1855 Jersey Street
Quincy, Ill. 62301
August 24 2006

Rep. Patrick M. Natale, Esq.
Room 167
The State House
Boston, MA 02133 – 1020

Dear Representative Natale:

I do not know if you perused the article in the Boston Globe on 7/3/06 regarding “nursing homes seen [as] deficient on basic care” by Alice Dembner; but allow me to reiterate certain salient points. According to this article “[m]ore than one-third of all hospitalizations of nursing home residents could be prevented if nursing staff recognized symptoms of increasing illness sooner and doctors were more readily available at the nursing homes…” According to Mary E. McKenna, Massachusetts chief consumer advocate for nursing home residents, “[t]hings get overlooked until a hospitalization is unavoidable…”

Allegedly the state is targeting four conditions that frequently culminate in avoidable hospitalizations – i.e., chronic pulmonary disease, congestive heart failure, urinary tract infection, and dehydration. I hope this is true, but unfortunately this effort has come to late to prevent the untimely, painful demise of my father.

Permit me, in the following chronology, to delineate how repeated, avoidable hospital transfers lead to the decline in my father’s health and ultimately to his death.

During the summer of 2004, my father was admitted to Winchester Hospital for cellulitis in his lower extremities. The Winchester Hospital (WH) case manager discharged my father to the Peabody (Kindred) rehabilitation hospital allegedly for “rehabilitation;” some rehabilitation was provided. Then, upon readmission in December 2004, my sister observed that my father received little if any rehabilitation, that he was overmedicated, that there was not sufficient staff to attend to patients (e.g., patients were left in bed unattended and in various states of dress), and that he fell twice while in their “care.” The family was notified of the first fall. The second fall occurred during a one week stay in December 2004; the staff never notified my sister; she learned of this fall by reading my father’s medical chart. His attending physician agreed that my father could be released home but the nursing staff was obstructionist. However, based on the non-existent rehabilitation and lack of care, my sister had my father discharged.

My father’s health appeared stable for approximately 8.5 months. He was then admitted to Winchester Hospital again for confusion, congestion, and cellulitis in his lower extremities. He spent approximately eight days there. The WH case manager didn’t want to release my father allegedly because he had manifested high blood sugar and poor nutrition, and he wasn’t receiving rehabilitation. Thus, my father was discharged to the Arnold House in Stoneham (see attachment 1 for the chronology of hospital/nursing home events).

My father spent seven days at Arnold House, during which time he received no rehabilitation and no dietary modifications – i.e., Arnold House did not institute a “no salt” diet. The poor diet administered at Arnold House exacerbated my father’s cellulitis and he was readmitted to Winchester Hospital.

The WH case manager was less than helpful. She gave my sister the impression that nursing homes were discriminating against my father because of his weight and that he was lucky to find any facility that would be willing to take him. She obviously was not advocating on behalf of a high risk patient to receive the best available care. She told my sister that Lexington Health Care (LHC) was the only facility available and that my father would receive rehabilitation/physical therapy.

My father spent approximately forty three days at LHC, during which time he received very little rehabilitation/physical therapy. During these forty three days, my sister observed nursing aides manhandling my father during hoya transfers. His leg wounds were not properly attended - e.g., bandages were not regularly changed, and were not covering the wounds. The LHC staff also tried to blame my mother for their lack of supervision which resulted in his falling out of bed. On 10/23/05 my father was transported to Winchester Hospital and he presented with a urinary tract infection (UTI), leg infections, and chest infection.

Again, in the hands of a case manager who was apparently indifferent to the needs of a high risk patient, my father was transferred to Blaire House in Tewksbury on 11/7/05 where he spent thirty eight days. On or about 11/14/05, he fell and was transported to the Lowell Hospital ER for x-rays. Then on 11/15, Blaire House staff, on their own initiative, without consent from the family, decided to send my father to Lawrence Memorial in Medford allegedly because they thought my father was difficult to deal with. My sister then had my father transferred to Winchester Hospital where he again presented with urinary tract infection (UTI), cellulitis, and other maladies. What patient wouldn’t be difficult to deal with when potentially overmedicated/immunosuppressed (see attachment 2 - dose of effexor, according to a pharmacist, was higher than warranted; a black box warning exists for seroquel and oral clearance is reduced by 40% for elderly patients) and struggling to fight infections that an indifferent and/or incompetent staff continued to ignore?

During this sojourn at Winchester Hospital (12/15/05 - 1/3/06), my sister indicated to the nursing staff that she was discussing my father’s medication regime with Dr. Arslanian, to which the “caring” nursing staff replied that “Dr. Arslanian wanted nothing to do with Warren.” This less than professional conduct notwithstanding, my sister saw Dr. Arslanian on 12/18/05 to discuss my father’s treatment and medications.

From 12/15/05 - 1/3/06 my sister was trying to place my father in a facility that manifested a better quality of care. Unfortunately the WH case manager consigned my father to one of the worst nursing homes in the state (as documented by Medicare) – i.e., Harborside in Wakefield, which had repeated quality of care issues such as the inability to provide “each resident care and services to get or keep the highest quality of life possible,” and the inability to “give each resident enough fluids to keep them healthy and prevent dehydration.” These blatant quality of care deficiencies greatly exacerbated my father's medical conditions and ultimately contributed to his demise.

During the next fifty two days, my father was subjected to the following mistreatment. My sister observed : nursing aides manhandling him while trying to move him from his bed to a chair; my father left sitting all day in a wheelchair; my father left waiting for help on a Hoya lift; my father found severely dehydrated with an irregular heart beat and electrolyte imbalance; my father found with a pus laden, bloody catheter bag, an improperly inserted catheter and a distended bladder; my father found overmedicated and discrepancies in his chart as to which medications were to be administered (see attachment 1).

During his time at Harborside, based upon my sister's observations and recollection, my father was never physically examined by Dr. Schwarz; yet, at the behest of Harborside staff, Dr. Schwarz prescribed such medications as zyprexa, effexor, and pamelor (see attachment 3). Upon conferring with a pharmacist, I was informed that the Harborside medication list (attachment 3) indicates that my father was receiving three times the dose of zyprexa that one would prescribe; that the dose of effexor appeared higher than warranted; that pamelor [nortriptyline] was contraindicated for individuals over the age of 75 and that said drug was prescribed at 25 mg/dose (the highest dosage manufactured); that the combination of these medication could/did result in fatigue/malaise, etc. (see attachment 4, drug data sheets); and that a compromised urinary function could/did result in the accumulation of these drugs in his system. In addition to the aforementioned drugs, my father also received Aricept which can precipitate such adverse reactions as cellulitis (see attachment 4).

The drug data sheets clearly indicate that "caution is advised if the concomitant administration of venlafaxine (effexor) and [other CNS-active drugs are] required." Furthermore, per the drug data sheets, pamelor should be given "only under close supervision" to patients with cardiovascular disease. It appears that my father's medical conditions were never considered in relation to the medications administered.

With every medication there are adverse side effects. The aforementioned drugs cause/exacerbate such maladies as hypertension, tachycardia, **arrhythmias**, heart block, stroke, **congestive heart failure**, **confusion**, disorientation, anxiety, restlessness, **agitation**, **drowsiness,** dizziness, weakness, **fatigue,** headache, peripheral neuropathy, **urinary retention**, **urination impaired, bone marrow depression** including agranulocytosis, anemia, **edema**, **weight gain**, cough, dyspnea, **chest congestion**, pleurisy, pulmonary embolus, hypoxia, **lung edema**, **skin ulcers**, etc.

Is it any wonder that my father was incapable of presenting in any state other than confused, anxious and disoriented (see attachment 5, mini-mental status examination). If one peruses the "interdisciplinary progress notes" generated at Harborside (see attachment 6), one quickly recognizes the pattern of categorizing my father as "alert/confusion…and c/o Ø pain." It appears that these individuals are not conversant with the side effects of the drugs that they administer. Review the "progress notes" and see the numerous entries regarding "cloudy yellow urine," "poor fluid intake," "face flushed," etc. and note that no further action was taken – i.e., these individuals either did not care about the change in my father's health parameters and/or they did not recognize them. In all likelihood, the lack of quality medical care in conjunction with the combination and dosages of these drugs contributed to my father's untimely death – i.e., months were taken from my father that he could have spent at home with his family. Furthermore, my father expressed pain to my sister after every manhandling event.

Moreover, to further compound the agony that my father and family were subjected to, the facility "social worker" and his counterpart at Minuteman Social Services displayed open hostility and animus towards my sister for actively advocating for a given quality of care for my father (see attachment 7).

At one meeting, Jeff White (Harborside "social worker") proceeded to tell my brother and sister about his mother who has/had Alzheimer's disease. He recounted how he had tried to care for his mother; how he could not control her; how he facilitated her relocation to his sister in Florida; etc. He matter-of-factly told my siblings "don't waste your time trying to help them because there is nothing you can do to stop the eventual outcome. Take over their possessions and write them off."

When my siblings didn't buy into Mr. White's philosophy, apparently he colluded with Lisa Walker, the Minuteman "social worker," to try to prevent my sister from effectively advocating for my father (see attachment 7). This is quite curious behavior for "professionals" who are allegedly hired to advocate on behalf of patients. Neither of these individuals were advocating on behalf of my father.

To better understand the role of the "ombudsman," my sister called the Department of Public Health and talked with Mr. Lenny Bruybtte. On 2/10/06, Mr. Bruybtte decided to visit Harborside. He arrived at approximately the same time as my sister. They found my father exhausted and dehydrated as a result of having been left in a wheelchair all day.

Mr. Bruybtte introduced my sister to the Director of Nursing who went over my father's medical records, presented the nursing home's position, and stated that my father didn't need transport to Winchester Hospital – i.e., that he could wait until Monday for any required testing.

Mr. Bruybtte didn't verbally participate in the meeting but later indicated to my sister that there was little that he could do to effect changes for my father; however, he would review compliance history/staffing issues.

My father's condition worsened and he was transported to Winchester Hospital on 2/11/06 where he spent the next twenty four days.

Again, the WH case manager was less than helpful/professional. She told my sister that most nursing homes were refusing placement for my father; and that "no one wants him; send him home and get help there." It appears, upon discussion with a Health South NE Rehabilitation Center employee, that my father wasn't even evaluated prior to the WH case manager's pronouncement. Also, we were faced with another problem - i.e., Lisa Walker would not allow my father to be discharged home.

Finally, with the help of an attorney, on 3/6/06 my father was placed in Pine Knoll, a facility with excellent quality of care. It is an outrage that he had to wait nearly two years to receive this level of care. As you can see from the information in attachment 8, pamelor, effexor, and zyprexa were discontinued at Pine Knoll.

After three months at Pine Knoll, my siblings wanted to implement hospice care and bring my father home. Lisa Walker did everything in her power to prevent this from happening, but she did not prevail.

The sad fact is had my father received rehabilitation from December 2004, he could have resided in an assisted living facility such as Longmeadow. However, to do so required that he be ambulatory. He was never given the opportunity to regain that motor skill. Longmeadow refunded the deposit that was made towards his admission.

As you are aware, my father died on 6/18/06 after a prolonged, convulsive struggle with and within the health care system in Massachusetts.

I beseech you to closely scrutinize this failed health care system and to implement legislation to prevent hospital case managers from writing off patients and knowingly placing them in substandard nursing homes (e.g., Gail Krom, WH ER case manager indicated to me that they are fully aware of which nursing homes are substandard); to prevent nursing homes from breaching their duty of care to patients; to prevent ill trained nurses and nursing aides from administering to patients; to prevent absentee doctors from prescribing medications at the behest of nursing homes that apparently are more interested in warehousing patients than alleviating their pain; to prevent nursing homes from discriminating against patients based on their physical parameters/maladies; and to prevent "social workers" from acting in their own best interest and /or that of the facility or acting out of animus instead of advocating for the patient. If, as in this case, members of this health care system acted with negligence and/or depraved indifference, breached their duty of care and caused harm to the patient, then there should be consequences. Kindly see that there is accountability at all levels of this health care system.

We have requested medical records from Harborside; they have selectively supplied certain records; some are of such poor quality that they are virtually illegible. We are trying to determine the release criteria for Winchester Hospital, Lawrence Memorial, Blaire House, and Lexington Health Care. If you can be of assistance, please let us know.

If we can provide you with any other information that may further your review/investigation, please inform us. Long-term health care in this state is a critical issue which requires immediate attention. Please do not let another human being be subjected to the abuses that my father suffered at the hands of this failed health care system.

Respectfully,

Sharyn Eklund

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attachments: 40 pages