Narrative on MA, dob **/**/***, compiled **/**/** by Steven J. Arnold, MD. [REDACTED]

Comments below are given after review of the following records:

a. ***** Fire EMS Run Report dated 08/26/****.
b. *****, M.D. records dated 7/22/2015 to 8/07/****.
c. ***** Hospital records dated 8/04/**** to 1/01/****.
d. ***** Medical Center records dated 10/02to 10/05/****.
e. ***** ALF records dated 10/21/**** to 8/26/****.
f. ***** Hospice records dated 3/14 to 8/26/****.
g. Death Certificate.
h. Complaint prepared for filing in ***** County Common Pleas Court entitled *****

Abbreviations used in this narrative:

***	*****, MD
***	***** EMS
***	***** Hospital
***	***** Medical Center
***	***** ALF
***	***** Hospice

MA was an 86 year old female with a medical history of Dementia with Psychosis at the time of her death. On 9/27/** she had a visit with her PCP who did a Mini-Mental Status Exam with a score of 22 indicating a mild neurocognitive disorder (*** p 35). On 5/19/** she had another visit with her PCP, at which it was noted she was having some auditory hallucinations (*** p 45). On 8/4/** she was seen in ***** ED for hallucinations; she was assessed as a UTI and was put on a course of levaquin (*** pp 32-50; *** p 22). Seen for a followup with her PCP on 8/9/** her daughter noted she was still hallucinating and the provider began filling out guardianship papers (*** p 49).

On 10/1/** she was again seen at ***** ED for altered mental status at the behest of her PCP; this was done with the expectation she would be admitted long enough to place her in an extended care facility due to the increased difficulty caring for her. As it was, workup was unremarkable and she was assessed as worsening dementia. Since she did not meet admission criteria she was sent home with advice to the family to look into safer living arrangements for her (*** pp 51-107). Dissatisfied with this the family then took her to ***** Medical Center on 10/2/** (*** p 5); she was admitted, seen by Neurology who adjusted some of her meds (*** p 1) and then discharged on 10/5/** to ***** SNF. Of note, her dysphagia screen during this admission was negative (*** p 86).

At ***** SNF her diet order was recorded as 'regular' (*** p 496). On 10/20/** she moved to *****, an ALF. A SLUMS exam on 10/21/** scored 17, indicative of dementia (*** p 387, compare to the 9/27/** result) and a Falls Risk Assessment the same day was 12, indicating 'high risk' (*** p 381). The record remarks repeatedly on her bouts of confusion, disorientation, and delusions. On 3/11/** she was seen at ***** ED again for altered mental status and slurred speech but her symptoms resolved spontaneously. She was seen by Neurology, assessed as TIA and returned to the ALF with plans for a non-urgent MRI (*** pp 108-159). She was seen by the NP on 3/15/** who noted Neurology's recommendations and started her on Zyprexa. The record does not show the MRI was ever done, but this is not relevant to her case.

On 4/9/** she was demonstrating increased agitation and was admitted to ***** Behavioral Health (*** p 358). During this time she was noted to have elevated ammonia levels and was started on lactulose (*** p 207); her SLUMS score now had declined all the way to 3 (*** p 386). She returned to

the ALF on 5/18/** and her physician orders for this month specified a regular diet (*** p 200). A Nurse note on 5/21/** noted she was pocketing food (*** p 357) and on 5/24/** she was seen by the NP who noted the staff's report she was having difficulty chewing and ordered a Speech Therapy eval (*** p 98). This was done on 5/28/** and no new recommendations were made (*** p 357; the record only contains a nurse note regarding this, and no actual copy of the eval).

On 8/13/** she was seen by her attending physician who noted the staff had told him the patient was again pocketing food and having difficulty swallowing some meds (*** p 69). The date of this visit can be verified by the fax time stamp of 8/16/** on the top of the attending's note. He ordered a mechanical soft diet and a Speech Therapy eval (*** p 247). A repeat SLUMS score on 8/28/** was now zero (*** p 385).

At this point it is important to digress to a secondary issue. At several points in the record MA's gait was noted to be unsteady (*** p 356) and her Falls Risk Assessment on 5/12/** was now up to 15 (*** p 380). On 7/15/** she was found to have a bruise on her left bicep (*** p 356). While her POA was alerted to the injury, there is no record of a call being made to her attending physician. On 7/17/** she was found sitting on the floor (*** p 356). In this population this usually indicates an unwitnessed fall; in any case it should be treated as such but there is no record of a post-fall risk assessment, neuro checks, or any other interventions. As it was, over the next year she had a total of *19 instances* of being found on the floor, sometimes in facility common areas, and *9 actual witnessed falls* (*** pp 354, 352, 351, 350, and 349). Some of these resulted in injury, such as a laceration to her head (this on 8/14/** in which the family and Hospice were notified, but again apparently not her attending physician [*** p 349]).

On 1/1/** she was complaining of right wrist pain and swelling (*** p 353), but there had been no witnessed fall (*** p 176). Xrays done at the ALF showed a mild-to-moderately displaced comminuted fracture through the distal left radial metaphysis and a mild ulnar styloid avulsion fracture. Though no injury had been reported, this type of injury usually is the result of a fall onto an outstretched hand (see American Academy of Family Physicians. (n.d.) *Common fractures of the radius and ulna.* Retrieved 8/7/2023 from https://www.aafp.org/pubs/afp/issues/2021/0315/p345.html). She was seen at ***** ED, put in a volar splint and advised to follow up with Orthopedics (*** p 180). This was done on 1/13/**, the fracture was reduced, the wrist was splinted, and she was given tramadol on a prn basis for pain (*** p 9).

On 2/9/** the ALF nurse notes record receipt of an order for a Speech Therapy eval (*** p 352); this is the first mention of any ST services since the attending physician's order of 8/13/**, six months prior. Again there is no record from ST of an evaluation, or their findings, or even if the evaluation was done. The NP note for 2/18/** mentions the 2/9/** order but also states she was still waiting for the results of the eval (*** p 29). The NP notes the wrist cast was affecting the patient's feeding and stated furthermore 'Issues with eating or *incorrect diet* could be attributing (sic) to weight loss' (emphasis added). It is unclear specifically what she meant by this statement aside from alluding that MA's diet order was not suitable. The record does not confirm that MA was on a mechanical soft diet, as per the attending physician's prior order, at this time.

On 3/14/** the patient was opened to hospice (*** p 243). The hospice admission note makes a useful summary of her course and mentions that she was recently pocketing food (*** p 5).

On 4/22/** she was seen by the NP who noted she was eating a regular diet (*** p 20) and on 6/3/** the NP reported the staff reported 'no… issues while eating' (*** p 18). On 7/25/** she was pocketing food again (*** p 89); a Nutritional Assessment by Hospice on 8/1/** noted difficulty chewing and swallowing and pocketing of food, but no new interventions were mentioned aside from educating the staff about appetite decreases in the terminally ill patient (*** p 1198). On 8/14/** she was found

to be COVID-19 positive and was placed in isolation. On 8/22/** the hospice nurse was assisting her to eat and noted once again she was pocketing food (*** p 831).

On 8/23/** the ALF nurse noted MA had developed a left facial droop, was drooling, and was unable to follow commands (*** p 349). Hospice was notified and saw her that night. They reported she could not swallow but there is no mention of a call to her attending physician (*** p 831), only that the facility nurse was updated on her condition. She was seen again by Hospice the following day where they noted staff's report that she had not been eating or drinking well, or talking much, for some days (*** p 832). A nutrition plan for that date (8/24/**) remained unchanged (*** p 1351) and the associated nutrition assessment recorded she was on a regular soft diet (*** p 1348). Later that evening she was found on the floor again and was still having difficulty swallowing. Hospice agreed to bring in thickened liquids for her (*** p 349).

On 8/26/** she was seen again by the NP who reported her diet had recently changed to thickened liquids and mechanical soft (it would appear this is in relation to Hospice's response on 8/24/**, though there is no order in the record to support this) (*** p 12). A neuro exam was not done and there was no mention of a facial droop. That evening at 1630 she was in the dining room and began choking. She was found to have a grilled cheese sandwich stuck to the roof of her mouth and became cyanotic. The staff called 911 who talked them through a Heimlich maneuver which was successful in dislodging a grape and seemed to resolve the issue (*** p 349), but EMS arrived shortly thereafter and noted she was still unresponsive and not breathing (*** p 2). They moved her into the ambulance where a pair of forceps were used to extract another (unspecified) piece of food. By then they had her DNR order in hand and terminated their efforts to resuscitate her, and she passed shortly afterwards.

In summary:

The most egregious issue regarding MA's death is the fact that she was eating grapes and grilled cheese at the time she began choking. Neither of these are considered a 'mechanical soft' diet item and, given that her attending physician had ordered a new diet *a year prior*, should never have been offered, or even anywhere within reach (especially given her very poor mental state). There is nothing in the record to indicate his order was implemented, much less that it may have at some point been rescinded, but the record does state on a number of subsequent dates that she was persistently on a regular diet. Furthermore the CVA-like episode of 8/23/** should have prompted an immediate diet downgrade which likewise is nowhere recorded.

In addition, her remarkable record of falls, witnessed and otherwise, the lack of followup by the staff and Hospice to these incidents, and the lack of efforts to notify her providers of her changing conditions, would seem to represent a serious lapse of adequate supervision. It is possible that effective interventions could have been made if only her providers had been fully aware of what was happening, and I feel this carelessness at least secondarily contributed to her death.

Thank you for the opportunity to review this case. Please let me know if you have any questions or concerns.

Respectfully submitted,

Steven J. Arnold, MD