursing care she should have received, and address the falls prevention protocol. I will also cite the applicable OBRA standards of care required for resident care in nursing facilities. I will discuss how failing to follow the nursing process contributed to Ms. Bigley's death.

SUMMARY OF CLINICAL EVENTS

Margaret Bigley, 82 years old, was admitted to Eagle Nursing Home in Las Vegas, Nevada on 08/05/2019 after living independently in an apartment with home health assistance. She reported she was unable to care for herself, often forgetting to eat and take her medications. Admission documentation reveals she was alert with periods of confusion, which continued to be reported throughout her medical record. She had a history of cardiovascular disease, stroke, dementia, arthritis and type II diabetes mellitus, and was taking many medications. On admission she required assistance with these activities of daily living: dressing, grooming, bathing, ambulating and transferring: Her vision was deemed adequate with glasses.

As a result of inadequate nursing care and supervision at Eagle Nursing Home, Ms. Bigley's abilities diminished significantly. She was an independent person who was self-aware who discharged herself on two occasions. One discharge was against medical advice (AMA) because the staff felt she could not take care of herself living alone due to her confusion and condition. During her stay at Eagle Nursing Home she suffered five falls, the last of which resulted in head injuries from which she did not recover.

Summary of Events After Admission to Eagle Nursing Home – 2019-2020

Date	Time	Event
08/05		Admitted to Eagle Nursing: Home.
08/08		Discharged home to live with niece.
10/08		Readmitted to ICF level of care. Periods of confusion.
10/09	10:40am	Fell out of bed. No apparent injuries.
11/02		Fall documented in untitled report. No further notes.
New Year		
01/08		Referenced on 01/16: Medication error. No further notes.
01/08	6:30pm	Found sitting on floor; slid out of bed. No apparent injuries.
01/13	2:55pm	Found sitting on floor beside recliner, "slid down."
02/03		Signed out AMA.
02/04		Returned to Eagle Nursing Home for admission.
02/05	11:55am	Found lying on floor, groaning, large knot on head. Diagnosis: multiple head injuries and closed head injury.
02/07		Readmitted to SNF (skilled nursing facility).
02/12		Fall risk assessed.
03/29-04/12		Condition deteriorated. Patient expired.

In my opinion, Eagle Nursing Home failed to meet the OBRA regulations and nursing standards of care with regard to the nursing process, as follows.

Federal OBRA Regulations

§ 483.20 Resident Assessment: The facility must conduct a comprehensive, accurate assessment of the resident's status initially and periodically, providing information necessary to develop a plan of care.

§ 483.20(k) Resident Assessment, Comprehensive Care Plans: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychological needs, identified from the comprehensive assessment. The care plan is prepared by the interdisciplinary team and is evaluated and revised as each resident's status changes.

§ 483.IO(b)(11) Resident Rights, Notification of Changes: The facility must immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative or an interested family member when there is an accident, clinical complications,

transfer or discharge from the facility.

§ 483.25 Quality of Care: Each resident shall receive, and the facility shall provide, care and services to enable the resident to attain or maintain the highest physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment in the plan of care.

§ 483.25(a) Quality of Care, Activities of Daily Living: A resident's abilities in activities of daily living, including ambulating, do not diminish unless the circumstances are unavoidable.

§ 483.25(h) Quality of Care, Accidents: Each resident receives adequate supervision and assistive devices to prevent accidents. The facility identifies each resident at risk for accidents and falls and plans care and implements procedures to prevent accidents.

§ 483.75 Clinical Records: The record must be complete, accurate and reflect the nursing process. The staff interventions and resident's response to treatment shall be documented. The nursing process, as a standard of nursing care, requires continuous assessment, identification of patient needs and problems, interventions to meet those needs, and evaluation of the patient's response. The nursing process dictates that the care plan is evaluated for effectiveness and revised as indicated to meet the patient's needs.

§ 483.25 Quality of Care, Nutrition: The facility must ensure that each resident maintains acceptable nutritional status.

§ 483.60(c) Drug Regimen Review: The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

FALL RISK FACTORS

Ms. Bigley should not have experienced the falls that occurred. The fifth fall which caused the fatal injuries could likely have been prevented if the proper precautions had been included in the plan of care and implemented on the patient's initial and subsequent admission assessments. The staff members were clearly aware of the patient's unsteady gait and the need for assistance when ambulating, using an assistive device (walker or cane) “when she remembered it.” Ms. Bigley had painful arthritis that potentially further limited her mobility. She had long used a narcotic pain reliever and an antihistamine for nausea, neither of which were integrated into the plan of care as risk factors for potential injury. Further, the fact that she was intermittently confused to the point of not being able to find her way back to her-room was noted in the care plan but not under prevention of injury. She experienced episodes of diarrhea which further added to her fall risk.

All the above symptoms are on the falls risk assessment that was in use at Eagle Nursing Home on 08/05/2019. Ms. Bigley's condition should have alerted the staff to the fact that a risk assessment was in order on each of her admissions. Had the assessments been performed, her scores would have dictated that a fall alert be implemented for safety.

When each fall occurred, the circumstances were not documented, i.e., call bell within reach, reminders to patient, glasses available, side rails up, etc. Using documentation in the medical record, the following fall risk assessments were simulated for each admission.

Risk for Fall Assessment

To place a patient on fall alert (high risk), 15 or more points must be scored.

To place a patient on fall precautions (risk for fall), 5-14 points must be scored.

CATEGORY	Points	08/05	10/09	02/05	02/12
1. History of previous falls.	**15**	--	15	15	15
2. Confusion.	**15**	15	15	15	15
3. Age over 70.	**5**	5	5	5	5
4. Impaired mobility (i.e., unsteady gait, ambulatory devices, etc.).	**5**	5	5	5	5
5. Impaired neurological status (i.e., dizziness, seizures, paresthesia).	**5**	--	--	5	5
6. Sensory limitations.	**5**	5	5	5	5
7. Impaired nutrition.	**5**	--	--	--	5
8. Impaired cardiovascular status.	**5**	--	--	--	--
9. Medications (i.e., laxatives, diuretics, sedatives, narcotics, antihypertensives).	**5**	5	5	5	5
TOTAL POINTS	**65**	**35**	**50**	**55**	**60**

In all cases, a fall alert protocol was indicated. The only fall assessment, after the 02/12 fall, was not documented until twelve days later and was not signed.

Contrary to the standard of care, attempts to notify the family or a contact person and a physician were made after only two of the five falls. The family or contact person and physician were also inconsistently notified of patient transfers out of Eagle Nursing Home for tests and hospitalizations.

NURSING STANDARDS OF CARE

I. Plan of Care

Assessing the patient's nursing care needs and evaluating any interventions to meet these needs is basic to the nursing process. This nursing home's documentation did not reflect the nursing process.

The care plans were rarely updated, even after the falls occurred. Of particular note, no plan of care was completed or revised on Ms. Bigley's return to the nursing home after her severe injuries when her care needs had changed dramatically.

II. Wound and Skin Condition

After a hospital discharge, a wound was noted on the patient's wrist. The wound was described as stage IV, covered with eschar (black, hard cover). While the treatment of the wound may have been appropriate given the patient's condition, a wound care specialist should have been consulted for proper staging and care. Once the resident became bedbound, the facility failed by not completing a pressure ulcer risk assessment in a debilitated, at-risk patient.

III. Medications

The nursing staff failed to recognize the possible effects of at least two of Ms. Bigley's medications. Darvocet is known to cause dizziness, sedation, nausea and vomiting. She began receiving Phenergan for complaints of nausea on 10/10/2019. Side effects of Phenergan include sedation, sleepiness, dizziness, increased or decreased blood pressure, nausea and vomiting. The cause of the patient's continued complaints of nausea were not investigated and the medication was continued.

Since any of these symptoms would increase a patient's fall risk, measures should have been taken to ensure Ms. Bigley's safety if the medications were deemed needed and appropriate for her comfort. Both medications are potentially inappropriate in the elderly and should be given for as short a time as possible.

No review of the drug regimen was found for August 5-10, violating the OBRA standard of monthly review. On those reviews that were found (October-April), the continued use of Darvocet and Phenergan was not questioned. Use of these medications was also not mentioned in the physician progress notes.

IV. Diabetes Mellitus

The facility did not meet standards for managing Ms. Bigley's type II diabetes mellitus. The plan of care did not reflect a goal for her blood sugar level until 04/0l. Consequently, her blood sugars remained well above the recommended levels. The nursing staff assayed blood sugars regularly and reported the results to the physician, but orders were rarely changed. Once again, this represents a failure to follow the nursing process.

V. Nutrition

The facility failed to ensure adequate nutrition for Ms. Bigley. Over a six-month period she gradually lost 17 pounds, a severe weight loss of 12%. After her fall on 02/05, Ms. Bigley's weight continued to decrease. Her nutritional status became even more perilous when she became unable to swallow.

The patient often admitted she forgot to eat. The need for supervision of her meals was not included in the care plan.

Had the nursing process been followed, the patient's nutritional goal of maintaining a weight of 155-160 pounds would have been reassessed, revealing the ineffectiveness of the therapeutic diet in maintaining goal weight and stabilizing blood sugar. As a result the care plan would have been revised to prevent further loss. A calorie count, monitoring of albumin levels and supplements could have reduced her nutritional risk early on.

VI. Complete Medical Records

The facility failed to maintain accurate and complete medical records. There are large gaps of time with no nursing documentation. The nursing aide records cover only April and are not complete. No records document activities of daily living, reflecting a disregard for the patient's health and wellbeing. Medication administration records are incomplete and often not dated.

VII. Injuries from Fall

Ms. Bigley's condition deteriorated dramatically after the 02/05 fall. She suffered severe head injuries and was returned for supportive therapy. She returned to the hospital for treatment of deep vein thrombosis and a heart attack. She progressively became more confused and was oriented to her name only. She was able to swallow only honey-thickened liquids and required total assistance with all her daily activities. She expired 04/12.

VIII. Summary of Deviations

Eagle Nursing Home failed to meet the standards of care for Ms. Bigley in at least, but not limited to, the following ways:

1. Failure to adequately assess the patient's risk for injury and falls at the time of each admission and then ongoing, shift-to-shift.
2. Failure to provide and follow an individualized plan of care that is appropriate to meet the resident's needs.
3. Failure to notify the physician when falls occurred.
4. Failure to notify the next of kin or contact person when falls occurred.
5. Failure to provide adequate supervision and assistance to prevent falls.
6. Failure to meet the resident's nutritional needs and properly monitor her nutritional state.
7. Failure to provide an accurate and complete clinical record and to document the nursing process.
8. Failure to monitor safe medication distribution and administration.

In my professional opinion, the fall and subsequent injuries that led to Ms. Bigley's suffering and death would not have occurred if her care had been based on the nursing process and if even minimal assessments and precautions had been taken to prevent the falls she experienced. The above deficiencies led to the death of this resident.

The records I have reviewed to date include:

- Medical records from Eagle Nursing Home, Las Vegas, NV, 08/05/2019-04/12/2020.
- Specific portions of the medical records from:

  1. Southwest Medical Center, Las Vegas, NV
  2. Rockaway Hospital, Boulder City, NV

The preceding report provides my nursing opinions based on the above information. This report does not necessarily embody the details of all my opinions. I reserve the right to amend and add to my opinions upon further review of the records.

Sincerely,

Andrea Bakas, RN, FNP-C, CLNC