STATE OF MICHIGAN

IN THE SUPREME COURT

ESTATE OF DOROTHY KRUSAC, deceased,
by her Personal Representative John Krusac,

Plaintiff-Appellee,

vs.

COVENANT HEALTHCARE assumed name for COVENANT MEDICAL CENTER, INC.; COVENANT MEDICAL CENTER-HARRISON assumed name for COVENANT MEDICAL CENTER, INC.; Michigan Corporations, jointly and severally,

Defendants-Appellants.

Sup Ct No. 149270
COA No. 321719
Case No. 12-15433-NH-4
Hon. Fred L. Borchard

/

CYRIL V. WEINER (P76914)
CARLENE J. REYNOLDS (P55561)
WEINER & ASSOCIATES, PLLC
Attorneys for Plaintiff
4000 Town Center, Suite 550
Southfield, MI 48075
248-351-2200

THOMAS R. HALL (P42350)
HALL MATSON, PLC
Attorneys for Defendant Covenant Healthcare
1400 Abbot Road, Suite 380
East Lansing, MI 48823
517-853-2929 Fax: -8062

/

AMICUS CURIAE BRIEF OF MICHIGAN'S STATE LONG TERM CARE OMBUDSMAN PROGRAM

Respectfully Submitted By:

Jules B. Olsman (P28958)
Olsman Mueller Wallace & MacKenzie, P.C.
2684 W. Eleven Mile Road
Berkley, MI 48072
248.591.2300

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Case Law

Statutes and Administrative Codes

INTEREST OF THE AMICUS CURIAE

This amicus brief is being offered on behalf of Michigan's State Long Term Care Ombudsman Program. This program, which receives both federal and state funding, is authorized by the Older Americans Act, 42 USC § 3001 *et seq*, and the Older Michiganians Act, MCL 400.581 *et seq.* The Long Term Care Ombudsman program was created to monitor the quality of care and quality of life experienced by residents of long term care facilities, to advocate for residents' rights, and to seek systemic changes to improve the quality of licensed long term care facilities. The program includes both a State ombudsman, who oversees the program, and a network of local ombudsmen, who advocate for residents of nursing homes, adult foster care homes, and homes for the aged across the state. A similar ombudsman program will soon be developed by the Michigan Department of Community Health to serve individuals eligible for Medicaid and Medicare who are enrolled in the new MI Health Link Integrated Care demonstration project. The new ombudsman program will assist MI Health Link participants in obtaining care from a wide variety of health care providers, including hospitals and long term care facilities.

The Long Term Care Ombudsman (hereafter "LTCO") is oftentimes the only voice for long term care residents who are unable to advocate effectively for themselves due to physical limitations or cognitive impairments, such as dementia or Alzheimer's disease. To achieve its goal, federal law permits the LTCO to meet with the residents, 42 USC 3058g(b); speak with their family members or guardians; and, in certain circumstances, gain access to the residents' medical records, 42 USC 3058g(b)(1)(B)(C)(D). *See also* MCL 400.586i. The LTCO works with the resident, family, or legal representative to resolve issues surrounding resident care and, when appropriate, reports suspected abuse and neglect to the relevant government agency. The

LTCO is also authorized to access a resident's medical records if the LTCO feels that a resident's guardian is no longer acting in the resident's best interest. The LTCO also works collaboratively with regulatory and advocacy organizations, compiles data, and spots trends affecting the health and quality of life of residents in health care facilities.

STATEMENT OF FACTS

The LTCO adopts Plaintiff's statement of facts.

INTRODUCTION

This Court's decision in *Krusac* will have significant ramifications for the work performed by the State Long Term Care Ombudsman Program. This Court's holding will impact the amount of factual information that health care facilities place in a resident's medical record. If this Court adopts Appellant's position, health care facilities will continue to omit critical, adverse factual information regarding resident injuries from the medical record. As in *Harrison, infra,* and *Krusac,* the factual information about an injury will only be found in the incident report. Locked tightly in the risk management office, that factual information will be seen by few and never be disclosed to the resident, family, legal representative, or the long term care ombudsman, who requires the information to pursue individual and systemic advocacy efforts. However, if this Court adopts Appellee's position, health care facilities will inevitably place more detailed factual information about the circumstances surrounding a resident's injuries in the resident's medical record. They will do this to prevent discovery or *in camera* review of the incident report. From this critical factual information, the LTCO will be able to understand the nature of a resident's injuries, monitor the facility during their frequent visits, provide

appropriate support to facility staff to resolve issues, and take the necessary steps to best protect the resident involved in the incident as well as other residents who may have similar care issues. For example, if the ombudsman becomes aware of a facility's failure to ensure that oxygen tanks remain filled through reviewing a resident's medical records, the ombudsman can immediately advocate for other residents in the facility who require oxygen. Or, if a medical record contains factual information about an assaultive resident, instead of that information being hidden in an incident report, the ombudsman can review how the staff are supervising the aggressive resident, whether the staff have an adequate care plan to minimize the aggressive behavior of the resident, and how they are seeking to protect the other residents from future assaults. None of these interventions would be possible if the adverse information was placed exclusively in an incident report.

The impact of adopting Appellant's position will result in a facility's own direct care staff not having the information they need to provide adequate care to older adults and people with developmental and other disabilities. Seventy percent of nursing facility residents suffer from some type of cognitive impairment. These residents do not have the ability to accurately and credibly recall a traumatic event, such as a fall or abuse. When, for example, a fall does occur, if the family is not alerted and appropriate documentation is not placed in the medical record, it can adversely affect a resident's health. A broken hip or brain bleed (subdural hematoma) may go undiagnosed or untreated for hours or days. In the time before the fracture or head injury is finally discovered, the resident suffers needless pain and the unaddressed injury may have put the resident in unnecessary peril. Direct care staff may have had no idea the incident occurred because the only place the incident is documented is in an incident report, which is locked in the Administrator's office. The medical record on which they rely to determine the resident's care

needs may offer no details of the traumatic event. Thus, while the factual information in the incident report may be a critical factor in determining how to meet the resident's changing care needs, the only people who know about the incident are the "peer review committee."

LEGAL ARGUMENT

A. FACTUAL INFORMATION ABOUT WHAT OCCURRED AT A HEALTH CARE FACILITY SHOULD NEVER BE PRIVILEGED.

In order to effectively protect Michigan's most vulnerable citizens and fulfill its federal mandate, the LTCO must have full and complete access to facts regarding residents' care and treatment. The importance of this information is especially evident in long term care facilities where many of the residents suffer from short or long term cognitive and communication impairments or other medical issues that limit their ability to share pertinent information about their needs and history. In addition, residents of long term care facilities often fear retaliation if they reveal harm that they suffered in the facility and often have little privacy to share their concerns with family or advocates. In these cases, having access to the factual information in the medical record is a very important tool in the LTCO's work.

Just as Ms. Krusac's medical records failed to contain complete information, the LTCO often reviews medical records that do not contain a complete recitation of the facts about how an injury occurred. Frequently, the medical record will merely state, "resident fell," "resident found on floor," or "resident lowered to floor." What happened in the minutes leading up to that fall, the circumstances contributing to the fall, who witnessed the fall, who found the resident, or where the resident was found are frequently omitted from the medical record. Although absent from the medical record, that information is almost always included within an incident report. In fact, many incident reports are preprinted forms that have specific prompts that request that type

of information. Attached as *Exhibit 1* are redacted nursing home incident reports. These incident reports demonstrate how these documents contain primarily factual information. Only a small portion of the actual document involves the peer review process or contains the findings or determinations of the peer review committee.

The factual information surrounding an injury should never be withheld from a resident or his or her advocate under the guise of the peer review privilege. That is not the result that was intended by the Legislature when crafting MCL 333.21515. Facts are not privileged. Only what the facility does with the facts may be privileged. This point was well-summarized by the Court of Appeals in discussing similar language found in MCL 333.20175(8):

> Certainly, in the abstract, a peer review committee cannot properly review performance in a facility without hard facts at its disposal. However, it is not the facts themselves that are at the heart of the peer review process. Rather, it is what is done with those facts that is essential to the internal review process, i.e., a candid assessment of what those facts indicate, and the best way to improve the situation represented by those facts.

Centennial, infra at 291.

The positions advocated for by Appellee and the LTCO are consistent with how the 'peer review' privilege has been applied historically in Michigan. For example, in the context of a skilled care nursing facility, i.e. a nursing home, the factual information contained within the incident report was held to be discoverable in *Centennial Healthcare Management Corporation v Michigan Department of Consumer & Industry Services,* 254 Mich App 275; 657 NW2d 746 (2002). *Centennial* involved the interpretation of MCL 333.20175(8), which states as follows:

> (8) The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena.

The Court considered this statutory language and its potential conflict with the record-keeping requirements set forth in Michigan Administrative Code, R.325.21101, which is applicable to nursing homes and requires that accident records or incident reports "shall be kept in the home and shall be available to the director or his or her authorized representative for review and copying."[1]

After considering MCL 333.20175(8), the relevant portions of the Michigan Administrative Code, and the precedential history available concerning the peer review privilege (which was largely interpreting MCL 333.21515), the Court held that the factual information contained within an incident report is not subject to the protections of the peer review privilege. Specifically, the Court stated:

> We do not believe that disclosure of this information invades upon the deliberative process of Westgate's Leadership Council. All it indicates is the basic facts around an event occurring a little over two months before the revisit survey. The details of the event, including the precise measurement of injuries and the time of the event, are not the type of information that would likely be readily available upon interview of the staff months later.

Centennial, supra at 294-295.

Following *Centennial, supra* there was briefly some dispute as to who was permitted to obtain the factual information in the incident report. This dispute was driven largely by the unpublished decision in *Maviglia v West Bloomfield Nursing & Convalescent Center, Inc*, unpublished per curiam opinion of the Court of Appeals decided November 9, 2004 (Docket No.

---

1 Within the Administrative Code, R 325.21104 requires the following information to be contained within a nursing home's incident or accident report: (a) name of person involved in accident or incident; (b) date, hour, place, and cause of accident or incident; (c) a description of the accident or incident by any observer who shall be identified and a statement of the effect of the accident or incident on the patient and any other individual involved; (d) name of physician notified and time of notification when appropriate; (e) physician's statement regarding extent of injuries, treatment ordered, and disposition of person involved; (f) corrective measures taken to avoid repetition of accident or incident; and (g) a record of notification of the person or agency responsible for placing and maintaining the patient in the home, the legal guardian, and, in a case where there is no legal guardian, the designated representative or next of kin. All of this information is similar to what would be seen in a hospital's incident or accident report.

248796) *Maviglia* held that the peer review privilege applied to civil litigants and not government agencies. While that decision may have briefly muddied the waters, this Court's subsequent decision in *Feyz v Mercy Memorial Hosp,* 475 Mich 663, 681 n52; 719 NW2d 1 (2006) resolved that conflict. In *Feyz,* this Court noted that the applicability of the peer review privilege does not depend on who is seeking the information.[2] Either a document is privileged or it is not.

Facts should never be privileged. The peer review privilege was not intended to conceal facts. The peer review privilege was not intended to prevent a patient or their advocate from knowing the facts of how an injury occurred. The peer review privilege was further not intended to allow a fraud to be perpetrated on the Court in the defense of the case, as was done in *Harrison v Munson Healthcare, Inc,* 304 Mich App 1; 851 NW2d 549 (2014). Where the facts of an incident are not disclosed in the medical record, discovery of the incident report, or at least an *in camera* review of the incident report, must be permitted. If not, how will anyone be able to advocate for our most vulnerable citizens?

B. FACTS ABOUT OBSERVATIONS MADE DURING AN IN-PATIENT STAY ARE MEDICAL RECORDS THAT THE LTCO AND RESIDENT ARE ENTITLED TO ACCESS.

The positions advocated for by Appellee and the LTCO are further supported by definition of a "medical record" stated in MCL 333.20175(1) and the Medical Records Access Act, MCL 333.26261, *et seq.* The Medical Record Access Act mandates that all patients have

---

[2] *See also Manzo v Petrella,* 261 Mich App 705; 683 NW2d 699 (2004) (holding that the discoverability of medical records, reports, and other information collected by peer review committees is not contingent upon the type of claim asserted by a subpoena proponent) and *Ligouri v Wyandotte Hosp and Medical Center,* 253 Mich App 372; 655 NMW2d 592 (2002) (holding that nothing in the plain language of statutes governing confidentiality of records, reports, and other information collected or used by peer review committees in the furtherance of their duties makes protection of quality assurance or peer review reports from subpoena contingent on the type of claim asserted by the proponent of the subpoena).

access to their medical records: "a patient or his or her authorized representative has **the right** to examine or obtain the patient's medical record." MCL 333.26265, emphasis added.

The scope of what encompasses a medical record is broad and includes all factual information that would be placed in an incident report. In accordance with MCL 333.20175(1), a health care facility is required to maintain a record for each patient that includes all observations made:

> (1) A health facility or agency shall keep and maintain a record for each patient, including a **full and complete record** of tests and examinations performed, **observations made**, treatments provided, and in the case of a hospital, the purpose of hospitalization.

(Emphasis added) In addition to MCL 333.20175(1), the Medical Records Access Act defines a "medical record" as:

> (i) "Medical record" means information oral or recorded in any form or medium that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a health care provider or health facility in the process of caring for the patient's health.

MCL 333.26263(i). Both of these definitions would cover the events that unfolded during Ms. Krusac's cardiac catheterization. Both of these definitions clearly show that factual information about a patient "in the process of caring for a patient's health" should be noted in the medical record and made available to the patient.

The Court of Appeals recently addressed the Medical Records Access Act in *Paul v Glendale Neurological Associates,* 304 Mich App 357; 848 NW2d 400 (2014). In analyzing the interplay between these subsections in the context of a worker's compensation medical examination, the Court noted:

> The MRAA provides in relevant part that "[e]xcept as otherwise provided by law or regulation, a patient or his or her authorized representative has **THE RIGHT** to examine or obtain the patient's medical record. MCL 333.26265(1). A

> "patient" means "an individual who receives or has received health care from a health care provider or health facility. MCL 333.26263(n). "Health care" means "any care, service or procedure provided by a health care provider or health facility to diagnose, treat, or maintain a patient's physical condition, or that affects the structure or function of the human body." MCL 333.26263(d). Finally, the MRAA defines "medical record" as "information oral or recorded **IN ANY FORM OR MEDIUM THAT PERTAINS TO A PATIENT'S HEALTH CARE**, medical history, diagnosis, prognosis, or medication that is maintained by a health care provider or health facility in the process of caring for the patient's health." MCL 333.26263(i).

Paul, supra at 363-364, emphasis added.

Michigan's broad definition of "medical record" is similar to the federal counterpart that is contained as part of the Health Information Portability and Accountability Act of 1996, 42 USC 1320d, *et seq*. 45 CFR 160.103 defines "health information" as:

> any information, including genetic information, whether oral or recorded in any form or medium that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; **the provision of health care to an individual**; or the past, present, or future payment for the provision of health care to an individual.

(Emphasis added) Certainly this definition encompasses the facts about what happened to a resident while they were admitted to a health care facility.

The above-noted authorities demonstrate a strong state and federal intent for residents to have the right to access a full and complete medical record that documents what occurred during their stay. In instances where federal law permits, the LTCO has the right to access that information as well. The right to a medical record is clearly meant to include the right to ALL resident information, whether it is positive or negative to the health care provider. If adverse events are included in an Incident Report, instead of the medical record, that <u>factual</u> information must be made available to the resident, their representative, and the LTCO.

C. APPELLANT'S POSITION VICTIMIZES VULNERABLE ADULTS AND IS INCONSISTENT WITH MICHIGAN'S STRONG PUBLIC POLICY OF PROTECTING VULNERABLE ADULTS FROM EXPLOITATION AND ABUSE.

To interpret MCL 333.21515 in the manner advocated by Appellant is inconsistent with Michigan's clear public policy of protecting vulnerable adults. Individuals who seek out a health care facility for their vulnerable adults do so with an immense amount of trust that their loved one will be properly taken care of. When something adverse happens, it should go without saying that the facts of what occurred should be given to the resident's advocate and, consistent with federal law, to ombudsman staff. Without the facts, how is the resident's family or the LTCO able to advocate for the resident?

If this Court adopted Appellant's position, its holding would be contrary to Michigan's strong public policy of protecting vulnerable adults. MCL 750.145m defines a vulnerable adult to include: "An individual age 18 or over who, because of age, developmental disability, mental illness, or physical disability requires supervision or personal care or lacks the personal and social skills required to live independently." Out of a strong desire to protect these individuals, our Legislature has taken steps to criminally punish individuals who victimize the elderly and disabled. MCL 750.145n states, in part, as follows:

> (2) A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the second degree if the reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm to a vulnerable adult. Vulnerable adult abuse in the second degree is a felony punishable by imprisonment for not more than 4 years or a fine of not more than $5,000.00, or both.
>
> * * *
>
> (4) A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the fourth degree if the reckless act or reckless failure to act of the caregiver or other person with authority over a vulnerable adult causes physical harm to a vulnerable adult. Vulnerable adult abuse in the fourth

degree is a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00, or both.

Id. The Legislature also adopted the Mozelle Senior or Vulnerable Adult Medical Alert Act, MCL 28.712. This statute established a system similar to the Amber Alert system for alerting authorities in multiple jurisdictions to elderly individuals and people with disabilities who are missing or unaccounted for.

It is beyond dispute that Michigan has a strong public policy that favors protecting vulnerable adults from abuse and exploitation. If this Court adopted Appellant's position, its holding would be contrary to Michigan's strong public policy of protecting vulnerable adults. The trial court's decision in *Krusac* should be affirmed.

CONCLUSION

A patient, resident, their authorized representative, or, in appropriate circumstances, their ombudsman, has a right to the resident's medical records. This right extends to all factual information available about the provision of health care. Given that "[p]rivileges ought to be strictly confined within the narrowest possible limits consistent with the logic of its principle,"[3] it is clear that this Court should affirm the findings of the trial court in *Krusac*. To do otherwise, would allow for health care facilities to hide adverse factual information in and incident report and inhibit the important individual and systemic advocacy efforts that federal law mandates that LTCO perform.

OLSMAN MUELLER WALLACE
& MacKENZIE, P.C.

Date: December 10, 2014

JULES B. OLSMAN (P28958)
Attorneys for *Amicus Curaie*

3 *Centennial, supra* at 289.

PROOF OF SERVICE

The undersigned hereby certifies that the foregoing instrument was served upon all parties to the above-cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings by first class mail this 10th day of December, 2014.

Brittney Dreyer

Brittney Dreyer

EXHIBIT 1

[redacted]

INCIDENT REPORT

Medical Care Facility

Confidential Review Document. This document is part of the records of a peer review committee, which has the function of professional review, reduction of morbidity and mortality and improvement of resident care. It is prepared and is absolutely confidential pursuant of MCL 331.531-553 and 333.20175.

Resident name: [redacted] Room No. 203 Unit S. S

Date of incident: 8-21-11 Time of incident: 2:25 am/pm

Location of incident: residents bathroom (203)

Description of the incident: Resident attempted to stand up off toilet and fell onto bathroom floor.

Injury: Yes ✓ No ____ Type: skin tear to ® arm, hip sore

Orthostatic BP: Lying 89/50 Sitting unable Standing unable

P 80 R 20 T 98.8° O2 sat 87% Accucheck N/A

Name of witness(es): ____

Name of legal guardian/responsible party contacted: [redacted] message left per supervisors Date: 8/21 Time: 5p top - 7p am/pm

Name of physician contacted: [redacted] per phone Date: ____ Time: ____ am/pm

Interventions initiated: BS sent to Hackley ER for evaluation + tx.

Level of Orientation/Cognition: A & O to person & place

Nursing Assistant assigned to resident: [redacted]

Transfer type 2 person			Call light on	Yes	(No)	N/A	Wheelchair locked	Yes	No	(N/A)
Floor wet	Yes	(No)	N/A	Call light in reach	(Yes)	No	N/A	Bed low-position	Yes	No	(N/A)
Walker used	Yes	(No)	N/A	Restraint on	Yes	(No)	N/A	Amb. w/help	Yes	No	(N/A)
Cane used	Yes	(No)	N/A	Restraint order	Yes	No	(N/A)	Brief dry	(Yes)	No	N/A
Footwear present	(Yes)	No	N/A	Restraint on correctly	Yes	No	(N/A)	Time resident last toileted 2:25			am/pm
Alarm present	Yes	(No)		Glasses on	Yes	(No)	N/A	Falls Assessment done	(Yes)	No	N/A
Alarm sounding	Yes	(No)		Showered recently	Yes	(No)	N/A	Wanderguard checked	Yes	No	(N/A)

Was there mechanical equipment failure Yes (No) N/A

If yes, Facility Medical Device Report completed Yes No (N/A)

Documentation of incident in the medical record (Yes) No N/A

Care Plan & profile re-evaluated and modified (Yes) No N/A

Any complaints of pain (Yes) No

Report completed by: Charge Nurse signature [redacted] RN signature [redacted]

Reviewed by R.N.: [redacted] Reviewed by Medical Director: ____

Reviewed by Administrator: ____

HCR ManorCare

INCIDENT REPORT - PATIENT INVOLVED

This Report is prepared for purposes of Quality Assurance, and is confidential pursuant to applicable state and federal law, including but not limited to the peer/professional review, work product, and self-evaluation privileges/protections.

Center: 4044 Patient's Name: [redacted]

Center Address: [redacted]

INCIDENT DESCRIPTION AND INVESTIGATION

Date of Incident: 2/7/12 3:09 pm Location of Incident: Shower Room

Description of Incident: Type: Fall without injury (or minor i

THE CENA WAS TRANSFERRING PATIENT FROM W/C TO SHOWER CHAIR WHEN SHE LOST HER BALANCE AND FELL TO THE FLOOR SKIN TEAR NOTED TO L ARM AND BUMP NOTED ON L SIDE OF FOREHEAD

MEDICAL DEVICE

Was a medical device involved? No If yes, type of device:

Manufacturer or Brand Name: Model Number:

CENTER ACTION: PHYSICIAN NOTIFICATION

Was physician notified? Yes If yes, Date: 2/7/12 3:10 pm

Physician name: DR. [redacted] By whom notified: TIFFANY [redacted]

CENTER ACTION: PATIENT'S CARE

Was patient seen by a physician at the center?: No If yes, Date:

Physician name:

Describe care and medications, if any, provided to patient following incident, and by whom provided:

NEURO CHECKS IN PLACE PER PROTOCOL, THOROUGH ASSESSMENT NOTED TX TO SKIN TEARS ON LARM

Was patient taken to a hospital? No If yes, Date:

Where: By Whom:

CENTER ACTION: PATIENT FAMILY/GUARDIAN NOTIFICATION

Name of person notified: [redacted] Date notified: 2/7/12 3:10 pm

Notification method: Phone Conversation Name of staff person notifying: [redacted] LPN

Person Preparing Report Name and Title	Signature	Date

Administrative Signature	Date

Administrative Director of Nursing Signature	Date

Medical Director Signature	Date

Reported By: [redacted], Twana Status: Completed

Date/Time created: 2/7/2012 3:11:31PM Printed: 2/28/2013 1:37:11PM

HCR ManorCare

INCIDENT REPORT - STATE ADDENDUM

Michigan

Center: 4044 Allen Park

Describe cause of incident, if known:

PATIENT WAS BEING TRASFERRED FROM W/C TO SHOWER CHAIR BY THE CNA

Corrective Action: Describe corrective action taken following incident, if applicable:

RE-EDUCATED CNA ON PROPER TRANSFER TECHNIQUE

[redacted]

1. Extent of Injuries	As Indicated in incident report
2. Treatment Ordered	As Indicated in incident report
3. Disposition of Patient	Patient remains at center

Signature of Physician [redacted] | Date

Patient's Name (Last, First, MI)	Attending Physician	Room Number	Patient Number
[redacted]	[redacted]		

UNUSUAL OCCURRENCE

This document is part of the records of a Quality Assurance Committee and is a professional review for reduction of morbidity and mortality and improvement of resident care. This document is not part of the medical record and remains confidential pursuant to MCL 331.521.533 and 33.20175.

Date/Time of Incident 7/9/10 Time: 535 ☐ AM ☒ PM

Facility Name: EGSCB

Resident Name [redacted] Gender ☐ Male ☒ Female

Room No. 31 32

Date/Time Filing Report 7/9/10 Time: 556 ☐ AM ☒ PM

LOCATION OF INCIDENT

☐ Residents Room ☐ Hall ☒ Dining Room 300 Hall ☐ Bathroom ☐ Outside ☐ Other

Specify: Resident was dozing in w/c just minutes prior

TYPE OF OCCURRENCE

☐ Fall ☒ Observed on Floor ☐ Injury of Unknown Origin ☐ Altercation ☐ Bruise ☐ Skin Tear
☐ Lowered to Floor ☐ Misappropriation of Resident Property ☐ Allegation of Abuse or Neglect
☐ Elopement ☐ Other

If other, specify: _____

IF APPLICABLE TO THIS EVENT DOCUMENT THE FOLLOWING

Diagnosis

B/P 200/98 T 97.4 P 88 R 21 O_2 Sat 95% Accu-v 93

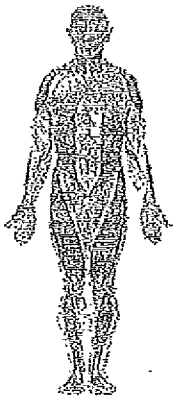
Drugs given in last 24°: See mars.

EQUIPMENT INVOLVED

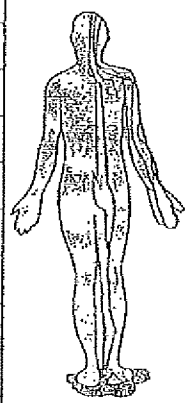
☐ Yes ☒ No If yes, explain:

Physical Assessment Abnormalities

Diagram and Number the Injuries from this Event



Number	Injury	Description
	Bruise	
	Abrasion	0 injuries
	Skin Tear	
	Laceration	
	Fracture	
	Sprain	
	Hematoma	
	Burn	
	Other	



PHYSICIAN NOTIFIED: ☒ YES

Physician's Name Dr. [redacted] Time/Date 7-9-10 1645

Physicians Instructions (document in clinical record also)

Physician Statement with Date

Ø N.O - (Dr Also made Aware of ↑ BP)

FAMILY CONTACTED: ☐ YES ☒ NO If not were you able to leave a message asking them to call the facility ASAP ☒

Time: 5555	Date: 7-9-10	Name of Contact [redacted] Spouse	Phone Number 969-9365

WITNESS: ☐ YES ☒ NO If Employee, no address etc needed

Witness Name(s)	Address	City, State, Zip	Phone Number

ITEMS WITNESSED AND IN PLACE AT TIME OF EVENT: CHECK ALL THAT APPLY

☐ Low bed	☐ Reg Bed	☐ Bed locked	☐ Gait Belt used	☐ Grab bars
☒ Footwear in place	☐ w/c locked	☐ Walker/cane in use	☐ Wedges in place	☐ Specialty bed
☐ Call light within reach	☐ Call light on	☒ Alarm in place, if yes type clip	☒ Alarm sounding	
☐ Bed rail(s) up - note type and side				

☐ Ambulating, if yes ____ Independently ____ with assistive device per care plan ____ with assistance

☐ Transferring, if yes ____ Independently ____ with assistive device per care plan ____ with assistance

Other: ____

Physical restraints in use: Yes ____ No X Type: ____

INCIDENT OCCURRED DURING TRANSFER:

☐ Bed to chair ☐ Chair to bed ☐ Bed to w/c ☐ w/c to bed ☐ Toilet transfer ☐ Lift

IMMEDIATE INTERVENTION/PREVENTION MEASURES TAKEN
CIRCLE AND DOCUMENT ALL NEW INTERVENTIONS INITIATED BECAUSE OF THIS EVENT

Transfer to Hospital	Provide diversional activities	Check resident every ___ minutes x ___ hours
Bowel/Bladder Assessment	Wheelchair	Neuro Check
~~Falls Risk~~	Cushion	Sensor Alarm
~~Pain Assessment~~	Perimeter Mattress	Hip Protectors
~~Smoke Assessment~~	Long or soft touch call light	Alarm bracelet
Therapy Assessment	Protect/long sleeves	Safe outdoor assessment
X-ray ordered (stat)	Bedside Mat	Floor pad/mat
On-site First Aid	Low Bed	Assistive device
Labs ordered	Smoker apron	Bed Bolsters
CPR	Chair and/or bed alarm	Safe Smoking
Non-skid footwear	W/C Wedge Cushion	Lotion
Reacher stick	Assess for Postural Hypotension	Padding added
Emergency 24 hour Restraint	~~Observe for bruising~~	Fingernails clipped
Commode at bedside	Re-arrange room/furniture	Non-skid pad
Keep light on	Re-arrange personal care items	

Other Intervention/prevention measures taken: Lay down when tired.

CNA Assigned: [redacted] Nurse Assigned: [redacted]

Signature of person completing this report: [redacted] Date: 7-9-10

Printed name of person completing this report: [redacted]

Care Plan Review & Update—Date: 7-9-10 By: [redacted]

Physician Signature: [redacted] Date: 7-15-10

DON: [redacted] Date: 7-15-10

Administrator: [redacted] Date: 7-15-10

Interdisciplinary Team Review Date: 7-12-10

NC-34

EVIDENCE OF INVESTIGATION OF UNUSUAL OCCURRENCE

Facility [redacted] Date 7-12-10

Resident Name [redacted] Room Number 313-2

Date of Occurrence 7-9-10 Time 535 PM Location 300 diningroom

Person in charge of investigation [redacted]

Person completing this form [redacted]

Brief description of Occurrence: Fell in diningroom

Was there an injury? Yes _____ No X

If yes, please describe: _____

To whom (family, doctor, state agency, attorney general, police, etc.) was the occurrence reported?

[redacted]

Name of reporter [redacted] Method of report (fax, phone, etc.) phone

Report time: 610 PM Date: 7-9-10

When and how was the person who reported this occurrence alerted about the occurrence?

MARIA DOWNING

Was the location of the occurrence examined? Yes X No _____

If yes, specify area _____

Was there an examination by a physician? Yes _____ No X

If yes: date of exam _____ time _____

Resident name _____ Physician name _____

Physician findings: _____

Were resident or employee records reviewed? Yes X

Was any other documentation or record reviewed? Yes X No _____

If yes, please identify _____

Is resident on a behavior management program? Yes _____ No X

If yes, what are behaviors _____

For each interview performed, please list the name of the person being interviewed, their title, reason for their interview (what information they may have), interviewers name and date interview took place. (attach additional paper if necessary)

For example: Pete Plumber, Maintenance Director. Pete was the second person on the scene. Interviewed by Nancy Nurse, 1-1-07.

[redacted]: Res ↑ in w/c in 300 hall dining room, dozing in w/c. Alarm sounded & resident found on floor.

After this investigation the following conclusion was drawn:

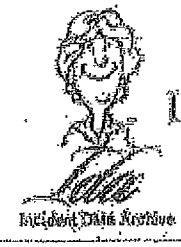
NO harm occurred X

Harm was NOT the result of abuse, neglect or misappropriation ____

Brief description of conclusion: Res fell from w/c in dining room while dozing.

Brief description of plan to avoid this situation in the future (if applicable). Include referrals to the Quality Assurance Committee, employee training, interdisciplinary team review, equipment or building modifications, updated care plans, corrective action implemented at the time of occurrence, Medical Director involvement, policy review, etc.

Lay down in bed as resident allows when tired.



Incident/Accident Data Entry Questionnaire

Life Care Centers of America, Inc.

Report Author : [redacted]	Date/Time : 3/27/2009 5:20:00 AM
Facility : [redacted]	Incident ID : [redacted]

Preliminary

Preliminary Information

Last Name	[redacted]
First Name	[redacted]
Gender	Female
Assigned Room Number	413-1
Type of Incident Alleged	Fall
Level of Incident	Level III

Injury Description

Type(s) of Injury - Check all that Apply.	Fracture
Body Part(s) Affected - Check all that Apply.	Hip

Outside Care

Was outside care needed to treat and/or diagnose this injury?	Yes

Incident

Incident Location

Did Incident Occur Inside or Outside the Facility?	Inside

Inside Location

Unit where Incident/Accident occurred	Sub-acute Care
Wing where Incident/Accident occurred	Other
Floor where Accident/Incident occurred	First

Occurrence?

Full Description of Incident/Accident	Nurse heard noise and found resident on floor on left hip, holding left forhead, complaining

Report Author : [redacted]	Date/Time : 3/27/2009 5:20:00 AM
Facility : [redacted]	Incident ID [redacted]

of left hip pain. Resident was cyanotic and lethargic.

Witness

Was incident witnessed?	No

Discovery

Person who discovered Incident - Last Name	[redacted]
Person who discovered Incident - First Name	Rebecca
Person who discovered Incident - Title	RN

Resident Condition Before

Resident`s Mental Function before Incident/Accident	Alert/confused
Was Resident non-compliant with care or transfers?	No
What is the Resident`s functional mobility?	Transfers - Need Assistance

Resident Activity

Activity at the time of the incident? Check all that apply.	In bed

Assistive Devices

What Resident Assistive Device was in use at the time of the incident?	Other

Restraints

Were any Restraints in use at the time of the Incident?	No

Resident Condition

Resident`s Mental Function after Incident/Accident	Alert/Confused

Vital Signs

What was the Resident`s temperature immediately after the Incident?	97.6
What was the Resident`s Pulse immediately after the incident?	65
What was the Resident`s Respiratory Rate?	16
What was the Resident`s Blood Pressure immediately after the incident?	129/65
Describe the Resident`s Intensity of Pain after the incident. (using the pain scale)	7 - 10

Report Author : [redacted]	Date/Time : 3/27/2009 5:20:00 AM
Facility : [redacted]	Incident ID : [redacted]

Physician/NP Info

Physician Notified/NP - Last Name	[redacted]
Physician Notified/NP - First Name	[redacted]
Date/Time of Physician/NP Notification	3/27/2009 5:30:00 AM
Brief Summary of Physician's/NP's Response or Orders	Transfer to hospital for eval and treatment

Representative Info

Family/Legal Representative Notified - Last Name	[redacted]
Family/Legal Representative Notified - First Name	[redacted]
Family Relationship to Resident	Spouse
Date/Time Family /Representative Notified	3/27/2009 5:40:00 AM
Method of Notification	Spoke with someone
Was any other Family Member notified?	No

First Aid

Was first aid administered at the facility?	Yes

First Aid Info

Type of first aid provided	neuro checks, and applied oxygen and ice pack
Who provided the first aid?	[redacted]
Date first aid was provided	3/27/2009
Time first aid was provided	5:30:00 AM

Outside Care Information

What type of outside care was utilized?	Hospital Emergency Department
Hospital or UCF Name	Henry Ford Wyandotte Hospital
Date taken to the ER or UCF?	3/27/2009
Time taken to the ER or UCF?	6:00:00 AM

Actions

What immediate actions were taken to provide safety for the resident and/or others?	Assessed resident for pain, assisted to bed, applied oxygen

Report Author : [redacted]	Date/Time : 3/27/2009 5:20:00 AM
Facility [redacted]	Incident ID [redacted]

Supervisor Info

Supervisor Last Name	[redacted]
Supervisor First Name	[redacted]
Supervisor Title	RN

Investigation

Occurrence Detail

Specific Location (check all that apply)	Hallway
Was an associate involved or providing care at time of the incident?	No

Data Entry

Person Entering Ida Data - Last Name	[redacted]
Person Entering Ida Data - First Name	[redacted]
Person Entering Ida Data - Title	RN

Current Status of Resident

How is Resident now?	Hospital Admission

Diagnoses

Primary Diagnosis	S/P back surgery
Primary Diagnosis	Dementia

Medication Usage

Were any one of the following medications in use at the time of the incident?	
List any drugs and date started within the last 14 days.	

Falls

Resident's Mobility Status? Check all that apply.	Unsteady Gait
Is the Resident Incontinent? (If yes, what type of toileting program)	No

Barriers

What if any, of the following barriers potentially contributed to the Incident? Check all that apply	No Barriers Noted
Was the floor wet? (If yes, with what substance?)	No

[redacted]

Facility : [redacted]

Resident Fall Detail

Fall Category As Defined By CMS	Fall with or w/o Injury
Was fall Attended/Unattended?	Unattended
What position was the Resident in when you found them? (e.g.,Resident found flat on back)	Laying on left hip on floor
Did the Resident have access to a call light when he/she fell?	N/A
Was call light on at time of incident?	N/A
When was the last Fall Risk Assessment done?	Admission
What was the Fall Risk Assessment score?	16
What fall reduction measures were in place at time of incident?	Chair alarm
What fall reduction measures were in place at time of incident?	Bed alarm
What fall reduction measures were in place at time of incident?	Low bed
Has resident fallen previously?	No

Hip Protectors

Is the resident a candidate for hip protectors?	No
If resident is not a candidate for hip protectors, reasons why. (Choose all that apply.)	Other
Were hip protectors on at the time of the fall?	N/A
If refused, reasons for refusal. (Check all that apply)	
If refused, was waiver signed?	

Consciousness

Was there a loss in Consciousness?	No
Were neuro-checks completed per protocol?	Yes

Care Plan/Chart

Date care plan reviewed and updated	3/27/2009
Date alert charting initiated	3/27/2009
What interventions were in place at the time of the incident?	low bed, personal alarm in bed and w/c
What interventions are in place now?	resident admitted to hospital will initiate

Report Author : [redacted]	Date/Time : 3/27/2009 5:20:00 AM
Facility : [redacted]	Incident ID : [redacted]

upon return: low bed, sensor pad to bed, velcro alarm seatbelt to w/c and mat at bedside.

State

Is this a state reportable incident?	No