

Connie B's story illustrates the importance of implementing and enforcing the 2016 CMS regulations to improve care and supervision at Skilled Nursing Facilities, specifically the regulations regarding:

- Person-centered care
- Staff training and communication
- Staff competency in identifying changes in a resident's condition, as well as the obligation to report and investigate those changes
- Continuity of treatment for psychological and behavioral health

Connie B died at French Hospital on January 21, 2018, after spending about 6 weeks at BV Transitional Care. The death certificate shows her cause of death as sepsis/urinary tract infection.

Connie was 74 years old. She was admitted to BV after being hospitalized for a broken hip. Before that injury, Connie was walking and living independently in an apartment, with support from an in-home-support services caregiver and her family.

Connie had been totally blind since the age of 15. She was hearing-impaired, and had very limited use of her hands and arms due to severe burns she suffered over 50% of her body in an accident in 1967. She had also been diagnosed with bipolar disorder and schizophrenia due to post-traumatic stress disorder. Connie had been treated by the same psychiatrist for many years, and – before she was hospitalized – was stable on a specific regimen of psychiatric medications. Her brother reported that Connie was very sensitive to changes in the brand or amount of medication and the medication schedule.

After surgery for her hip, Connie had difficulty swallowing; while she was in the hospital, a PEG tube was placed to provide nutrition and hydration. She was working with a speech therapist at BV so she could resume eating. Connie and her family expected she would return to her apartment.

Connie's brother Les was her health care agent and is her executor. He visited Connie at least three times every day she was in the hospital and at BV, for as much as two hours each time.

He had many concerns about her care, and contacted the local Long Term Care Ombudsman office. Les has given written permission for information and photographs of Connie to be used for advocacy purposes.

Here are some of the major issues Les identified:

- Delays at Admission. Connie arrived at BV from the hospital on a Sunday afternoon without medical records or any documentation of her condition. She was laid flat in bed (patients with PEG tubes are supposed to have their heads elevated at all times), and no one came to admit her for 1-1/2 hours. The aide who came to change her diaper during that time was about to roll her onto her injured hip before Les intervened.
- Lack of Continuity in Care. Connie had been receiving psychiatric care for many years for depression, anxiety, and post-traumatic stress disorder (related to the fire). She was stable on medication prescribed by her treating doctor. The psychiatrist at BV, Dr. W, never consulted with Connie's treating psychiatrist. Les offered Dr. W records of her treatment and psychiatric history, along with his many years of observations of her condition, but said that Dr. W refused to review the records of Connie's treatment or discuss it with him. He reported Dr. W's response to offers of information as "let us do what we think is best for Connie." When Les reviewed Connie's medical records from BV, he found that she had been given different psych medications on a schedule different from the one she had been following prior to her hospitalization.
- Staff Not Trained or Oriented to Connie's Condition. Aides and other staff that came to provide care was often unaware of Connie's conditions – particularly her blindness – and did not take routine measures to ensure her safety and comfort, like returning her tray table, call bell, tissues and other items before leaving the room. Connie needed the tissues because she had to clear her mouth of phlegm often on account of the PEG tube. Connie's call bell was often placed out of reach.
- Because of the PEG tube, Connie was not supposed to take food or water by mouth and had an "NPO" order. Les came into the room one day just as an aide was offering

Connie a glass of water. The aide told Les she didn't know that Connie was NPO and had said "I'm thirsty."

- The Director of Nursing told Les that the staff assigned to Connie on each shift got information about Connie at report, but sometimes the CNA assigned to her was not available when Connie needed assistance and the aide who responded did not know about her particular needs. After Connie had been at BV for more than a month, Les met with the Director of Nursing, who suggested that Les prepare a list of the "top 10 things people should know about Connie" that would be posted on her bed to inform and/or remind staff of necessary procedures.
- Failure to Respond to Changes in Condition. Connie was upset by a resident screaming during the night of 1-12 and became very anxious and restless. She dislodged her PEG tube, and was combative with staff that tried to assist her. She was sedated and sent to the hospital on 1-13, to have her PEG tube was reinserted. She returned to BV the same day.
- Connie continued to be agitated. Les warned staff that her condition could deteriorate unless her medication routine was adjusted. Staff told him that Dr. W only came once a week and would not see Connie until 1-19. At that time, Dr. W prescribed Lorazepam, a medication she had had been removed from previously. Les told Dr. W and BV staff that Connie had not tolerated that drug in the past, and Dr. W again told him "Let us do when we think is best for Connie."
- Connie got her first dose of Lorazepam the next day and, within a few hours became unresponsive. BV sent her to the hospital about 4 hours later. The ER doctor found she had a urinary tract infection. The hospital also did an MRI of her brain, which the ER doctor said showed a recent stroke. Connie died at the hospital within hours of arriving.

Connie's experience demonstrates so many common shortcomings in the treatment patients receive in licensed skilled nursing facilities. Rolling back recent regulatory changes that require care that is truly patient-centered with a trained staff informed of each patient's needs leaves people like Connie at risk of injury and death.