When assisted living isn't enough, the consequences can be deadly

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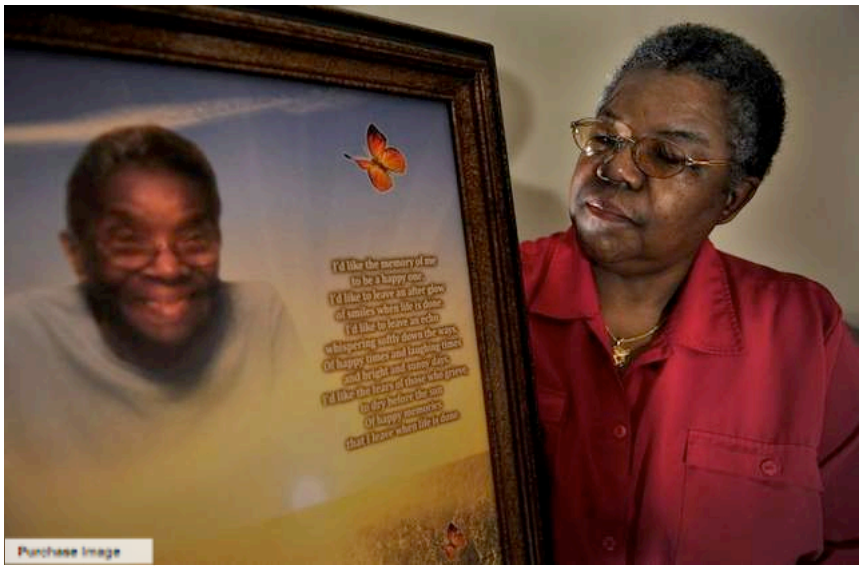

In December, Ruby Anderson tripped, fell and broke her neck at Elm Croft of Twin Hills. Her daughter, Janice Anderson, said the facility knew her mother was prone to falls. / Jae S. Lee / File / The Tennessean

Written by
Walter F. Roche Jr.
The Tennessean

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Herbert G. Jones Jr. was 82 and suffering from later stages of Alzheimer's disease and dementia when his family placed him in an assisted living center in Franklin on Nov. 5, 2009.

A photo taken on Thanksgiving that same month shows his wife of 62 years, Anita, visiting him, the pair dressed festively in matching red shirts, holding hands in a fond embrace.

A few days later Jones became agitated as sometimes occurs with dementia and began to bother another resident, putting his hand in her hair.

A caregiver separated Jones from the woman, who also was an Alzheimer's resident, at least three times that day. But the staff member was helping another patient when the woman later shoved Jones away. He fell backward, hitting his head on the floor, cracking his skull, according to a police report.

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He died four days later — less than a month after moving in.

Jones' death illustrates a little-known problem in assisted living centers, which market a wide range of services for the elderly as they move into later stages of life.

Sometimes, residents simply need more care or supervision than is offered. And when they don't get it, consequences can be tragic and not just for themselves.

A Tennessean investigation using public records discovered one Nashville assisted living center where four people died within three years.

One man was beaten with a cane by a roommate with whom he had been squabbling. Both had Alzheimer's. Another went down a flight of stairs in a wheelchair and broke his neck. A woman was given the wrong insulin by staff and died shortly after being taken to the hospital. Eventually the state said 22 residents in that facility needed to be transferred because they required more care than the center was equipped to provide.

In another Nashville case uncovered by The Tennessean, a man with dementia in an assisted living center exhibited "sexually aggressive inappropriate and intrusive behavior" toward five elderly women who also lived there, touching and fondling them in inappropriate places and taking one woman's clothes off, according to state inspectors.

Staff at the assisted living center tried to address the problem and alerted state officials. But the behavior continued intermittently for 20 months before he finally was moved to a different location.

State inspectors cited the assisted living center for failing to protect the elderly women. The man has since died.

In other assisted living centers, state inspectors discovered dementia patients who were hitting other patients and caregivers; examples of drugs being improperly handled or dispensed; and instances in which residents were repeatedly falling with no plan of care to address the issue as required by regulations. In some cases, falls led to the deaths of residents.

Advocates and families of victims are starting to raise concerns that some centers are not adequately staffed for the condition of their residents, and that too often staff is not adequately trained to deal with the behavior brought on by aging and dementia.

People with dementia, according to the Alzheimer's Association, "may have problems with short-term memory, keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments or traveling out of the neighborhood."

They also may be subject to mood swings and become "confused, suspicious, depressed, fearful or anxious."

A Tennessean examination of the most recent inspection reports of 56 assisted living centers in eight Middle Tennessee counties showed that nearly one-fifth have been cited by the state Health Department for admitting or retaining residents who needed a higher level of care, not providing proper protection for residents from acts of fellow residents, or not doing the required medical screenings that would determine their needs and suitability of care.

Regulations vary widely

Concerns by families and advocates about assisted living facilities come as the number of those facilities and the population likely to use them is on the rise. In Tennessee, the number of assisted living beds has jumped 30 percent since 2007 to 14,757.

"With the increase in population we're in unchartered waters," said Chicago attorney Jonathan Rosenfeld, who has represented families in Tennessee cases against assisted living facilities.

"There is no clear definition of exactly what assisted living is. There is often a real divergence between the expectations of the resident and his or her family and what is actually provided."

State officials and assisted living industry officials, however, say the requirements in Tennessee are clearly spelled out.

Under state law and regulations, assisted living residents must be ambulatory or able to get in and out of a wheelchair without assistance. A facility should not admit a resident requiring around-the-clock nursing care.

There must be a certified administrator and a nurse on staff or available. But unlike in other states, Tennessee does not set specific minimum staff-to-resident ratios for assisted living facilities. Tennessee's regulations state that a facility "shall have a sufficient number of employees to meet the residents' needs, including medical services as prescribed." About 20 other states set mandatory staffing levels.

Many assisted living centers in Tennessee and elsewhere offer Alzheimer's units, also called memory care units or secure units because they are designed to keep residents in a contained space so they don't wander away, for example.

The state requires that there be at least one staffer on duty and awake at all times in those units. However, there is a difference between regulation of the Alzheimer's units in assisted living centers and the same units found in nursing homes.

In nursing home Alzheimer's units, for instance, the state requires a minimum of 3½ hours per day of direct care for each patient, which drives staff levels.

Nursing homes are subject to uniform federal regulation because of funding through Medicare and Medicaid programs. Generally, Medicare and Medicaid don't pay for care in assisted living centers — most of the residents pay their own fees. That leaves the states to set standards, and regulation can vary widely.

Jay Moore, spokesman for the Tennessee Health Care Association, which represents assisted living centers, said it was difficult to compare the state's regulation of the industry with that of other states.

"We do believe, however, that the (state Health Department) is fairly aggressive in enforcement of the regulations that are in place," Moore said.

State records show the Health Department has imposed fines of $22,500 on licensed assisted living facilities since 2009. No facilities have been ordered to shut down or freeze admissions, according to the department.

Slew of serious problems

At the edge of a residential Madison neighborhood, the two-story assisted living facility Elmcroft of Twin Hills is set back from the road behind a parking lot. A large portico flanked by trees and landscaping leads to the front entrance, where white rocking chairs offer a place to rest and enjoy some fresh air.

It was in June 2011 that state health officials, responding to a dozen complaints, learned of serious problems at the center, then known as Carestone at Rivergate. In fact, no other assisted living center in Middle Tennessee came close in The Tennessean's investigation to the volume of problems eventually uncovered since 2009 at the stately red brick, white-trimmed 113-bed center, which has had two corporate owners in that time period.

Inspectors learned during their visit that two people had died at the center in the previous two years, but in both cases, officials at Carestone had not informed the state, a required action that could have triggered an immediate investigation.

One of those who died was Elizabeth Vaughn, who was administered the wrong insulin by a Carestone worker. According to state records and a lawsuit filed by her family, her doctor had prescribed a specific type of insulin to be administered on a sliding scale depending on her blood sugar levels.

But at 6 a.m. on Oct. 4, 2009, a Carestone aide gave her the wrong insulin. Her family said in court papers that she was found five hours later slouched over a chair, foaming from the mouth. Although rushed to the hospital, she died a little more than a week later, having suffered a severe brain injury.

The family reached a confidential settlement in its lawsuit against Carestone.

A second death, in 2010, involved a man who went down a flight of stairs in his wheelchair, breaking his neck. But Carestone officials told state inspectors they could give no further details because they couldn't find the victim's records.

In addition to the deaths discovered, the inspector also went on to document at least one wheelchair-bound resident whose speech was unintelligible, who stared ahead when asked a question and who needed “total assistance” in daily living activities such as eating and even propelling his wheelchair.

“The resident no longer meets the definition of ambulatory and needs to be transferred to a higher level of care,” the May 18, 2011, report states. In seven case files, inspectors said required medical assessments were missing. And in one case, a resident wandered out of the building and fell, suffering a broken nose and jaw.

Inspectors recorded complaints from residents about lack of staff and poor response from aides. “They need more staff,” one resident told an inspector.

Carestone filed a plan of correction after the inspection — an account of how it would address the state’s concerns — which included contacting the family of the man in the wheelchair about the need for a higher level of care.

But in August, just a few months later, Carestone’s owners sold the facility to Senior Care of Louisville, Ky., which renamed it Elmcroft of Twin Hills.

The new owners became aware of problems. One of the facility’s own documents stated that as of Dec. 9, 2011, a total of 26 residents required “immediate move out” because they needed a higher level of care.

Also in December, Ruby Anderson, 85, wandered into another resident’s room, tripped over a bench and fell, breaking her neck. Her daughter, Janice Anderson, said she had complained earlier to administrators about the level of care her mother had been receiving. She said the facility knew her mother was prone to falls — in fact, it was one of the reasons she put her mother there to begin with.

Ruby Anderson died Dec. 20. “I still thank God for allowing me to have her for 61-plus years of my life,” her daughter said.

Then, on Christmas Eve, an ambulance was called to Elmcroft to respond to a man found bloody and beaten in one of the rooms. Donald Reeder, 83, who had Alzheimer’s disease and dementia, had been clubbed with a cane by his roommate in the two-bedroom unit. The two had been arguing for weeks, and Reeder’s wife said she had pleaded four times with the center’s staff to move her husband. Reeder died later in a hospice.

Reeder’s widow and Anderson’s daughter later reached confidential settlements with Elmcroft, according to Joe Dughman, the attorney who represented both families.

The two deaths triggered another state inspection on March 1, 2012. In that report, the state concluded that Reeder never should have been admitted to the facility because he required care provided in a secure unit and Elmcroft wasn’t licensed for a secure unit.

The June 2011 report showed one man who needed to be moved

out. Now, the state documented that 22 residents needed a higher level of care than the facility could provide.

At one point an official with the new company told a state inspector, “We considered closing this (facility) because things were so bad.”

Senior Care officials declined to comment on the Reeder and Anderson deaths, citing confidentiality requirements. They say they cannot be held responsible for the two deaths that occurred before they bought the facility in August 2011.

Robin L. Barber, vice president and general counsel for Senior Care, wrote in an email response to questions that her company had no affiliation with the previous owner, Carestone.

She said that after the takeover, Elmcroft began reviewing and updating care plans and working with families “when appropriate ... to (move residents to) alternative settings.”

She noted that the company filed plans of correction for the Madison facility and another assisted living center, Elmcroft at Brentwood, which also was purchased from Carestone. The Brentwood facility had been cited for failing to perform quarterly assessments on three residents in a secured dementia unit.

“Elmcroft is committed to providing quality care to its residents,” she said.

Carestone is no longer in existence. The corporation was dissolved, according to state records.

In the wrong place

Advocates say that one of the most difficult problems in assisted living centers is the admission and retention of residents who need more care than the facility is staffed to offer.

Jesse Samples, executive director of the health care association, said the higher cost of nursing home care and recently implemented restrictions on nursing home coverage by TennCare “could significantly reduce the options” for those no longer able to live independently. As a result, even more senior citizens may turn to assisted living.

Ann R. Reed, director of licensure for the state Health Department, said the problems found at the Madison facility with so many wrongly placed residents are not common.

The Tennessean found eight other cases in recent and previous inspection reports in which facility officials kept residents who needed more care, or staff failed to evaluate residents on their care needs.

At Clare Bridge of Goodlettsville, for example, state inspectors last year found that four of 13 patients had been placed in a secure unit without undergoing an interdisciplinary review by a team consisting of a physician, social worker, registered nurse and family member.

The state requires semi-annual medical evaluations and care plan updates for assisted living residents. More detailed, quarterly reviews are required for those in secure Alzheimer’s units.

The reviews are important in determining how much care residents need, particularly as needs increase.

If not done, the result can be a staff ill-equipped to handle some residents. Dughman said it was his view that “a lack of staff is the bottom line in many assisted living cases,” adding, “There’s a need for staffing ratios that meet the needs of the patients based on acuity.”

Rosenfeld, the Chicago lawyer, said some assisted living centers might accept or keep residents even though they need more care because they are trying to keep the beds full and the revenue up.

“It’s the name of the game, keep the beds full,” Rosenfeld said. “There are some very high-quality assisted living facilities, but many are not.”

Samples suggested another reason that residents might be kept when they should be moved to a higher level of care.

Stating that the rules are very clear, Samples said, “We understand that sometimes family members may want to have their loved one continue to stay in the same (assisted living) setting.

“However, families must realize that the rules are designed to protect the residents’ well-being, and sometimes that means being placed in a more supervised setting.”

Advocates say that the state should set minimum staffing requirements and increase mandatory training requirements, especially for those facilities that have separate units for Alzheimer’s residents.

“The staff training requirements for those in Alzheimer’s units are very loose,” said Tiffany Cloud-Mann, vice president of programs and outreach for the Mid-South regional chapter of the Alzheimer’s Association. “There needs to be further training on how to deal with different behaviors.”

The state requires assisted living facility staff in a secure unit to have annual training on management of Alzheimer’s and related diseases, including dealing with dysfunctional behavior and identifying safety risks.

But even with the training requirements, The Tennessean’s review revealed serious problems in how staff responded.

Inappropriate behavior

Details of the “inappropriate sexual behavior” at Mary, Queen of Angels, a facility affiliated with the Diocese of Nashville, are contained in state Health Department report dated March 30, 2011.

Citing records reviewed at the center, the state report describes instances in which an unnamed retired Catholic priest engaged in “sexually aggressive inappropriate and intrusive behavior” with five female residents.

A nurse note on Aug. 19, 2009, documented that, while living in the facility’s secure memory impaired unit, “the resident was found in a female resident’s room displaying inappropriate touching.” A note on Oct. 21, 2009, documented that the man was found in a female

resident's room three times and had been in bed with her.

"Resident is displaying inappropriate sexual behavior toward female resident in the memory impaired unit which is sometimes forceable," the nursing director wrote at the time.

On Jan. 21, 2010, the staff documented that the man was with a different female resident and "had the female resident's incontinence brief and her pants pulled down and he was fondling her."

That day, after consulting the man's physician, he was moved to a psychiatric facility, where a drug, Seroquel, was prescribed to control his behavior. Nashville Bishop David Choby was told immediately about the January incident, said Rick Musacchio, director of communications for the Diocese of Nashville.

"I met with him after an incident was reported to me," Choby said, adding that the behavior was due to "a lessening of inhibitions after a series of strokes."

"I know as soon as we received the report of the incident, we reported it to the Department of Human Services. It was reported as it should have been. All of that was done within hours," Choby said.

"I feel that we responded promptly and appropriately," Choby said.

The man was discharged from the psychiatric facility and later returned to Mary, Queen of Angels on Feb. 11, 2010, this time to live in the nonsecured area under his new treatment plan. But after he was showing "symptoms of weakness and unsteady gait," his Seroquel dosage was reduced.

Three other incidents occurred after that in March, April and July, the state report showed.

In November 2010, when a state health inspector went to the man's room in an attempt to talk with him, he answered the door with his pants down and insisted the inspector enter his room. The state employee declined.

According to the report, staff at the facility attempted to stop the behavior by reminding the male resident that he was a priest. The report states that the bishop "had been to talk with him about the inappropriate behaviors, and they were considered interventions that had worked."

State inspectors noted, however, that there was no documentation for those interventions.

Musacchio said that after another incident of inappropriate behavior with a female resident on April 7, 2011, the assisted living facility's director of nursing ordered him transferred to a hospital, with directions that he not be permitted to return. The incident was reported to the state.

Musacchio noted that the facility complied with state requirements on reporting inappropriate conduct. He said families of the other patients also were notified.

"A loss of inhibition related to many areas of personal behavior is

common among dementia patients, and that requires an ongoing effort between caregivers and medical teams," Musacchio said.

He said Mary Queen filed a corrective plan with the state Health Department, which was accepted, and received no citations, fines, sanctions or penalties after that.

The man was put in a private home before being moved to a hospice, where he died this year. Musacchio said the long delay in moving the man was because they were unable to find another facility that would take him.

Police told by others

Although the incidents were reported to the state, Metro police spokeswoman Kristin Mumford said they were not notified of any potential sexual assaults at Mary, Queen of Angels.

The facility was not required to do so, Mumford said. Police often hear about these types of incidents from Adult Protective Services, but that did not happen in this case.

The Tennessean discovered that in other cases of resident-on-resident incidents at assisted living centers, police found out about them not from assisted living center staff, but rather from emergency workers or other medical staff.

Jones' death after being shoved in the Franklin assisted living center in 2009, for example, was investigated by Franklin police only after a forensic investigator spotted a reference to a pushing incident in an emergency medical technician log during a transfer to Vanderbilt Medical Center, where he died.

And it was an ambulance worker who called police after picking up the badly injured Reeder, who had been beaten up by his roommate at Elmcroft. Police investigated, but the district attorney ultimately decided against charging the other man, who also had Alzheimer's.

In Jones' case, the emergency response officials first on the scene at Belvedere Commons of Franklin were told only that Jones had fallen and bumped his head, according to the Dec. 10, 2009, police report.

Police then questioned caregivers who were on duty the day of the incident and learned details, including how Jones had bothered the woman several times, increasingly upsetting her until she was heard yelling, "Get away from me," before the fatal shove.

The woman was never charged.

Jones' family filed a lawsuit against Belvedere Commons, saying Jones' death happened because the owners understaffed the facility and allowed "two Alzheimer's patients to become agitated and entangled."

Officials of the facility declined to comment, citing the litigation, but the case was resolved on Aug. 30. The terms were confidential.

Belvedere has been cited in its most recent inspection report for failing to document quarterly reviews of residents in its secure dementia unit.

The June 26 inspection report states that one of the residents in the memory care unit had yet to undergo a quarterly review since being admitted in early January. Two quarterly reviews were missing for a second resident.

Contact Walter F. Roche Jr.
at 615-259-8086 or wroche@tennessean.com.

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