

Complaint Record Report

I. Case Name: Forest Hill Manor
V#: 000393925
7806 Forest Hill Ave.
Richmond, Virginia 23225

II. Summary of Contacts:

12/08/00 – Received case in Licensing
12/11/00 – Case assigned to inspector
12/11/00 – TC – Mabel Jones, Acting Administrator, Forest Hill Manor
12/11/00 – TC – Dr. Chaudhary
12/11/00 – TC – social worker, Adult Protective Services (APS) Rich. City
12/14/00 – TC – Mabel Jones, APS came by
12/18/00 – TC – APS
12/18/00 – FV – Mabel Jones, reviewed record of , continues to be hospitalized at Chippenham
12/20/00 – TC – Lt. John Thomas, Assistant Fire Marshall, left message on voice mail
12/20/00 – TC – social worker, Chippenham Hospital
12/21/00 – TC – John Thomas
12/21/00 – TC – social worker, Mrs. died today. Copy of medical report requested
12/21/00 – FV – Forest Hill Manor (11:00 P.M.-12:30 A.M 12/22/00)
12/22/00 – FV – Forest Hill Manor (8:00 A.M – 8:30 A.M)
01/04/01 – TC – John Thomas, left message, returned call from Jan. 2,3, 2001, pager
01/04/01 – TC – John Thomas, arranged for JEC inspection (Joint Enforcement/Task Force) to be held 01/11/00 @ 9:00 A.M.
01/04/01 – TC – Clevester Ferrell, Property Maintenance Inspector, City of Rich. confirming inspection date for 01/11/01 @ 9:00 A.M
01/10/01 – TC – John Thomas, inspection time change to 12 or 1 P.M. 01/11/01
01/10/00 – TC – John Thomas, inspection back to 9 A.M.
01/11/01 – FV – Forest Hill Manor, JEC: City Code Enforcement, Fire, Health Soc. Services, VDSS, Licensing
01/18/01 – FV – Forest Hill Manor, Monitor Fire Watch, 8:15 A.M.-9:25 A.M.
01/18/01 – TC – Clevester Ferrell
TC – Bruce Epps, Acting Deputy Fire Marshall
TC – Lic. Admin.
01/18/01 – TC – Cle Ferrell, re: emergency meeting, 2:00 P.M. 508, City Hall (2)
01/22/01 – TC – social worker, Chippenham Hospital re: medical information
01/22/01 – FV – Chippenham Hospital Medical Records, reviewed record of

01/23/01 – TC – Ruth Wiggins, Staff person, Forest Hill Manor
01/29/01 – TC –

- * TC - Telephone Call
- * FV – Facility Visit

III. Description Of Complaint:

Licensing received the complaint report on 12/08/00 as referred by _____ Social Worker, Richmond Department of Social Services, Adult Protective Services. According to the report, “_____ will be assigned the case. Ms. _____ admitted to Chippenham Hospital from Forest Hill with hypothermia, is presently on life support. _____ from Chippenham called APS, _____ Physician is Dr. _____

IV. Investigation Report:

Standard (s) : 420.E.; 510.C.1.2.3.
Issue: Alleged Neglect- Low body temperature
Category: 50 Abuse/Neglect
Findings: 2. Founded
Action: Consultation

Basis of Determination:

It must be noted that Mabel Jones apprised the inspector of the situation on 12/04/00 for informational purposes. She indicated that Ms. _____ was placed in Forest Hill Manor on 10/17/00 from Richmond Community Hospital. Ms. _____ had been hospitalized there since August 17, 2000. The resident had been residing with Mrs. _____ at her personal home (was an Adult Home Administrator). According to Mrs. Jones, Ruth Wiggins went to resident's room at 7:15 A.M on 12/03/00 to give a bath. Ms. _____ was found lathargic, cool to touch. The ambulance was called, Medics stated that her body temperature was 80 and her pulse was 40 upon arrival at the hospital. Currently, the resident is at Chippenham Hospital on life support. Ms. _____ niece is aware and involved.

Mrs. Jones telephoned the licensing inspector on 12/11/00 to indicate that APS, Michel Cooper has been assigned Ms. _____ case. Ms. Jones stated that she plans to speak with Ms. Cooper on this date.

On 12/11/00, the inspector spoke with Dr. Chaudhary by phone re: Ms. _____ and the heating situation. According to Dr. Chaudhary, he saw Ms. _____ on 11/26/00 and she was more alert. He claimed that the heat had been fixed. In addition, Dr. Chaudhary indicated that he turned the thermostat up from 72 degrees to 75 degrees. The box had been locked and covered so that staff could not change the thermostat. Dr. Chaudhary informed the inspector that there was no heat in the two-story building last night(12/10/00); however, that heat was fixed. The inspector was not aware of the heating problem in the two-story building.

Ms. continues to be hospitalized as of 12/11/00. A voice mail message was left with Ms. Cooper re: a joint investigation. She was informed that the inspector would be out of town and at a training the remaining part of the week.

On 12/14/00, the inspector contacted Mabel Jones to inform her that a visit will be made on Monday re: the status of Ms. Ms. Jones' beeper # is

The inspector received a voice mail message from Ms. , APS worker, on 12/18/00. According to Ms. " staff explained that woman, Ms. was naked on the bed because they were preparing to give her a bath. Although bedroom # 5 was hot on the date of the APS visit on Wed. 12/13/00, the woman had been moved from room # 23 which was cold. Ms. expressed the opinion that residents at Forest Hill Manor are at risk because of the existing heat problem. At this point, the inspector plans to contact the Fire Marshall's office, obtain Ms. records from the hospital and review resident's records at Forest Hill Manor.

A visit was made to Forest Hill Manor on 12/18/00. The record was read belonging to Ms. Please see attached notes from direct care workers at Forest Hill Manor. Upon reviewing the record, it was found that Ms. was admitted to the facility on 10/17/00. Her date of birth is and social security # is . Her attending physician is Harold Green, and Dr. Chaudhary, Richmond, Va. 23225. Admission data revealed that Ms. is confused to time and place and needs assistance with bathing, dressing, and toileting. It was noted that Ms. had experienced gall bladder surgery. The UAI (Uniform Assessment Instrument) was completed on 10/17/00. Ms. was ambulatory upon admission but had been in the hospital since 08/17/00. Prior to hospitalization, Ms. had resided with Ms. (a previous Adult Home owner at Richmond, Va. 23224. As of 12/18/00, Ms. continues to be hospitalized at Chippenham Hospital. According to Ms. Jones, Acting Administrator, Universal Heating and Plumbing, was at the home at 10:10 A.M. and will return on Wed. 12/20/00. She explained that the workers stated that they need a whole day to do what needs to be done.

On 12/20/00, the inspector contacted John Thomas, fire inspector to apprise him of the situation at Forest Hill Manor. A message was left on the voice mail, or . A call was also made to the social worker at Chippenham Hospital working with Ms. & family

On 12/21/00, the inspector received a call from John Thomas. He indicated that he gave permission for Forest Hill Manor to use heaters for one week and that he specified that they should be checked every fifteen minutes and turned off every hour. Because of the history described relative to the heating problem, Mr. Thomas agreed to contact the appropriate building inspectors/persons to check the heating units at Forest Hill Manor. In addition, on 12/21/00, returned call and stated that Ms. died today. When questioned re: the reason, she informed the inspector that "Dr. says basically that Ms. was unattended and froze to death". A copy of the medical record was requested. There is no verification of this statement from a doctor.

It must be noted that as a result of the ongoing heating problem at Forest Hill Manor, the inspector made unannounced visits to the facility to monitor the heating situation. There was concern re: the

other residents as a result of defective heating system and the complaint re: hypothermia on 12/08/00. Please refer to the case narrative dated 12/22/00 reflective of 12/07/00 through 12/22/00.

Through contacts with John Thomas, arrangements were made for an inspection of Forest Hill Manor with the Joint Enforcement Committee, a team of individuals from property and maintenance, fire department, health department, City Attorney's office, Richmond Social Services and Licensing.

A joint inspection was held on 12/11/00. Several serious safety violations were cited regarding the fire protection system. As a result, Forest Hill Manor was placed on a 24 hour/day, 7 day/week fire watch. Other building code violations were cited. A defective heating system was also documented. As a result, several meetings re: these issues were conducted by the team in order to identify a plan of action to assure safety of the residents.

On 01/22/01, the inspector contacted _____ to inquire about the medical findings of _____. She indicated that medicals are currently filed in medical records division at the hospital. She provided the inspector with the phone # to medical records. According to Ms. _____, a release of information form will need to be signed. It was suggested that the inspector visit the office to complete the form. The inspector did visit Chippenham hospital on 01/22/01 and did review the patient record. Excerpts were xeroxed by medical records staff for licensing documentation. (See attached report). Ms. _____ had a multitude of health problems that could have attributed to her death.

According to Ruth Wiggins, staff person at the facility, Ms. _____ was a wanderer. When first admitted on 10/17/00, she was in room # 9 East near the nurse's station. At times, she would go to various rooms. Ms. Wiggins had no recall of Ms. _____ being in room # 23, which was a cold room. Ms. Wiggins also noted that the bed linen was off in room # 5 when the ambulance arrived to carry the resident to the hospital; however, Ms. _____ was fully dressed.

It must be noted that there are conflicting accounts of whether or not the resident was dressed prior to going to the hospital. In addition, there are conflicting accounts of which room the resident was removed from when placed in room # 5 and the time frames of the move.

According to hospital report, Ms. _____ was admitted to Chippenham Hospital with a diagnosis of Hypothermia. There has been a recurring problem with the heat dating back to at least the winter of 1999.

S. Bennett

L354

01/30/01