County Of Sacramento

Elder Death Review Team

2008 Report

Acknowledgements

The Elder Death Review Team 2008 report was made possible by the efforts of a committee composed of the staff of the California Department of Social Services - Community Care Licensing; and the Sacramento County Department of Health and Human Services (DHHS), Senior and Adult Services (SAS) Division; and the District Attorney's Office.

We thank the Sacramento County Elder Death Review Team for contributing content of this report. A subcommittee of team members provided direct oversight and approved the final report. The subcommittee's dedication and writing the report was instrumental in its completion.

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EDRT 2008 Report

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EDRT Background

Formed in 1999, the Sacramento County Elder Death Review Team (EDRT) was the first such effort in the nation. Spearheaded by the County District Attorney's Office and the Department of Health and Human Services, a local partnership was formed to sponsor and write the initial legislation (SB 333, Escutia). SB 333 approved in 2001, that authorizing the establishment of elder death review teams in California. The bill also allowed the third party exchange of vital information, thus eliminating confidentiality barriers.

Elder Death Review Teams are developing throughout the country, including teams in the states of Washington, Oregon and Maine. California has more than 30 teams although their size and practices vary.

EDRT's goal is to eradicate elder abuse by advocating for systemic changes that improve the community's response to the needs of older victims of abuse and neglect. Its mission is to examine deaths associated with suspected elder abuse and/or neglect, and identify and implement prevention strategies to protect the county's elders.

Since 2001, EDRT's multidisciplinary team has reviewed more than 200 cases of suspicious elder deaths in skilled nursing facilities, residential facilities and the community. The EDRT partnership has enhanced communication and cooperation among agencies and fostered a clear focus on the victims of elder abuse.

More information about EDRT can be found on its website, www.edrtsac.org

Executive Summary

In the two years since the last Elder Death Team Report, the Committee has reviewed and analyzed 39 cases. These cases were referred to the Committee due to concerns for abuse and/or neglect of an elder or disabled person. This report outlines some of the cases reviewed, presents proposed recommendations proposed based upon all cases reviewed, informs the reader about the elder system of protection by highlighting one of the agencies providing oversight to care facilities, presents data on elder death from the coroner's perspective and outlines some of the accomplishments as a result of the work by the Committee.

In addition, the Committee attempts to bring about positive change in the lives of the elders in our community either through Committee based projects or through collaborative efforts with those who provide services to our elder population. The following is a list of some of the completed and on-going projects the Committee members have worked on since the last report in an attempt to improve Sacramento County's prevention, response and intervention in elder abuse and neglect:

- The completion of a brochure addressing the most central and fundamental needs of the elder community. The brochure will be available to seniors through organizations such as religious centers, pharmacies, senior centers, medical clinics, etc. The brochure is entitled, "Independent Living: Resource Guide."
- Based on a need identified by EDRT, the Sacramento County Coroner's Office and Adult Protective Services (APS) have begun a project whereby they share information on a daily basis in an attempt to identify elder deaths that have APS allegations of abuse and/or neglect. This permits the Coroner's Office to identify and review deaths of elders with abuse indicators, and conduct autopsies where appropriate.
- Based upon a recommendation from EDRT, an inter-disciplinary team of APS staff, in partnership with Kaiser Foundation Hospitals and the Sutter Medical Center, provide intensive case management services, including extended intervention for up to six months. The objectives are to improve safety, quality of life and continuation of care issues for the elderly population. Since its inception, the program has seen a 49% to 69% reduction in emergency room visits for participating clients.
- Based on an idea generated by EDRT, the District Attorney's Office has taken the lead to develop and distribute an informational DVD focused on issues that impact the lives of seniors. The topics will include neglect, mandated reporting, appropriate care, the identification of care issues, financial scams targeting the elderly, drug interaction, and other topics that arise where education would be of benefit. A "Train-the-Trainer" model will be implemented, where teams of two senior volunteers will go into the community to facilitate the DVD presentation to their peers.
- Based on discussions within EDRT, the Sheriff's Department launched a volunteer program within their Elder Abuse Unit. Volunteers with financial backgrounds assist Sheriff's detectives with organizing and reviewing complicated and voluminous financial fraud cases.

In each report, a "spot-light" agency is identified in an attempt to educate the reader as to the myriad of public and private agencies that provide a safety net for the older adult community. This year, the spotlight agency is Community Care Licensing (CCL). The goal of CCL is to promote the health, safety and quality of care of each person who is in out-of-home care through a regulatory enforcement system that works collaboratively with clients, their families, advocates, care providers, placement agencies, regulatory agencies, and others involved in community care.

The section entitled "The Coroner's Experience – 2004 to 2007" is a comprehensive review of the elder death investigations completed by the Sacramento County Coroner's Office between 2004 and 2007, with and an emphasis on trends and new findings not previously reported. One trend observed was the increased incidence of pressure ulcers listed as either a primary or contributing cause of death. It is unclear whether this "trend" reflects a true increase in the number of elderly people with severe pressure ulcers or merely an increased awareness of the significance of these types of wounds on an individual's overall morbidity and mortality. Between 2004 and 2007, there were 17 deaths where pressure ulcers were considered to be either the primary cause of death (9 cases) or a significant factor to their death (8 cases).

This "trend" was also observed by the Committee in its review of elder death cases for this reporting period. One-third of the elderly persons represented by the 39 cases reviewed for this reporting period had evidence of significant pressure ulcers. A "significant" pressure ulcer was determined to be a wound that had progressed to either Stage III or Stage IV. A Stage III pressure ulcer is a wound where there is no skin remaining in the affected area and the wound may extend under the edge that is visible on the surface. A Stage IV pressure ulcer is a wound that is so deep it involves underlying bone and muscle, which may in turn lead to infection of the bone and sepsis. Pressure ulcers not only affect the quality of life due to the pain and discomfort that are associated with these wounds, but pose significant health risks that can, as noted above, result in death. These concerning findings of the Coroner and the Committee gave rise to two of the recommendations contained in this report.

The first recommendation is that the Board of Supervisors encourage hospitals and skilled nursing facilities in Sacramento County to develop and distribute information at the time of hospital discharge on the identification and treatment of pressure ulcers. This information, a "Beyond the Crisis Fact Sheet," could be used to assist caregivers when caring for the elderly and/or non-ambulatory. The fact sheet would include preventative strategies, signs and symptoms of pressure ulcers, and encourage contacting a medical provider when there are early indications of skin breakdown. The second recommendation dealing with pressure ulcers is that the Board of Supervisors support the creation of a Public Service Announcement (PSA) to educate the general public about pressure ulcers: what and how serious they are, how quickly they can develop, how not to treat them and where to obtain treatment information. The last recommendation requests that the Board of Supervisors direct the county legislative advocate to communicate to state legislators the County's support for increased funding and opposition to cuts for state programs that provide long-term care management for seniors who are able to remain in their homes but are still at risk for significant health crises.

It is said that change comes to all things…this is certainly true of the System of Protection that is in place for Sacramento's senior population. As the senior population experiences explosive increases (anticipated to increase 193% by 2040) and massive budget deficits force cutbacks in services, we are all forced to do more with less. One thing that has remained consistent…for years the individuals from both the public and the private sector who comprise the membership of the Elder Death Review Team have given unselfishly and freely of their time and expertise. I want to take this opportunity to thank these individuals… for without them the elder and dependent adult community would lose one more voice advocating for its safety and well-being.

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Jeff Rose, Assistant Chief Deputy District Attorney
Sacramento County District Attorney
Chair, Elder Death Review Team

Recommendations

The following is a list of recommendations based on cases EDRT has reviewed.

1. During this review period, EDRT recognized that many of the evaluated elder deaths were due to decubitus ulcers (also known as bedsores or pressure ulcers) and the fact that the caregiver was not aware of the conditions that contribute to the development of pressure ulcers, the staging of pressure ulcers, and how rapidly the condition can deteriorate to the point of being life threatening. In general, it can be said that the caregivers did not have the knowledge to recognize or skill to treat decubitus ulcers.

   Therefore, EDRT recommends that the Board of Supervisors encourage hospitals and skilled nursing facilities in Sacramento County to develop and distribute information at the time of hospital discharge on the identification and treatment of pressure ulcers or a "Beyond the Crisis Fact Sheet" to assist caregivers when caring for the elderly and/or non-ambulatory. The fact sheet would provide preventative strategies, signs and symptoms of decubitus ulcers, and encourage contacting a medical provider when there are early indications of skin breakdown.

2. Four of the six cases reviewed for the 2008 Elder Death Team Report indicated that the decedent received inadequate care in the home. Although each case involved frail elderly persons with interrelated medical, psychiatric, economic, social and functional problems, three of them had no outside gatekeepers (e.g., agencies, family or friends) to monitor the care that was being provided. The only situation in which an agency was involved was with a County of Sacramento DHHS, Senior and Adult Services Division In-Home Supportive Services Family Services Worker who provided nutritional supplements, but no ongoing monitoring or referrals to outside resources. In each of the four cases, the decedent's poor quality of life and premature death could have been avoided with a strong care coordination presence.

   Professional care managers have regular contact with patients and their caregivers to monitor the patient's medical care, to connect them with community resources, and to help navigate the medical and social service systems. In the cases presented, the care manager, for example, would have been in contact with the physician, educating the caregiver on wound care or nutritional needs, watching for signs of neglect or abuse, and suggesting behavior modification techniques.

   Currently no programs receive county funds to consistently monitor vulnerable elders or dependent adults who are not in an active crisis. Adult Protective Services is responsible for responding to crisis situations in which an elder's health or safety is at risk; however, once the situation has stabilized they must close the case. In-Home Supportive Services social workers, as a rule, only see the client for an annual reassessment of hours. Other programs such as Meals on Wheels may see the client more frequently but the volunteer drivers are not trained to help people through very complicated social service and medical systems. A long-

term care management program can provide coordination of services through regular monitoring.

The state funds three care management/coordination programs in Sacramento County. These programs are responsible for providing long term case management to help Sacramento seniors and dependent adults to remain in their homes safely and to prevent premature institutionalization or hospitalizations. These programs, Sutter PACE (Program of All-inclusive Care for the Elderly), the Multi-purpose Senior Services Program (MSSP) and Linkages, have served Sacramento County's most frail and vulnerable population for decades. The Sutter PACE program is funded by Medi-Cal and Medicare. MSSP is a Medi-Cal waiver program while Linkages is funded through State General Funds. These programs are woefully under funded due to years of flat funding and recent budget cuts. While approximately 400 people in Sacramento County receive care coordination services each year, the number of people eligible to receive these services is far greater- at least an estimated 10 times greater.

MSSP and Linkages are programs that assist Sacramento County's most vulnerable adults at no cost to the County they a vital role in the safety net for Sacramento County seniors and dependent adults. **Therefore, EDRT recommends that the County Board of Supervisors support proposed budget augmentations to these programs and oppose any further cuts. EDRT recommends that the Board of Supervisors directs the county legislative advocate to communicate to state legislators the county's support for increased funding and opposition to cuts for these programs.**

3. In the majority of cases that EDRT reviews each year, decubitus ulcers are present. Some have been determined by the Coroner to have contributed to or been the cause of death. Most people, including health providers, do not fully understand the cause, preventative strategies or proper treatment of these skin conditions. Pressure ulcers are dying skin tissue and require careful treatment and monitoring. Over-the-counter medications and home treatments do not work, but were unfortunately noted as the sole treatment in two of the cases reviewed. Decubitus ulcers are painful and potentially deadly. If untreated, the ulcers will continue to grow and create a condition called sepsis where toxins can quickly enter the blood stream and infect other parts of the body often resulting in death.

EDRT members want the public to be more aware of this matter as a public health issue. **Therefore, EDRT recommends the development of a Public Service Announcement (PSA) to educate the general public about pressure ulcers. EDRT believes that once the public better understands pressure ulcers, they will be more likely to call for help.**

This production would include information on what not to do and explain how decubitus ulcers develop rapidly and are potentially life-threatening without medical attention. This PSA is not to be considered as a form of medical advice and would direct viewers to their medical providers for more information.

EDRT requests the support of the Board of Supervisors on this effort. The production will rely on financial support through in-kind donations, grants, and some county funding.

Accomplishments

The 2006 Elder Death Review Team Report (EDRT), made seven recommendations:

- Improve IHSS consumer safety
- Expand IHSS training for care providers
- Prevent IHSS provider fraud and neglect
- Conduct community outreach events
- Increase public awareness
- Increase cooperation between all agencies in elder protection
- Expand law enforcement investigative capacity

During the past two years, EDRT members have worked with community partners within the Sacramento County System of Protection for Elders and Dependent Adults (SPEDA) to improve Sacramento County's prevention, response and intervention in elder abuse/neglect. The EDRT reports the following accomplishments for the above recommendations:

Hospital/APS/Coroner Protocol – The Sacramento County Department of Health and Human Services, Senior and Adult Services Division, Adult Protective Service in partnership with Kaiser Foundation Hospitals and Sutter Medical Center provide social work and public health nursing interventions for APS clients at risk of requiring emergency medical care and hospitalization, combined with high risk of abuse or neglect.

In order to improve safety, quality of life and continuation of care, an inter-disciplinary team of Adult Protective Service staff provides intensive case management services including extended intervention up to six months. This partnership has seen a 49% to 69% reduction in Kaiser North and Roseville emergency room visits for clients participating in the program. The early success of this program demonstrates the effectiveness of community collaborations in serving vulnerable high-risk elders.

Sacramento County Coroner's Office and Adult Protective Services collaborate daily to identify elder deaths that have APS allegations of abuse or neglect. This helps the Coroner's office identify and review deaths of elders with abuse indicators and conduct autopsies where appropriate.

Consumer safety - Mandatory training of In-Home Supportive Services care providers and criminal background checks, to prevent provider fraud and abuse, are being addressed by the newly-established IHSS Task Force approved by the Board of Supervisors. The committee has met five times and is now fully staffed by county agencies, providers and other interested parties. They will continue to meet through the remainder of this year and present their recommendations to the Board of Supervisors.

Community Outreach – Based on the ideas from EDRT, the District Attorney's office has taken on the task of producing a DVD to provide information to the public, through speaking

engagements, on how to protect themselves from different forms of fraud and crime. A more complete description of the program can be found on page 12 of this document.

Public Awareness – The Sacramento County Department of Health and Human Services, Senior and Adult Services Division, Adult Protective Services program initiated the development of a brochure in collaboration with the District Attorney's Office and community partners. The brochure, "Independent Living : Resource Guide," is being delivered to public agencies, medical offices and the general public offering help in finding resources for the elderly and disabled. The brochure can be found on EDRT's website at: www.edrtsac.org

The Sacramento County District Attorney's Office, in collaboration with the DHHS, Senior and Adult Services Division, Adult Protective Services program, has created and maintains a website for the Elder Death Review Team. The website contains information about EDRT including its history, membership, a list of EDRT teams in California, reports, other EDRT publications and resources from member agencies.

Sacramento County District Attorney
Seniors Assisting Seniors

By Jeff Rose, Assistant Chief Deputy,

Sacramento County District Attorney's Office

Elder Abuse DVD

Seniors Assisting Seniors is a program wherein teams consisting of two senior volunteers go out into the community to provide information intended to protect the elderly population. The venues where the training will take place is anywhere where seniors congregate, such as religious organizations, senior centers, retirement communities, assisted living facilities, and convalescent hospitals.

The training material will include a DVD containing information from experts on topics relevant to the senior community.

The teams of two retired senior volunteers will be trained to facilitate the DVD presentation to their community peers. Estimated completion and roll-out date is Fall 2009.

The video will open with introductory remarks from District Attorney Jan Scully. Topics will include why seniors are targeted, types of financial crimes, current scams, how to be protected from these crimes, and what to do if they become a victim of financial abuse. Presenters will be specialists from the District Attorney's Elder Abuse Unit, a retired detective with expertise in senior financial scams, and a banking industry representative discussing their role in identifying and reporting suspected elder abuse. The DVD will have a menu that allows facilitators to navigate to specific topics and select information that is of most interest to their audience.

Once the program has been completed and shown to be a successful vehicle to connect with the elder community, it will be expanded to include additional topics that pose either a financial or health risk to the elder population. Some of the topics under consideration include prescription and over-the-counter drug interaction, in-home care and home safety for the elderly.

An evaluation will be distributed for audience comments and suggestions. This feedback will help assess the effectiveness of the DVD presentations and allow further enhancement of this educational outreach effort. DVD updates will be made as needed to keep information current.

Sheriff's Department Volunteers

By Craig Kielborn, Detective, Sacramento County Sheriff's Department

Early in 2008, the District Attorney's Office approached the Sheriff's Department suggesting the utilization of volunteers within the Department's Elder Abuse Bureau to assist with their massive financial crimes case load. The District Attorney's Office had identified three potential volunteers during a presentation to a group of retired Bank of America employees.

An orientation meeting was held with the potential volunteers to outline their responsibilities and to use their knowledge of the banking industry for financial crime investigations. The volunteers are part of the Volunteers in Partnership with the Sheriff (VIPS) program.

Two volunteers applied for the program and were the first banking experts in this new pilot program. The volunteers started working in July of 2008 after extensive training.

The two volunteers have worked approximately 100 hours and have assisted detectives with the tedious and extensive work involved with these cases.

The volunteers' expertise and experience has saved detectives numerous hours spent reviewing bank statements and financial documents, which has sped up the investigation process immensely.

The Sheriff's Department has been very pleased with the enthusiasm of the financial crimes volunteers and is looking forward to continued success.

Kaiser Permanente's
Perspective and Experience with EDRT

By Jim Kelleher**,** Continuum Administrator, Kaiser Permanente

Kaiser Permanente is dedicated to the optimal care and well being of the frail elderly of Sacramento and has been an active participant in the EDRT since its inception. We are committed to continuing our participation on the EDRT to further advance care for frail patients in all settings in the Sacramento community.

The value of participation on the EDRT is the opportunity to examine and investigate circumstances which place the frail elderly at risk for abuse, neglect, and/or inadequate care. Through the review of identified cases, post-death, from all the health care systems and eldercare agencies in Sacramento County, we have identified key lessons which are helping to advance discharge planning processes at health care facilities.

Key lessons from EDRT case reviews:

- Reinforce the need to involve protective service agencies as soon as an abuse or neglect issue is identified or suspected.
- Involve law enforcement as early as possible when financial or willful neglect or abuse is suspected.
- Continue to identify issues that may result in unsafe situations for frail patients, for example: assessing if the identified care provider is willing and able to carry out the needed care.
- Understand the importance of reporting challenges that will impede the well being of patients when they are in a community setting, whether it is a private residence or a care facility.

The other invaluable lesson from membership in the EDRT is the ability for health care providers to review these cases with a broad spectrum of community agencies represented on the team. Challenging issues and perspectives are presented by disciplines as diverse as law enforcement, the Ombudsman's Office, Adult Protective Services, financial advocacy agencies, and health care systems. The value of this multi-disciplinary review is that it provides perspectives usually not available to these agencies. These nontraditional "partners" share their perspectives as to contributing factors to potential or actual risk situations and offer what could be possible solutions for future frail patients in similar situations. In addition to the value of review and investigation of cases, partnership relationships have been forged between agencies that traditionally have not had the benefit of engaging in joint problem solving. Examples of this are:

- A recent presentation by Dr. Stephany Fiore, Sacramento County Medical Examiner to South Sacramento Kaiser Permanente Ethics Forum, related to the dangers and challenges of patient with decubital ulcers.
- A presentation to the Kaiser Permanente Home Health and Hospice Department regarding identification and mandatory reporting of requirements related to elder abuse and neglect.

Pressure Ulcers and Death

By Diana Koin, M.D., Consultant

What are Pressure Ulcers?

Pressure or decubitus ulcers are wounds in the skin that occur in frail, debilitated patients whose care is inadequate. Commonly referred to as "bed sores," they can be prevented. Although pressure ulcers have multiple names, the term pressure ulcer is used because it emphasizes the number one cause: pressure. When they occur, they are a hallmark of elder neglect. Nursing home and hospital regulators view pressure ulcers as major deficits in care. Care of patients at home is not scrutinized by external reviewers and thus pressure ulcers may only be revealed at the time of death.

When are Elders at Risk for Developing Pressure Ulcers?

Multiple factors may contribute to the development of pressure ulcers. The patient is typically frail and has underlying disease processes that make it difficult to move and relieve the pressure. A list of risk factors includes:

- Pressure unrelieved by turning at least every two hours
- Moisture
  - Incontinence
  - Adult diapers
- Malnutrition
  - Weight loss
  - Low protein diet
- Dehydration
- Immobility
- Decreased sensation due to disease (e.g. diabetes, stroke)
- Underlying neurological disease that limits mobility
  - Stroke
  - Parkinson's disease
  - Multiple Sclerosis
  - Quadriplegia
- Friction and shear injury
  - Patient dragged across sheet rather than lifted and turned

Understanding Pressure Ulcers and Their Stages

Pressure ulcers are most commonly found on the skin that covers boney parts of the body. Hips, buttocks and heels are most frequently involved. However, for some patients other areas are involved, including the back of the head, ears, shoulder blades, and elbows.

To aid in diagnosis and management, pressure ulcers are staged to describe their severity. The stages are similar to cancer staging, with stage I being mild and readily treatable versus stage IV being severe and difficult to treat. The stages reflect the depth of the ulcer:

- Stage I: redness that persists even if the area is touched
- Stage II: the superficial skin is absent
- Stage III: there is no skin remaining in the area of the wound and the wound may extend under the edge that is visible on the surface
- Stage IV: the wound is so deep that it involves underlying bone and muscle; this may lead to osteomyelitis (infection of the bone)

Healing pressure ulcers is a slow process that requires oversight by health care professionals. In addition to treatment of the wound itself, all of the risk factors must be addressed. Adequate nutrition is key and may require high-protein supplements. If turning every two hours is not possible, special mattresses that automatically relieve pressure are indicated.

Consequences of Pressure Ulcers

Pain is the most often overlooked consequence of pressure ulcers. The affected skin is painful, as are the areas underneath the wound. Much like a burn unit, actual treatment must be preceded by pain medication.

Sepsis is the medical term for infection throughout the entire body. Pressure ulcers that are severe lead to this condition as the skin wound allows bacteria into the body. Sepsis is typically a lethal condition in a frail patient.

The Sacramento EDRT Experience with Pressure Ulcers and Sepsis

During the two year period studied for this report, almost one-fourth (24%) of the deaths were due to sepsis. Pressure ulcers were the leading cause of sepsis in this population. Family and friends often did not appear to appreciate the gravity of pressure ulcers and sepsis. Care-giving at home is the preference of most patients, but it requires adequate knowledge of pressure ulcers and their potential consequences.

The Coroner's Report – 2004 to 2007

Stephany Fiore, M.D., Samantha Smith, and Brandon Jaimes
Sacramento County Coroner's Office

INTRODUCTION:

The 2004 Annual Report for the Elder Death Review Team provided a summary of deaths involving elderly citizens of Sacramento County from the year 2003 based on the experience of the Coroner's Office. This report reviews the elder death investigations completed by the Sacramento County Coroner's Office from 2004-2007 with emphasis on trends and new findings not previously reported.

BACKGROUND:

The Sacramento County Coroner's Office investigates deaths as outlined in Government Code 27491. These include all non-natural deaths, all deaths related to contagious diseases, and individuals who have not been seen by a physician for more than 20 days prior to their death. The Government Code was recently amended per Senate Bill 1196 such that deaths of hospice patients are no longer reportable to the Coroner's Office if the patient has been seen by a hospice nurse or physician within 20 days prior to his/her death. This change became effective in January 2009. Emergency room deaths continue to be reported to the Sacramento County Coroner's Office as a matter of policy.

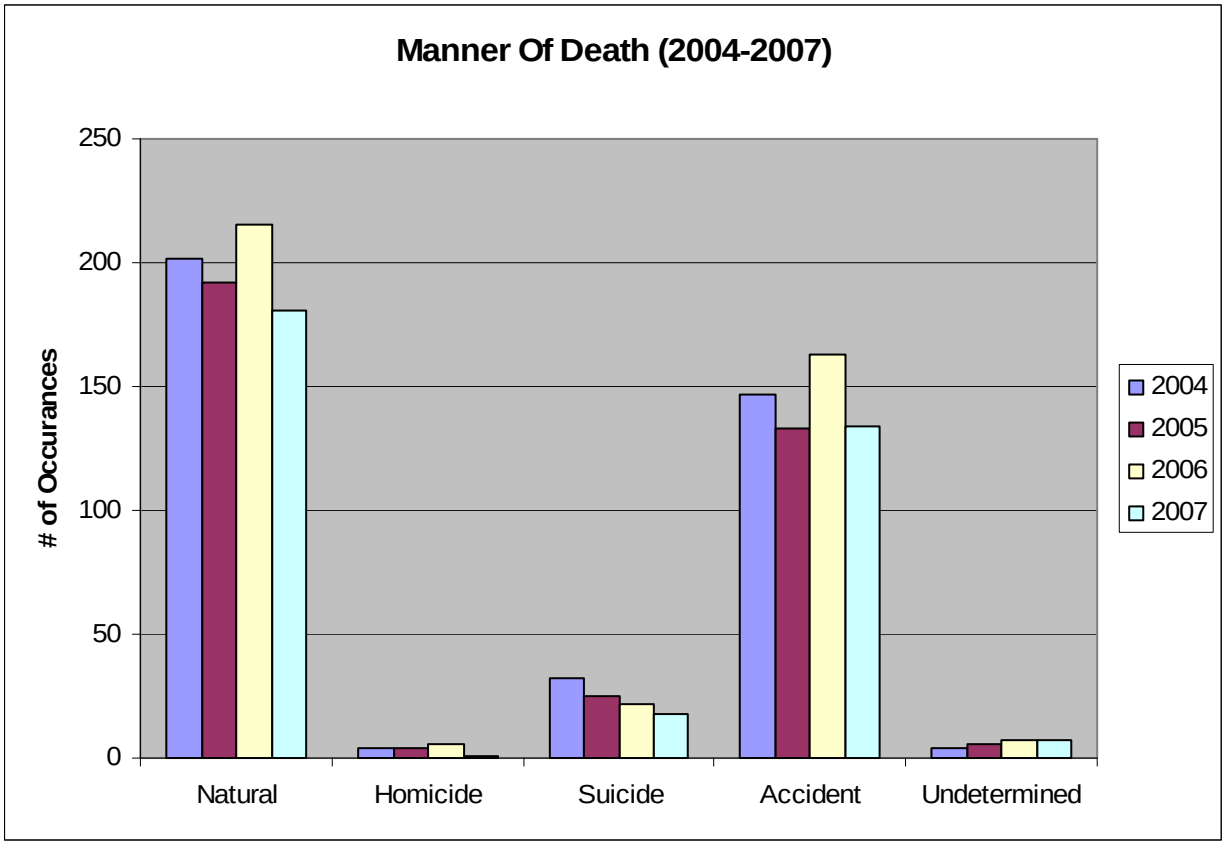
Between 2004 and 2007, a total of 27,154 deaths were reported to the Sacramento County Coroner's Office, averaging 6,788 reported deaths per year (6552-6941). The Coroner's Office investigated 7,369 (27%) deaths during this four year period. The remaining deaths were considered Non-Coroner Investigations (NCIs). NCIs are natural deaths within jurisdiction of the Coroner's office; however, the decedent's physician is willing to sign the death certificate. Of the deaths investigated, 1,503 (20%) concerned individuals 65 years of age and older.

Manner of death is a classification which addresses the circumstances under which an individual dies. There are five classes of manner that are recognized in the State of California: Natural, Homicide, Suicide, Accident, and Undetermined. Table 1 is a cumulative breakdown of the manner assigned to elder deaths investigated by the Sacramento County Coroner's Office between 2004 and 2007. Figure 1 compares the classification of manner by year.

Table 1.

Manner of Death Classification	Description	Total Deaths Investigated (1,503)
Natural	Death attributed to progression of significant medical conditions, primarily related to heart disease or chronic illness.	**790 (52.6%)**
Homicide	Traumatic death occurring at the hands of another (Proof of intent to inflict harm on another is not required.)	**15 (1%)**
Suicide	Self-inflicted traumatic death (Proof of intent to inflict harm on oneself is required.)	**97 (6.5%)**
Accident	Traumatic death where the investigation of circumstances has shown that no foul play was involved (includes falls, drowning, etc).	**577 (38.4%)**
Undetermined	Death where, after a thorough investigation of the circumstances and a complete autopsy, there is insufficient information to render an opinion regarding the manner of death with a reasonable degree of certainty.	**24 (1.6%)**

Figure 1.



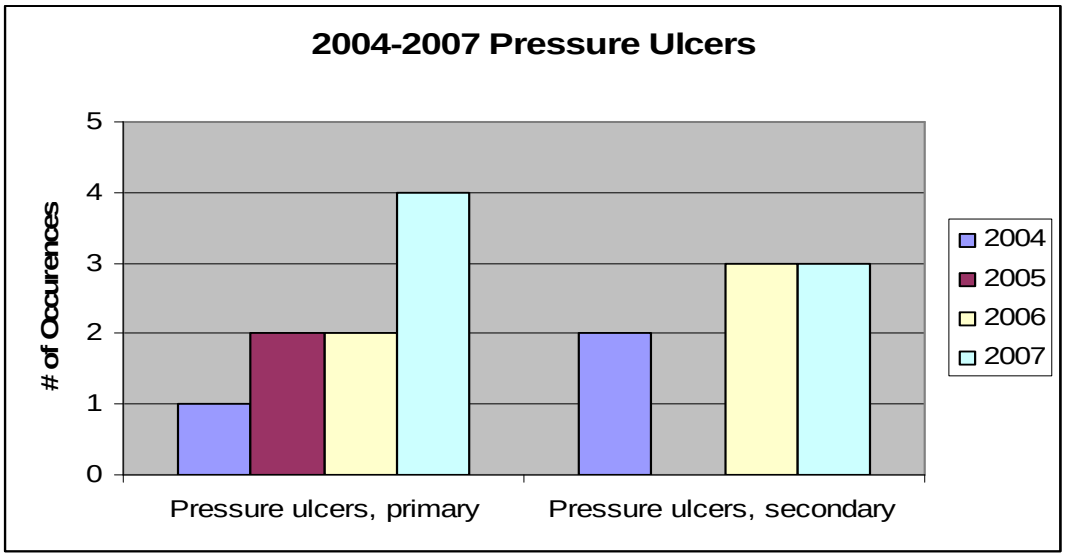
NATURAL DEATHS:

Heart disease continues to constitute approximately 80% of the natural deaths in people over the age of 65 with the remaining 20% divided among other acute and chronic disease processes. Two new trends were identified concerning the less common primary causes and the contributing factors to natural death. These will be discussed in further detail.

We are beginning to see a rise in deaths related to the long-term affects of drug abuse in the aging population. In the 1950s and 60s, there was an increase in the use of illicit drugs such as heroin, amphetamines, and cocaine. The younger patients in this cohort were born in the early 1940s, making them young adults during this era and ripe for experimenting with these types of drugs. Deaths related to chronic drug abuse are mostly from complications of the intravenous administration of these drugs (e.g. viral hepatitis). As the population of Sacramento County continues to mature and the Baby Boomers become of age, it is expected that we will continue to see a rise in these types of deaths. Deaths related to acute drug intoxications are also on the rise in this population. Most of these deaths are considered accidental and will be discussed in the following sections.

The other trend is the increased incidence of pressure ulcers listed as either a primary or contributing cause of death (see Figure 2). It is unclear if this trend reflects a true increase in the number of elderly people with severe pressure ulcers or merely an increased awareness of the significance that these types of wounds have on an individual's overall morbidity and mortality. Between 2004 and 2007, there were 17 deaths where pressures ulcers were considered to be either the primary cause of death (9 cases) or a significant contributing factor to their death (8 cases). In the cases where a pressure ulcer was found to be a primary cause of death, the ulcers were very large and infected resulting in overwhelming sepsis that directly caused the death. Pressure ulcers were considered to be contributory if they were multiple in number and/or quite large but not infected and there was clearly another primary cause of death. Of these 17 cases, a little over half were women (10:7) and the women tended to be a little older than the men. The age range for women was 76-97 years while the range for men was 68-91 years. All but two of the cases were living at home under the care of a family member (11 cases) or a paid live-in care provider (4 cases). Only two people were living in a skilled nursing facility when they developed their pressure ulcers. The classification of manner of death in these cases is currently under debate. These types of wounds are considered preventable and are a sign of neglect. However, many of the individuals also have significant co-morbidities (e.g. diabetes and peripheral vascular disease) that affect the development and treatment of these sores. In addition, most of the care providers are not trained to recognize the significance of or properly care for these types of wounds. Between 2004 and 2007, most of these deaths were classified as Natural; however, there were two that were classified as "undetermined" because of concerns over caregiver neglect. Both of these elders lived at home. A more detailed discussion of pressure sores is included in this report.

Figure 2.



The year 2006 was unique in Sacramento County because of the prolonged heat wave in the month of July. There were 10 deaths that year where the stress from the unrelenting heat was felt to have significantly contributed to but was not the direct cause of death in these individuals. Deaths directly related to environmental temperatures are considered accidental and will be discussed below.

ACCIDENTAL DEATHS:

The accidental deaths are compared by year in Figure 3. Deaths associated with falls (57%) and motor vehicle accidents (22%) continue to be the number one and two leading causes of accidental death in the elderly. Of the less common types of accidental deaths (see Figure 4), fire comprises approximately 6%, drug overdoses 5%, choking on food 3%, and drowning 2%. The remaining 5% is a mixture of unusual events.

Figure 3.

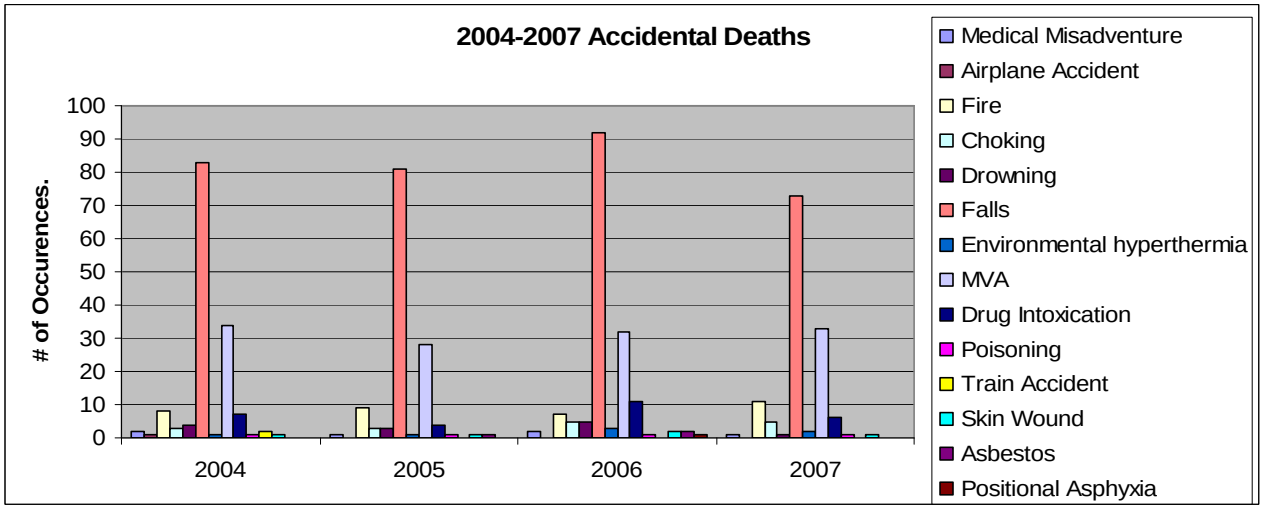
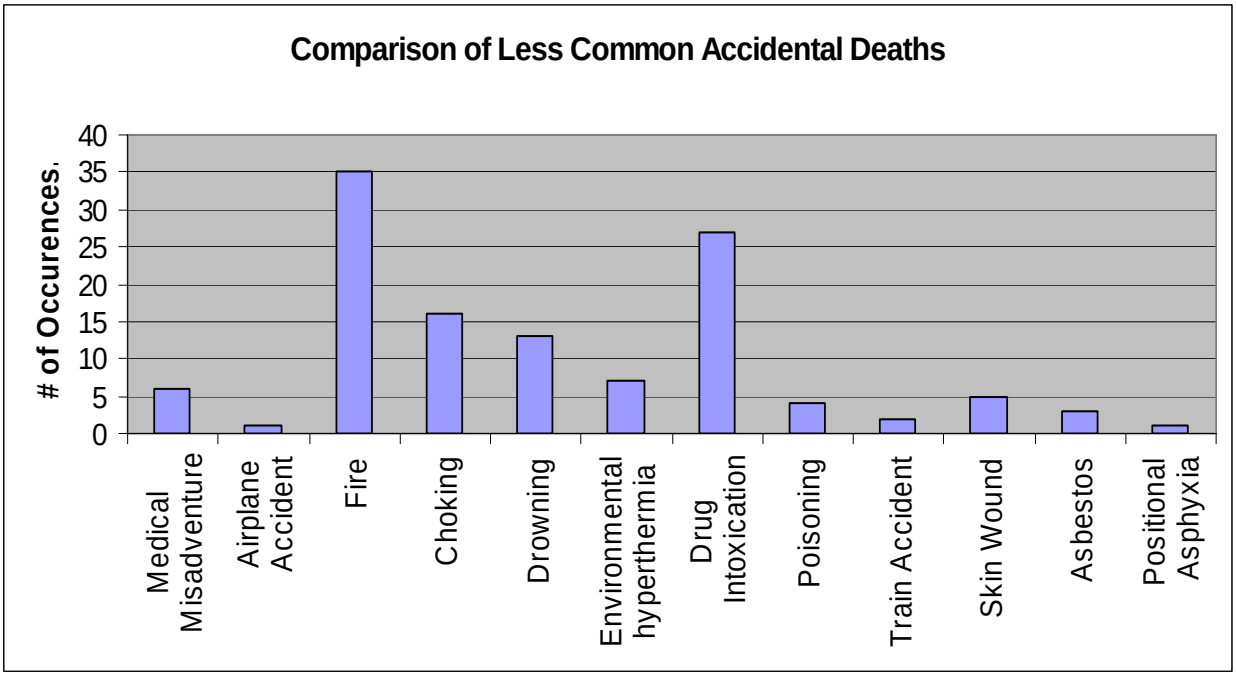


Figure 4.



Falls

There were 329 deaths related to falls between 2004 and 2007. These deaths involved slightly more men (52%) than women (48%). Most of the victims were in their 80s (45%), while 26% were in their 70s and 21% in their 90s. Only a few were in their 60s (7%) or over 100 years (1%). Nearly half (42%) of the victims had a prior history of falls or were known to be unsteady on their feet. The fall resulted in lethal head trauma in 60% of the cases or an isolated fracture in 35%. A history of dementia and/or the use of anti-coagulative medications continue to be the major risk factors for the development of significant head trauma in the elderly. Osteoporosis is the major risk factor for isolated fractures occurring after a fall. Fractures of the femur (hip) are by far the most common (46%) and carry a high rate of mortality in the elderly. The second most common site of bony fractures in the elderly is the neck, particularly the second cervical vertebra. This bone is commonly called the axis because it possesses an upward projection that serves as the focal point for head rotation. This projection is vulnerable to fracture, particularly with falls where the face strikes the ground first, resulting in hyperextension of the neck. Deaths related to rib fractures made up 11% of the cases and those involving other areas of the pelvis and spine are both 9%. The remaining 4% were a mixture of bones that typically do not carry a high degree of mortality when fractured, such as those in the ankle or arm. Multiple injuries were found in only a small number of cases (4%) and were typically the result of a fall from an elevated height.

Figure 5 shows an annual comparison of where the falls occurred. Most of the accidents occurred in the victim's home (61%), while 21% occurred at a long-term care facility and 19% while the individual was out in the community. In 25% of the cases, the fall occurred in a county other than Sacramento; however, the individual was transferred to this county for medical attention, whether it was for acute or long-term care. There are two level 1 trauma centers in

Sacramento County that draw patients from all over Northern California. In addition, patients with Kaiser health care are often transferred to Sacramento because of the neurosurgery specialization at one of their facilities in this county.

Figure 5.

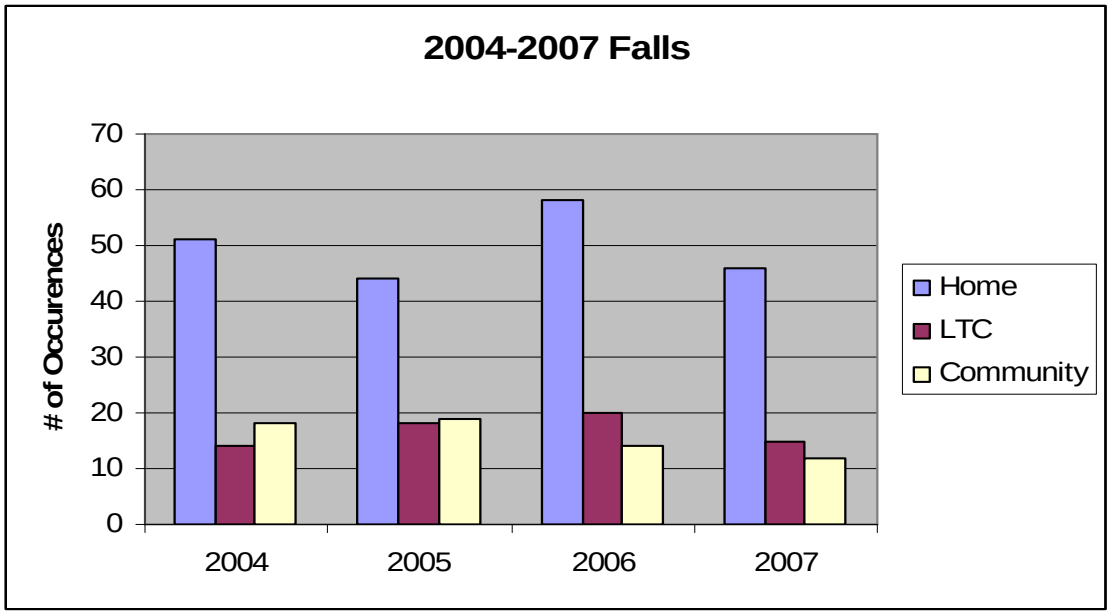


Figure 6 shows a breakdown of the circumstances under which the falls occurred. In most of the deaths (76 cases) where the circumstances were known, the individual either lost his/her balance, tripped, or slipped while walking. Navigating a few steps (such as a curb, porch, or flight of stairs) was a factor in 36 of the falls. In 34 of the cases, the individual either fell out of bed or a chair. In 29 cases the fall occurred shortly after or while attempting to get up, usually to use the bathroom. Some of the individuals (20) fell while performing a simple task such as getting dressed or folding clothes. It appears that the activity caused them to lose balance and fall. Sixteen of the victims reported feeling dizzy before they fell, suggesting that a natural event was the reason for their collapse. Approximately 20% of the falls were unwitnessed and the individual was found down on the ground. It is unknown if the fall was precipitated by a mechanic or natural event. The location where these victims were found is summarized in Figure 7. Most of the unwitnessed falls occurred in the bathroom (43%) or bedroom (29%), followed by the kitchen (11%), hallway (9%) and yard (8%). In 8% of cases there was not enough information to draw any conclusions about the fall. This was either because the individual had experienced multiple falls during a short period of time, their fall was unwitnessed and the onset of their symptoms was delayed, or the accident occurred out-of-county and the death followed prolonged convalescent care.

Figure 6.

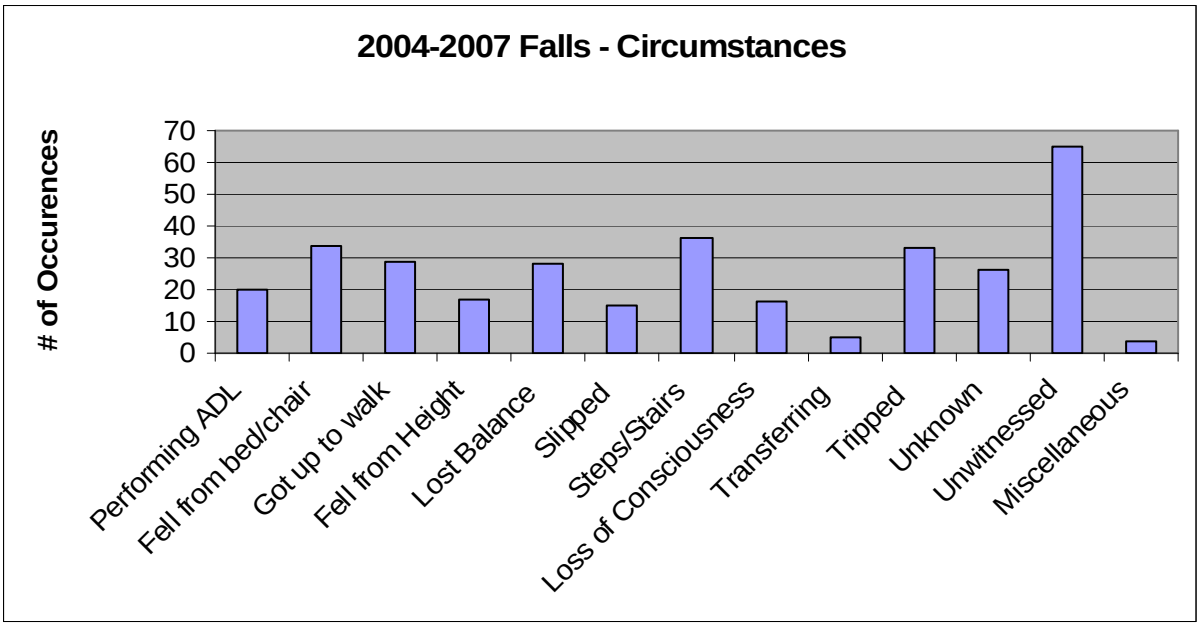
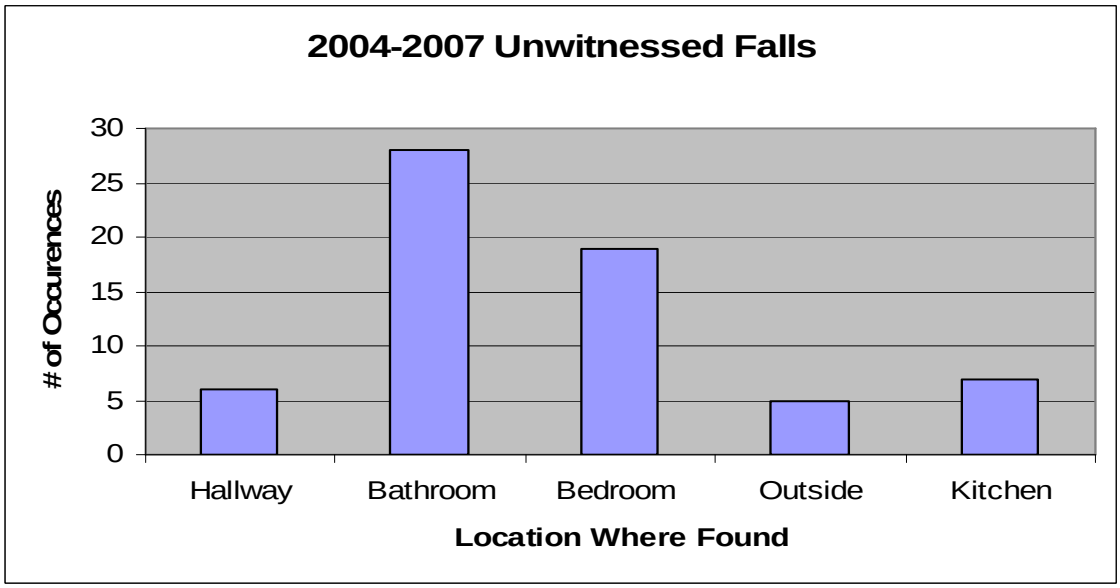


Figure 7.



Motor Vehicle-Related Deaths:

Between 2004 and 2007, 127 deaths in the elderly population were related to motor vehicle accidents with 61 involving more than one vehicle and 16 a single vehicle. Fourteen accidents involved a vehicle other than a typical passenger vehicle, such as a bicycle or scooter. There

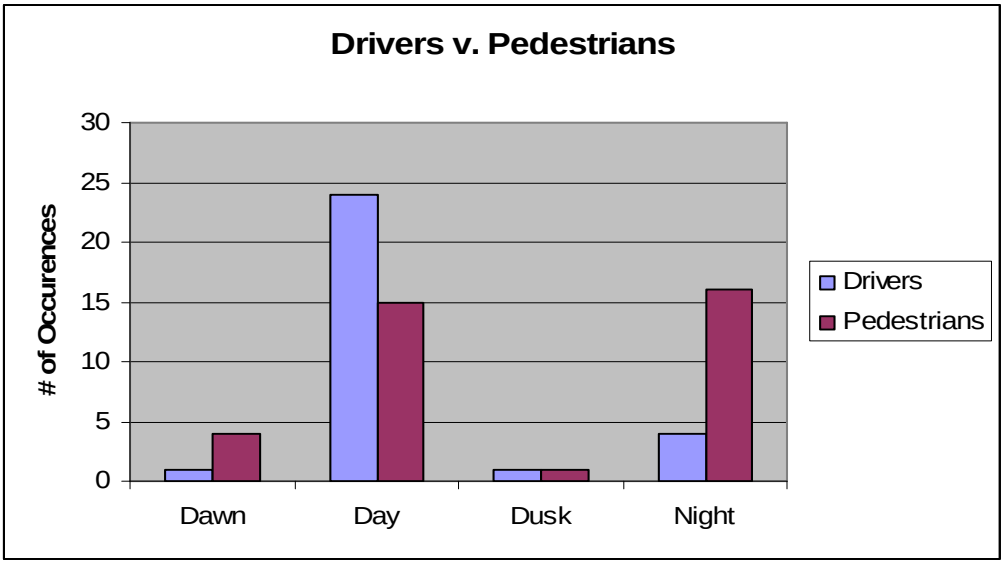
were 36 pedestrians struck by a motorized vehicle. Of the 16 drivers involved in solo motor vehicle accidents, only three were female. The ages of the female drivers were 65, 74 and 85 years. There were four male drivers in their 60s, six in their 70s and three in their 80s. The vast majority of the accidents occurred during daylight hours (12) and under clear (10) and/or dry (12) conditions. Five of the accidents were thought to have been precipitated by medical conditions, five due to traveling at excessive speed, and the reason for the other five was unknown. Twelve of the drivers had evidence of heart disease, two were alcoholics, and one had dementia. Only one of the drivers was determined to be under the influence of alcohol.

Of the 61 people who died in a multiple vehicle collision, 33 were elderly drivers and 28 were elderly passengers. Most of the drivers were male (24) with only nine being female. The age of the male drivers ranged from 66-91 years and that of the female drivers from 69-88 years. The elder driver was found to be at fault in approximately 60% of the accidents. Of the 19 at-fault drivers, 5 were female and 15 were male. The ages of the at-fault female drivers were 69, 72, 82, 85, and 88. One of the at-fault male drivers was in his 60s, eight were in their 70s, and six in their 80s. Most of the accidents where the elder driver was at fault occurred during daylight hours (16) and under clear (14) and/or dry (16) conditions. Only two of the at-fault elderly drivers were intoxicated with alcohol. Eight of the accidents involved head-on collisions after the elderly driver crossed over into the path of oncoming traffic.

Compared to drivers, there were more female passengers than male (18:11). The age range of the female passengers was 66-91 years and the range of the male passengers 71-91 years. In 50% of these accidents, the driver of the elderly passenger was at fault. In 10 of the 14 accidents where the victim's vehicle was at fault, the driver was also elderly. Again, the vast majority of the accidents occurred during daylight hours under clear, dry conditions.

The ages of the 36 pedestrians who were struck by a car ranged from 65 to 89 years of age; 21 were male and 15 female. As expected, most of the accidents occurred when the pedestrian was attempting to cross the street (78%). Two pedestrians were walking along the roadway when struck and three were hit by cars that were in the process of parking. One victim was struck by a car that left the roadway and one was found on the roadway, a victim of a hit and run accident. In the other 35 accidents, the drivers remained at the scene. In 75% of the cases, the pedestrian was found to be at fault for failing to use a crosswalk or illegally walking along a freeway or road. The drivers were at fault in 7 cases and both the driver and pedestrian were at fault in one. In four of the accidents, the individual at fault is unknown. When examining the time of day when the accidents occurred, a bimodal distribution emerges (see Figure 8): 15 accidents occurred in the daylight hours and 16 occurred at night. Only four accidents occurred at dawn and one at dusk. This is quite different from the pattern seen with elderly drivers where most of the accidents occurred during daylight hours. Of the 16 pedestrians walking around in the dark, four were female and twelve male. Four of the men killed at night were intoxicated with alcohol. None of the pedestrians killed at other times of the day were intoxicated.

Figure 8.

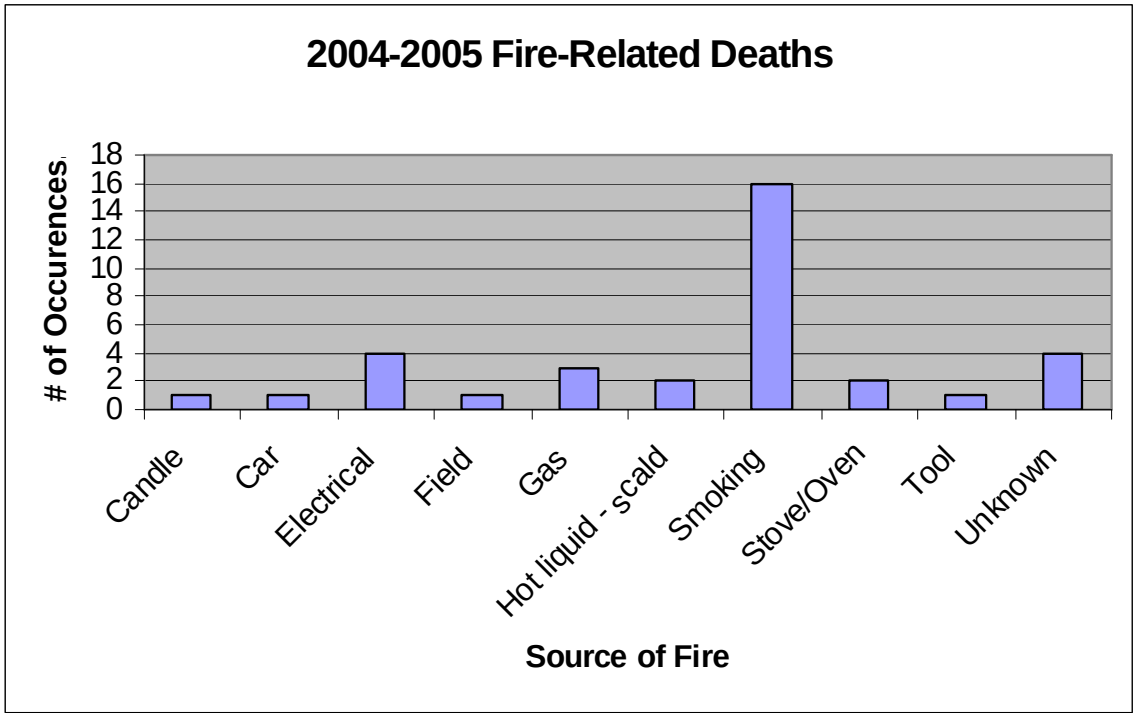


In the accidents that involved something other than a standard passenger vehicle, there were eight involving a bicycle, two a scooter (Lark), two a farm tractor, one motorcycle, and one golf cart. All of the victims were male; nine were Caucasian, four Hispanic, and one Filipino. The ages of the cyclists ranged from 65 to 83 years, the farmers were both 80 years old, and the drivers of the scooters 83 and 96 years. The man riding the motorcycle was 67 years old and the golfer 79 years. Two of the cyclists were intoxicated with alcohol. The toxicology results are unknown on one of the cyclists, the golfer, and one of the scooter operators. The rest tested negative for alcohol. None of the cyclists were wearing a helmet and the motorcycle driver was wearing a half helmet, which though legal provides no protection. Six of the cyclists and one scooter operator were found to be at fault for either running a stop sign or red light, or veering into traffic. The golfer was struck by his unmanned golf cart when his bag fell on the accelerator. One of the farmers was struck by an unmanned tractor that began to move for unknown reasons. The other farmer appeared to have a natural event while operating the tractor causing it to go off a levee and overturn onto the driver.

Fire-related Deaths

There were 35 deaths caused by burns resulting from a fire or hot liquids (see Figure 9). The ages of these elders ranged from 65 to 92 years with relatively equal numbers of males and females. Almost half of the fires were started by cigarettes (16). Most of the fires occurred in the residence of the elder; however, four occurred in Board and Care type facilities. All four of these latter deaths were related to cigarettes. Two of the victims were burned when their clothing caught fire while they were smoking. The other two were victims of a structural fire that occurred when a demented patient was allowed to smoke in her room and caught a chair on fire. The owners of this facility lost their license and are being prosecuted by the District Attorney's office for their negligence.

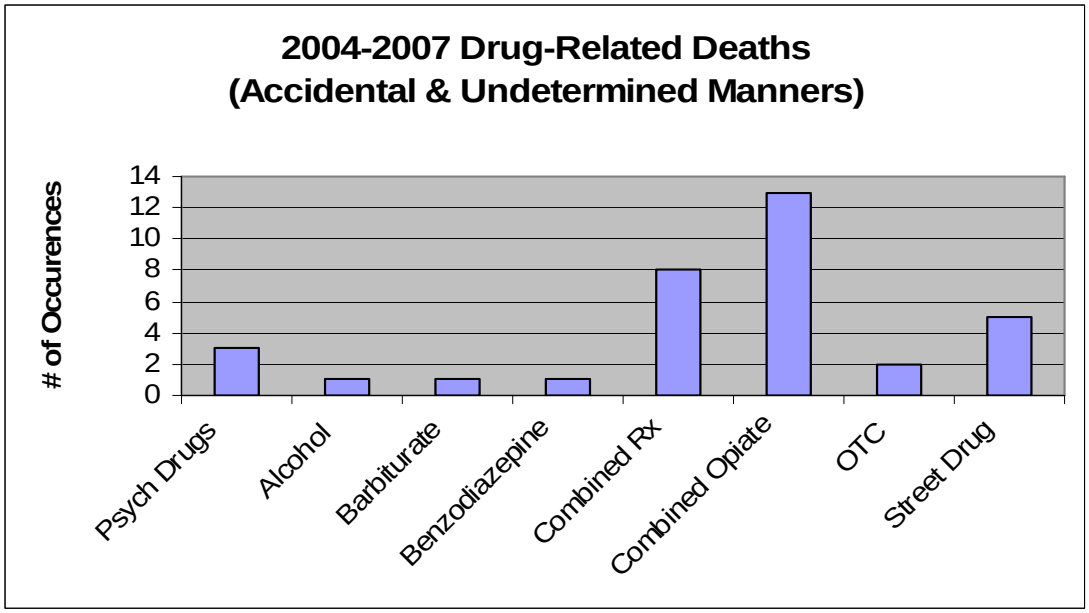
Figure 9.



Drug-Related Deaths

Accidental drug overdoses were the cause of death in 29 elderly people between 2004 and 2007. The ages ranged from 65-87 years; 17 in their 60s, 10 in their 70s, and 2 in their 80s. Seventeen were male and eleven female. Most victims died from a combination of prescribed medications that typically included at least one opiate issued to treat a chronic pain syndrome. A history of prescription drug abuse and depression were common findings in these deaths. Factors such as a person's ability to manage taking multiple medications or their body's ability to process and clear the drugs from their system are of concern in the elderly patient. Because of these factors, manner of death can often be difficult to determine. Figure 10 gives a breakdown of the types of drugs that were detected in drug-related deaths. Five of the deaths were from common street drugs (cocaine, heroin and methamphetamine). The ages of these victims ranged from 65-72 years and all were male. Two of the deaths were caused by over-the-counter medications. One was an 86 year old woman who died from liver failure after accidentally taking too much acetaminophen (e.g. Tylenol). The other was an 88 year old man who took too much cold medication. This case was actually classified as undetermined as there was a possibility of suicidal intent.

Figure 10.



Choking-Related Deaths

Choking-related deaths can be difficult to diagnose. Not everyone who dies while they are eating has choked on their food; some individuals just happen to have their natural event while eating. People who are neurologically intact do not typically choke on food as they have a functioning gag reflex that helps prevent food from becoming lodged in the upper airway. People who have had strokes, who have a history of dementia or psychiatric illness, who have no teeth or poor-fitting dentures, or who are under the influence of alcohol or drugs are at risk for choking. In some cases, the food becomes lodged in the esophagus because of an obstructing mass and the trachea becomes compromised from the outside. Therefore, a complete investigation into a person's medical history and interviews with witnesses and medical personnel are critical for making this diagnosis. Many elderly patients are prescribed special diets because of known swallowing difficulties; therefore, neglect can also be an issue in these deaths if the individual was fed food that had been determined to be unsafe because of their medical condition. During the period of this report, there were 16 deaths that were determined to be caused by food obstructing the airway. Seven of the victims were female and nine male. Their ages ranged from 65-91 years. Five of the victims had a history of dementia, three had an unspecified psychiatric illness, three had Parkinson's disease; two had had multiple strokes, two had an obstructed esophagus (one from a tumor and one from reflux disease) and one had multiple sclerosis. Five of the people were known to have trouble swallowing and required soft diets, two needed to be fed by another person, and two had a history of eating too fast and not chewing their food. Eating habits and dietary restrictions were unknown in seven cases. Eight of these deaths occurred at an assisted living or skilled nursing facility, two were being fed by paid home care providers, five by family or friends, and one was living independently. Large pieces of meat (chicken, hotdogs, and steak) were the obstructing foods in ten deaths and sandwiches (deviled egg, ham and cheese, and roast beef) in four deaths. Hash browns and chunky carrot raison salad were the foods being consumed in the other two deaths.

Drowning

Similar to infants and small children, bodies of water can present a hazard for the elderly. There were 13 deaths attributed to drowning during this period. Four of the victims were female, ages 74-94 years, and all drowned in a swimming pool. The other nine victims were male, ages 65-95 years. Three drowned in a pool, three in the bath tub, one in a hot tub, one in a pond, and one in the river. There is always a contributing factor to explain a drowning that occurs in a bath tub or hot tub. Typically the person suffers a natural event, such as a cardiac arrhythmia or seizure, that renders them unconscious; or they pass as a result of being under the influence of alcohol or drugs. The three bath tub deaths were determined to be due to underlying heart disease while the man in the hot tub was intoxicated in addition to having significant heart disease. All of the other victims fell into the body of water in which they drowned. Confusion, unsteady gait, and underlying heart disease were contributing factors in these deaths.

Miscellaneous Deaths

The remaining 24 accidental deaths represent an assortment of events. Seven deaths were determined to be directly related to environmental hyperthermia. Three of these deaths occurred during the heat-wave of 2006. All of the victims were in their 80s, two were female and one male. All died inside and none had access to air conditioning. One heat-related death occurred in 2004. In this case, an independent 72 year old woman with dementia forgot to turn off the burners on her stove causing her home to become stifling hot. There was one heat-related death in 2005. This case involved an 87 year old man who was found unresponsive in his driveway. It appeared he had fallen and was unable to get up, lying for several hours under the direct heat of the sun before he was found. The other two deaths occurred in 2007. One involved a 72 year old woman who died in her home during a heat wave without access to air conditioning. The other was a 91 year old woman who was working in her garden during a period of high environmental temperature. All six elderly victims had significant underlying medical disease that contributed to their death. There were six deaths caused by medical misadventures. Three were related to medication errors and three from mal-placement of a vascular catheter. There were four deaths caused by accidental poisoning. Three were women who ate wild poisonous mushrooms that they picked from their yard. All three women were of different ethnic origins; one was Hispanic, one Russian, and one English-American. The fourth was a 91 year old man with dementia who started up a car in a closed garage and succumbed to carbon monoxide. Five deaths were related to complications of a skin wound. Three of these wounds became infected; one was caused by a dog bite, one from stepping on a nail, and one was suspected to have been a spider bite. The fourth puncture wound was caused by broken glass which injured a blood vessel causing the individual to lose a significant amount of blood. The fifth wound was an ulcer that developed on the ankle of an 80 year old woman with poor circulation in her legs. The ulcer eroded into a varicose vein causing the women to lose a significant amount of blood. During this four year period, there were two people who were struck by trains. Both had a history of dementia and wandered onto the train tracks. A 72 year old man who enjoyed flying was struck by the prop of his plane as he was manually starting it. The last accidental death was a case of positional asphyxia. This case involved a 65 year old intoxicated male who became stuck as he tried to climb out a small window in his trailer.

SUICIDAL DEATHS:

In 2004, suicides made up approximately three percent of deaths in people 65 years or older. The percentage of deaths by suicide has increased on average to 6.4% (range 5-8%) in this population per year; however, the number of cases seen each year is showing a slight downward trend. There were 32 elders who ended their own life in 2004, 25 in 2005, 22 in 2006, and 18 in 2007. The ages ranged from 65-95 years; 76 were male and 21 female. When looking at the overall group, elderly men were 3.6 times more likely to commit suicide than elderly females; however, when comparing the sexes by age the odds change dramatically. Younger men (those in their 60s and 70s) have an odds ratio of 2.5:1 compared to older men (those in their 80s and 90s) who are six times more likely to end their life than their female counterparts (see Figure 11). Almost 90% of the victims were Caucasian, six were Asian, two African-American, three Hispanic, and one a Pacific Islander. Firearms continue to be the preferred method (66%), followed by drug overdose (18%). The balance consisted of seven hangings, four drownings, two suffocations from placing a bag over the head, and two stabbings to the torso (see Figure 12). Of the four drownings, two used the pool on their property, one the bathtub, and one the American River. Failing health was cited as the motive in 69%, followed by loneliness 10%), financial concerns (5%), and pre-existing mental illness (5%) [see Figure 13]. Unlike young adults, relationship problems were a factor in only two cases. Fear of deportation was the concern of an 89 year old Asian man whose visa had expired. The motive was unknown in seven cases. All but eight chose to end their life somewhere around their home, whether it was in the house, in the yard, or in a car parked on their lot. Of the eight that chose another location, two went to a hotel, one to a parking lot at a funeral home, one to a relative's house, two to the river, and one went behind a nearby business. The eighth person was an 84 year old man who hanged himself with a pillowcase while lying in bed under observation at a psychiatric hospital where he was taken for his suicidal behavior. This case exemplifies how determined some people are in ending their life, how fast the act can occur, and how easy it is to accomplish the act without elaborate resources.

Figure 11.

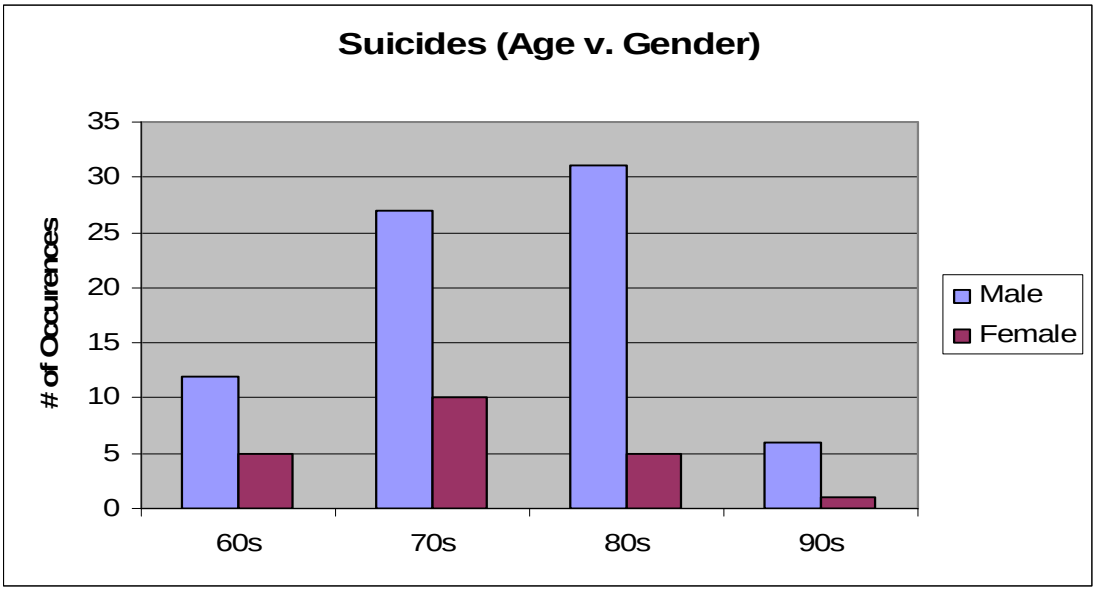


Figure 12.

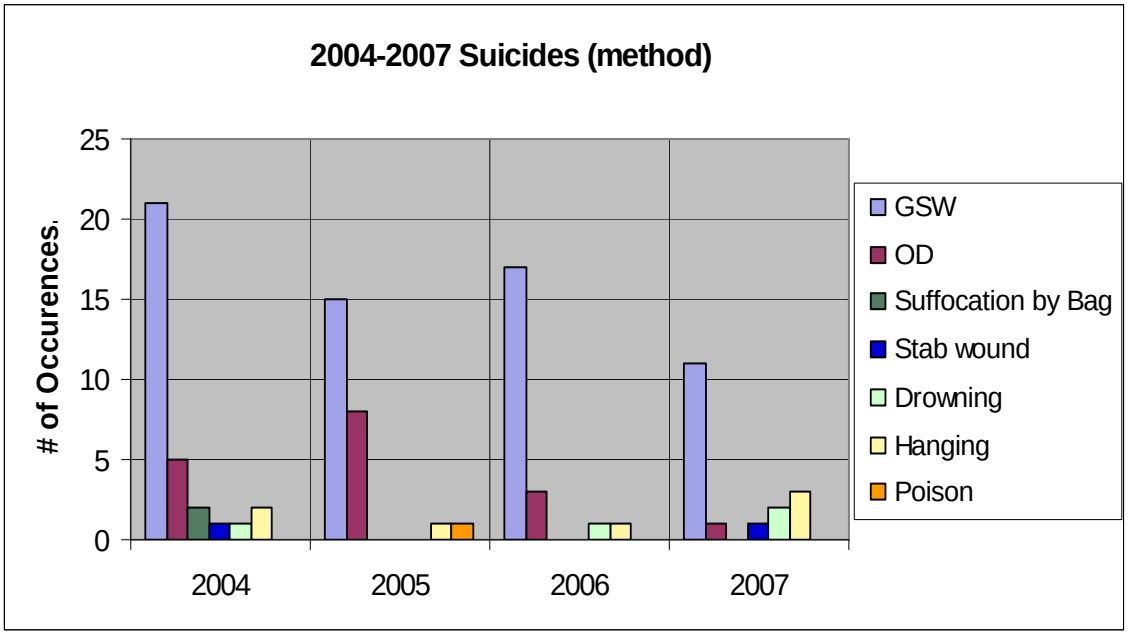
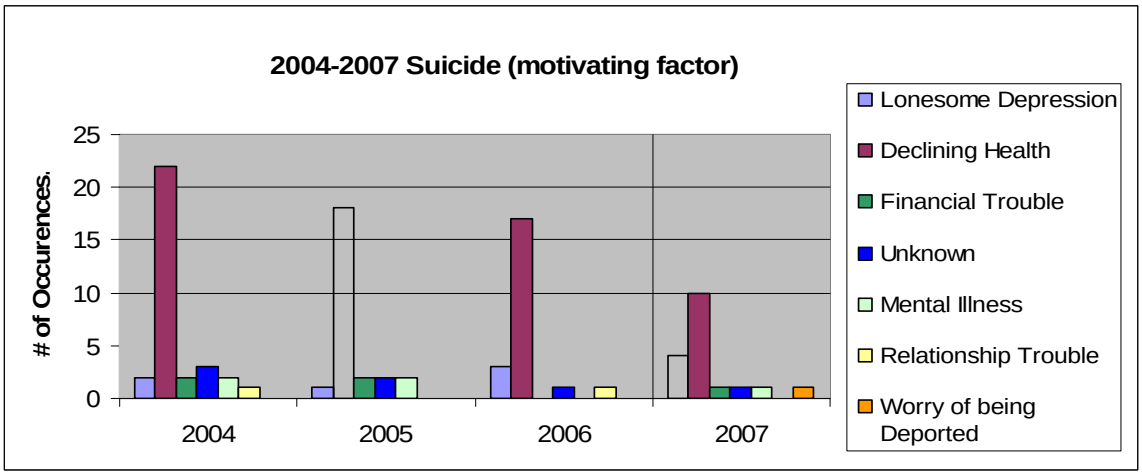


Figure 13.



HOMICIDAL DEATHS:

There were 15 deaths classified as homicides between 2004 and 2007. Nine of the 15 victims were male and six female. Most of the victims were in their 60s (9 out of 15). Two of the remaining six were in their 70s, two in their 80s and two were 90 years of age. Nearly three quarters of the victims were Caucasian (11 out of 15) while only two were African American and the other two Asian and Hispanic. Two-thirds (10 out of 15) of the violent acts occurred in the victim's private residence, three occurred outside in an alley or on the street, one was at work and one took place in a skilled nursing facility. Within the Sacramento region, six homicides

occurred in the northern part (Rio Linda/Del Paso), five in the southern part (Florin/Oak Park), two occurred downtown, and two in the east county (Carmichael/Orangevale).

Robbery/theft was the motive for six of the crimes. The perpetrator for five of these deaths was someone who was an acquaintance of either the victim or someone in the victim's family. These acquaintances included friends, neighbors, and people hired to do handy work around the house. Three of these victims were male; two were strangled and one bludgeoned with a hammer. The other two victims were female; both were beaten. The sixth robbery victim was a female who was stabbed by a total stranger during a purse snatching.

The perpetrator of four of the homicides was a member of the victim's family. Two of these deaths were mercy killings. Both victims were male; one killed by drug overdose and the other by being shot in the head. Mentally disturbed children were the perpetrators in the other two family-related deaths. Both victims were female; both were beaten and strangled. In another case, a male live-in care provider strangled his female employer following an argument during which he was threatened with eviction.

Three deaths occurred under unusual circumstances. One was an officer involved shooting of a 68 year old man with schizophrenia who was threatening citizens with a knife. Another involved an altercation between two demented male patients at a nursing home with one suffering a heart attack immediately following the assault. The third unusual case resulted from a teenager discharging an assault weapon inside his home and the victim being struck as he drove his car passed the teenager's house. The final case was thought to be gang-related shooting. In this case the alleged perpetrator was an acquaintance of a family member and the victim was an unintended target.

UNDETERMINED DEATHS:

In 24 deaths, the manner of death could not be adequately determined. Seven of the deaths (four drownings and three drug overdoses) were highly suspicious for suicides but there was no evidence (e.g. a suicide note) to support an intentional act. In two cases, the cause of death could not be determined due to advanced decomposition. The deaths appeared natural but accidental trauma could not be ruled out. In another case, an elderly woman with Alzheimer's disease died from a drug overdose. It was unclear whether the elevated drug levels were caused by a drug interaction or possibly from forgetting she had already taken her medications. Three of the deaths were related to an asbestos-associated cancer and it was unknown if there was an occupational exposure.

Five of the deaths were declared undetermined because of suspicions of foul play. In two of these cases, the decedents were found on the ground in a public space following an unwitnessed event. Both had suffered head trauma that was consistent with a fall but there was also evidence of a possible robbery. Another case involved a transient who was found on fire in his camp. It was unknown whether the victim had accidentally caught his clothing on fire due to smoking while intoxicated or if he was set on fire by another individual while he was asleep in his camp. Two of the cases suspicious for foul play involved potential drug overdoses by caregivers who

stood to gain financially following the death of the individual. One was an 88 year old man married to a 44 year old woman that he had met under unusual circumstances and who may have been a victim of undo influence by the woman. The other involved a private pay in-home care provider assigned by APS who unethically befriended the decedent and his significant other and assumed fiduciary responsibilities. The cause of death could never be determined as the care provider had him immediately cremated following death.

The final six cases were declared undetermined due to suspicions of caregiver neglect. Two of the cases concerned skilled nursing facilities, two paid live-in care providers, and two family member care providers. In the two nursing home cases, one appeared to be a possible medication error. The patient was found to have severe hypoglycemia for unknown reasons. The most likely explanation was that she had received someone else's diabetic medication in error; however, documentation of this error could not be found. The other patient died from complications of multiple injuries he had sustained from multiple undocumented falls in the care facility. There was evidence of medical neglect in all four cases where the individual was cared for in his/her own home, whether by a paid live-in care provider or from family members. Two cases had advanced pressure sores, one died from untreated diabetes, and the fourth untreated pneumonia and dehydration. In addition to the medical neglect, one individual also had evidence of trauma that was suspicious for physical abuse. The District Attorney's Office is currently pursuing prosecution of one of these six cases.

SUMMARY:

The Coroner's Office investigated the deaths of 1503 elders in Sacramento County from 2004-2007. When categorized by manner of death, or the circumstances under which the death occurred, 52.6% were certified as natural, 38.4% as accidental, 6.5% suicidal, and 1% as homicidal. The manner of death could not be determined in 1.6% of cases.

Heart disease continues to be the leading cause of death in the elderly. Two new trends were identified related to primary and contributing causes of natural deaths. Of note, there appears to be an increase in deaths associated with chronic drug abuse as the Baby Boomers come of age in this community. There has also been an increase in pressure sores listed as a primary or contributing cause of death. The reason for this increase is more likely related to an increased awareness of the significance of these wounds than to an actual increase in prevalence. The presence of large pressure sores is a sign of neglect. Hospitals and nursing homes have already implemented protocols for prevention and amelioration of these wounds in their facilities. Most of the severe wounds seem to develop in the home under the care of family members or paid care providers. Education of home care providers is needed to prevent and care for these wounds in community-dwelling patients.

Falls continue to be the leading cause of accidental deaths in the elderly. As people age and become less active, they lose muscle and bone mass, strength and flexibility causing them to become weak and more unsteady on their feet. The resulting frailty leads to loss of mobility and independence. This weakness and loss of coordination and balance also makes a person susceptible to falls. Regular participation in exercise that promotes muscle strength, balance, and

flexibility can help reduce the risk and fear of falling, thus increasing mobility and the quality of life and decreasing the morbidity and mortality associated with the resultant injuries.

Of the less common types of accidental deaths, fire and drug-related deaths occur most frequently, followed by choking and drowning deaths. Cigarettes are responsible for most of the fire-related fatalities. The combination of multiple prescription medications used to treat chronic pain, depression, and anxiety is the leading cause of drug overdoses, whether the manner is classified as accidental, suicidal, or undetermined. Medication abuse or overuse, chronic liver and kidney disease, and drug interactions are just some of the factors that can contribute to drug overdoses in the elderly. All of the choking fatalities were associated with underlying medical conditions that placed the individual at risk. Many of the individuals had known difficulties with swallowing but were eating foods that were not on their prescribed diets. Two of the victims were being fed by another individual. High patient to care provider ratios leads to hurried feedings and thus increases the risk of choking events. Bodies of water can prove fatal to elderly people who suffer from confusion or an unsteady gait. Fences should be placed around home pools to help prevent accidents from occurring. Caution should also be used in designing care facilities for the elderly. While water features add a nice aesthetic affect, they can prove to be a fatal hazard for the residents.

Suicides continue to be of concern in the elderly. As health begins to fail and friends and family pass before them, some elders are choosing to meet death on their own terms. We learned in the last report that elderly men are more likely to end their lives than women. However, as age increases so seems this ratio. While men in their 60s or 70s are 2.5 times more likely to end their life than age matched women, those in their 80s and 90s appear to be six times more likely. Homicides continue to be uncommon in the elderly with most the result of a robbery or theft committed by someone they know.

2008 EDRT Spotlight Agency:

STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES OVERVIEW OF COMMUNITY CARE LICENSING (CCL)

MISSION OF COMMUNITY CARE LICENSING

The mission of Community Care Licensing (CCL) is to promote the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system. The responsibility of CCL is to:

- Promote strategies to increase voluntary compliance;
- Provide technical assistance to and consulting with care providers;
- Work collaboratively with clients, their families, advocates, care providers, placement agencies, related programs and regulatory agencies, and others involved in community care;
- Train staff in all aspects of the licensing process;
- Educate the public about CCL Division (CCLD) and community care options; and,
- Promote continuous improvement and efficiency throughout the community care licensing system.

CCL Historical Timeline

- **1973:** Legislature enacts Community Care Facilities Act within Department of Health. Establishes a statewide system of community care (separate from health care) for persons with mental and developmental disabilities, socially dependent children and adults and creates new regulations for licensing non-medical out-of-home care facilities.
- **1978:** Licensing responsibilities for all Community Care Facilities (social models/residential settings) were transferred to the new California Department of Social Services (CDSS).

Community care was originally envisioned as a way to normalize care in the least restrictive environment for persons needing assistance and supervision in the performance of activities of daily living. It was assumed that children and adults placed in such settings required little more than a healthy, safe and supportive environment.

Today the nature of community care has changed significantly and now includes care for persons with severe behavior adjustment problems, serious mental disorders, and significant medical needs. The CCL program is now governed by three separate licensing Acts and a fourth statute that was enacted in 1990 as a result of the program's expanded responsibilities.

Facility Types

CDSS licenses care facilities for persons who cannot live alone but who do not need extensive medical services. The services provided in these facilities vary according to the needs of the individual, but typically include help with medications and personal hygiene, dressing and grooming. Facilities also may provide supervision and programs for individuals with dementia, including Alzheimer's disease.

Residential Care Facilities for the Elderly (RCFE)

Residential Care Facilities for the Elderly (RCFE) provide care, as described above and may provide incidental medical services under special care plans.

The facilities provide services to persons aged 60 years and older and persons under 60 with compatible needs. RCFEs are also known as assisted living facilities, retirement homes, and board and care homes. The facilities can range in size from fewer than six beds to more than 100 beds. Consumers select facilities that best meet their needs. Sacramento County currently has 476 RCFE facilities with a total of 7266 beds. Table 1 gives a comparison of the number of RCFE facilities and total number of beds in each county within California.

Continuing Care Retirement Community (CCRC)

Today's seniors are faced with many attractive options for retirement living. One of these options is a continuing care retirement community. CCRCs offer a long-term continuing care contract that provides housing, residential services, and nursing care, usually in one location, and usually for a resident's lifetime.

Continuing care contractors must obtain a certificate of authority and a RCFE license. In addition, CCRCs that offer skilled nursing services must hold a Skilled Nursing Facility License issued by the California Department of Health Services.

The CCL Division (CCLD) has two branches that regulate CCRCs. The Senior Care Program monitors for compliance to the CCL laws and regulations on buildings and grounds, accommodations, care and supervision of residents, and quality of service. The Continuing Care Contracts Branch reviews and approves applications to operate a CCRC and monitors the ongoing financial condition of providers and their ability to fulfill the long-term contractual obligations to residents.

GENERAL STATEMENT

CCLD is a regulatory enforcement program responsible for protecting the health and safety of children and adults in out-of-home care. CCLD is responsible for administering the Community Care Facilities Act, the Residential Care Facilities for the Elderly Act, Residential Care Facilities for the Chronically Ill Act, and the Child Day Care Act.

The CCL Program Analyst's (LPA) responsibilities include prevention, compliance and enforcement.

- **Prevention -** Reduce predictable harm by screening out unqualified applicants and by providing applicants and licensed providers with information regarding the laws and regulations concerning the operation of community care facility. Prevention includes:
    - Orientation prior to licensure
    - Screening applicants
    - Performing background checks
    - Plan of operation
    - Fire clearances
    - Staffing requirements
    - Financial verifications
    - Health screenings
    - Pre-licensing visit to inspect physical plant
    - Providing information regarding laws and regulations
- **Compliance -** Ensure that facilities operate according to applicable laws and regulations. Compliance is maintained through facility inspection, issuing deficiency notices, and providing deficiency correction consultation. Compliance includes:
    - Unannounced facility inspections
    - Complaint investigations
    - Issuing deficiency notices
    - Consultations
    - Education and technical support
- **Enforcement -** Corrective actions taken when a provider fails to protect the health and safety of residents or is unwilling or unable to maintain compliance with licensing laws and regulations. Enforcement is maintained through:
    - Fines and civil penalties (these may vary according to the violation)
    - Non-compliance office conferences
    - Administrative legal actions
        - Denial of applications
        - Compliance plans
        - Probationary license
        - Temporary suspension of license
        - Revocation of license
        - Licensee and employee exclusion

Types of Licensing Visits:

Pre-licensing visits are conducted to ensure the facility meets licensing requirements. Multiple visits may be needed to verify that the facility has made the corrections needed to meet licensing standards. Pre-licensing, collateral and case management visits are made by appointment. All other visits are unannounced.

Post licensing visits are made within 90 days of the approval of licensure to evaluate the facility's compliance with licensing requirements.

Required annual visits review the facility's operation prior to the license anniversary date and are conducted for any of the following reasons:

- A licensee is on probation.
- The terms of agreement compliance plan requires an annual evaluation.
- An accusation against a licensee is pending.
- A facility requires an annual visit as a condition of receiving federal financial participation.
- Verification that a person who has been banned from a facility by the Department is no longer at the facility.

Random sample site visits are made to 20 percent or more of facilities that are not subject to annual visits to evaluate the facility's compliance with licensing requirements.

Complaint visits are made to facilities to investigate allegations lodged against the facility.

Collateral visits are made in connection with complaint investigations, to follow up on incident reports, or to gather additional information needed as a result of any type of facility visit.

Case management visits are made to facilities needing increased supervision, to review operational concerns, and/or facility consultation.

Plan of correction visits are made to facilities cited for licensing violations to determine if those deficiencies have been corrected.

Evaluation for Compliance

Facilities are evaluated to ensure they are in substantial compliance with licensing laws and regulations. If out of compliance, the facility is cited to protect the clients in care. There are three types of violations:

1. **Immediate impact violations** have a direct and immediate risk to the health, safety or personal rights of clients.

2. **Potential impact violations** are those that, without correction, could become a health or safety risk to the clients.

3. **Technical violations** are regulatory violations that do not present an immediate or potential negative impact to the health and safety of clients.

Licensing Reports

An LPA writes a Licensing Report for each visit. It contains information gathered during the visit and includes deficiencies and citations issued. The licensee or designated representative is responsible for developing and implementing a plan of correction. A time frame for correcting each deficiency is established based on the type of impact of the violation.

Civil Penalties

If the first cited deficiency is not corrected within the specified time frame, a civil penalty of $50 per day, per violation, up to $150 per day maximum, is assessed. The penalty will continue until correction is made and the licensing agency is notified. If there is a second cited violation of the same regulatory subsection within 12 months of the first citation, an immediate civil penalty of $150 per violation, will be assessed. A daily penalty of $50, per violation will continue until the deficiency is corrected and the licensing agency is notified.

If there are subsequent cited violations of the same subsection within 12 months of the previous citation, the civil penalty increases. For RCFEs and residential care facilities for the chronically ill, there is an immediate civil penalty of $1,000 and a daily penalty of $100 for each day until the deficiency is corrected.

If there are cited violations that lead to death, injury, or sickness of a client there is an immediate civil penalty of $150 assessed that day, per violation. A daily penalty, per violation, of $150 is assessed beginning the day after the immediate civil penalty assessment and continues until the deficiency is corrected and the licensing agency is notified.

If there are cited violations of the Title 22 regulations for failure to obtain, or associate, required fingerprint clearances or exemptions there is an immediate $100 per person civil penalty.

If civil penalties are not paid after receiving the bill, the licensing agency has other methods of collection, such as:

a. Offset Program – attaching the individual's State personal income tax return.

b. Revocation of license based on unpaid civil penalties.

Appeal Process

The licensee has the right to appeal any licensing action without retaliation from licensing staff. The licensee has the right to discuss the penalty assessments with the licensing agency. When civil penalties are involved, the licensee may request a formal review to amend, extend the due date or dismiss the penalty.

Administrative Hearings

Administrative Hearings may lead to the revocation of a license or the denial of an initial license. Hearings can also be used to resolve whether employees or other persons should be excluded from facilities.

Administration Action Process

The goal of regulatory enforcement is to gain compliance. Closing a facility is an action of last resort. The policy of the CCLD is to ensure that licensees are afforded an opportunity to correct deficiencies prior to initiating an administrative action.

There are some situations that warrant a temporary suspension order (TSO) or the immediate closure of a facility and the removal of all clients. A TSO is done when there is imminent danger to the health, welfare or safety of clients or there is no other way to protect the clients or remove the risk. A hearing is held within 30 days of the closure.

There are other situations where the clients are not in imminent danger, but the licensee is unwilling to operate in compliance with the laws and regulations. In these instances, the Department initiates a **revocation action** against the facility. During this process, the facility may continue operating prior to an administrative hearing, and the clients are normally not removed. The licensing agency schedules a noncompliance review conference with the licensee to review problem areas and shares concerns of the seriousness of the situation. The licensee is advised that an administrative action is pursued if the deficiencies are not corrected.

Administrative Actions Resulting in Client Relocation:

After the licensing office has utilized all available and appropriate enforcement actions, and the licensee is still failing to comply, administrative action is the next step. There are no hard and fast rules as to what action is appropriate in a given case; each case is assessed individually. The following is a list of primary options available in dealing with a non-compliant facility that may result in facility closure:

- Temporary suspension orders.
- Telephone temporary suspension order.
- Denial of an application when the facility is in operation.

- Denial of an application for which the facility has been issued a provisional license and is currently operating.

- Legal actions taken if an unlicensed facility does not pursue the licensing process as directed by the department.

- Implementing a Decision and Order revoking the license of an operating facility.

- Implementing a Decision and Order resulting from a Stipulated Agreement.

- Implementing a Decision and Order revoking a probationary license of an operating facility.

In addition to the administrative actions listed above, immediate client relocation may be required when a licensing analyst or other representative of the licensing agency identifies a threat so severe that emergency personnel must be summoned while that licensing representative is at the facility.

NON-COMPLIANCE CONFERENCE

The purpose of the Non-Compliance Conference is to review problem areas and impress upon the licensee the seriousness of the situation. The need for a Non-Compliance Conference may arise from a series of repeated licensing violations, issuance of civil penalties, informal meetings or telephone conversations with the licensee. The licensee is informed that unless deficiencies are corrected and compliance is maintained, the case will be referred to the legal division for administrative action. In addition, it is made clear to the licensee that the conference does not excuse past problems or resolve the department's case against the licensee if the problems are not corrected. The Non-Compliance Conference is the last step prior to initiating administrative action following unsuccessful attempts by the LPA should compliance not be attained. The regional manager makes the final decision whether to pursue legal action or to conduct a Non-Compliance Conference.

SETTLEMENTS, STIPULATIONS, PROBATION

In many cases, the parties in an administrative action may choose to negotiate a settlement rather than participate in a hearing. The settlement agreement includes specific terms and conditions or stipulations. The local licensing office continues to be responsible for licensing services to the facility while administrative action is under consideration.

Denial of Application: No Care Being Provided. When a person or organization cannot or will not comply with the requirements of statute and regulations before licensure, and the applicant has been advised of the deficiencies but has failed to correct them, the initial application should be denied. An applicant has 15 days to appeal the

denial of the application and exemption (if included). The applicant may not operate the facility pending the hearing on the appeal.

Denial of Application: Care Currently Provided. In cases where a facility is operating without a license and continues to operate after the application for a license has been denied, an injunction or a referral for criminal prosecution may be ordered.

License Revocation: When all attempts to correct the problems have been exhausted, the local licensing office may choose to recommend that the provider's license be revoked.

In addition, if the Caregiver Background Check Bureau or county denies a criminal record exemption or receives notice of a conviction of a non-exemptible crime for a licensee or spouse or dependent adult who resides in the facility, the license must be revoked.

In the absence of a temporary suspension order, the licensee may continue to operate a facility after an Accusation has been served. The facility may continue to operate until a Final Decision and Order revoking the license is adopted by CDSS.

Expedited Accusation: When the regional manager, assistant program administrator or Program administrator have determined that a case is urgent, but does not meet temporary suspension order criteria, an expedited Accusation may be appropriate.

An expedited Accusation is drafted by an attorney as quickly as possible. The hearing however will be scheduled with the Office of Administrative Hearings within the normal time frames and will not result in a more timely hearing.

Temporary Suspension Order: A temporary suspension order is sought when an immediate health or safety hazard exists in a facility and the operation must be closed immediately. The temporary suspension order will specify an effective date when the operation of the facility must cease. The temporary suspension order is an extreme measure because it will result in the immediate closure of a facility and the need for clients to relocate, and will have an immediate adverse effect on the livelihood of the licensee.

In preparation for a Temporary Suspension Order, the CCL program manager may call together all involved agencies that will be instrumental in the closure of the facility and the relocation of clients. During the relocation process, clients must continue to be fed, receive their medications and continue to receive help with things like ADLs. Also, they oftentimes need emotional support because of the loss of their home.

Superior Court injunction proceedings or criminal prosecution will be considered in the following unlicensed operation situations, including, but not limited to: (1) A failure or refusal to apply or cease operation after notice, (2) A failure or refusal to cease operation after application denial, (3) Operation after service of a Temporary Suspension Order,

and (4) Operation after service of a Decision and Order or a Stipulation and Order revoking the license.

Complaints

A complaint is an allegation that any DSS licensing regulation or law is being violated. The source of the information may be anyone that believes there is a problem. As long as the complainant raises reasonable questions about the care of the clients or possible facility violations, the information is taken as a complaint. Complainants may remain anonymous. Complaint visits are made to facilities to investigate allegations.

The most serious complaints is Priority I. The local unit manager or regional manager will refer all complaints that meet the criteria for Priority I and/or II cases to Program Investigations for investigation.

Priority I (**MANDATORY REFERRAL)**

1. Complaints of **sexual abuse** that involve the penetration of the genitals, anus, or mouth of any of the persons involved or **physical abuse** that involve acts resulting in great bodily injury when:

    a. The victim is a client or the alleged sexual conduct poses a potential health and safety risk for clients.

    b. The suspect may or may not be associated with the facility (for example: licensee, staff, relatives of licensee, unknown perpetrator).

    c. The abuse is alleged to have occurred in the facility or while the client was under the care and supervision of the licensee/staff.

2. Complaints involving suspicious circumstances regarding the **death** of a client, either in or out of the facility.

3. Complaints of lack of **care and supervision** which result in sexual or physical abuse to a client (e.g., stage three and four dermal ulcers, malnutrition, dehydration, hypothermia).

4. Complaints of **abuse** that involve acts such as assault and/or battery, which if successful, would result in death or great bodily injury.

5. Complaints of **unlicensed operation** where a temporary suspension order is in effect or the license has been revoked. Complaints of unlicensed care that involve, physical abuse, sexual abuse, death or lack of care.

6. Complaints of licensee, staff, others residing or present at the facility providing, using, selling or manufacturing **drugs** that may result in **felony offenses**.

Priority II (MANDATORY REFERRAL)

1. Complaints of **sexual abuse** that involve sexual behavior (not penetration) such as voyeurism, masturbation, exhibitionism, exploitation, inappropriate sexual touching, and/or fondling, and **physical abuse** that involve acts resulting in minor injuries or bruises, when the same criteria are present as in Priority I.

    a. The victim is a client or the alleged sexual conduct poses a potential health and safety risk for clients.

    b. The suspect may or may not be associated with the facility (for example: licensee, staff, and relatives of licensee, unknown perpetrator).

    c. The abuse is alleged to have occurred in the facility or while the client was under the care and supervision of the licensee/staff.

2. Complaints of actions by another.

3. Complaints of **unlicensed operation** where entry has been denied to Community Care Licensing Division staff. Complaints of unlicensed operation that involve Priority II allegations.

4. Anyone present in the facility using, or selling illegal drugs other than "felony" drugs.

Priority III (OPTIONAL REFERRAL)

1. Complaints of **physical abuse** that involve acts such as assault and/or battery, shoving, pushing with no injuries or bruises.

2. Complaints of actions of **misdemeanor** offenses, including but not limited to, neglect, or lack of supervision.

Priority IV (REGIONAL OFFICE RESPONSIBILITY)

1. Complaints of physical punishment/corporal punishment to clients defined as spanking (using the hand), lack of supervision that did not result in any abuse or injury, unsanitary conditions and other regulatory violations.

2. Includes complaints of client on client conduct that does not meet Priority I, II, or III criteria.

Conducting an Investigation

An LPA reviews the facility file to become familiar with the current status of the facility and to look for complaint trends. Depending on the nature of the allegation, the LPA may make a joint visit with another agency to conduct the investigation.

Complaint visits are made without prior notice to the licensee. In all cases except those involving Priority I or II allegations, the analyst shall apply the standard practice of divulging the substance of the complaint during the ten-day on-site visit.

Next the LPA gathers information from various sources of evidence including statements from eye witness and other witnesses. Review of source documentation includes hospital and medical records; police reports; court documents; abuse reports; resident records; facility and staff records; photographs; declarations; incident reports; paramedic reports; death certificates; autopsy reports; fire inspector reports; building and code enforcement records; and Ombudsman's reports.

Arriving at a finding of unfounded, inconclusive or substantiated rests on a careful assessment of the quantity, quality and context of the evidence.

The proper standard of proof for a Community Care Licensing administrative action is ***preponderance of the evidence.*** This means that 51 percent of the evidence must support a substantiated finding that the alleged sexual or physical abuse occurred. Put another way, preponderance of the evidence means that one body of evidence has more convincing force than the evidence opposed to it. The results of each allegation will be deemed unfounded, inconclusive or substantiated.

Unfounded: The allegation is false, could not have happened, and/or is without a reasonable basis.

Inconclusive: Although the allegation may have happened or is valid, there is not a preponderance of evidence to prove that the alleged abuse occurred.

Substantiated: The allegation is valid because the preponderance of the evidence standard has been met.

Acquiring Information from CCL or Registering A Complaint

To assist the public in acquiring information about Community Care Licensing and facilities, a web site was created. It can be accessed at www.cccld.ca.gov The public can search for facilities, view regulations, learn how to apply for a license and a myriad of other items. For general information or more information regarding a facility (eg: a file review) contact the Senior Care Duty Officer at (916) 263-4700

To register a complaint about a licensed Residential Care Facility for the Elderly, contact the Senior Care Duty Officer. Complainants may request to remain anonymous. The Senior Care Duty Officer is on duty from 8:00 am to 5:00 pm Monday through Friday.

Table 1. County Comparison of Licensed Facilities in California

County Name	# of Facilities	# of Beds
Alameda	369	7,340
Alpine	0	0
Amador	5	134
Butte	39	1,110
Calaveras	3	64
Colusa	1	15
Contra Costa	448	6,538
Del Norte	1	63
El Dorado	32	347
Fresno	180	3,371
Glenn	4	69
Humboldt	33	622
Imperial	5	199
Inyo	1	76
Kern	101	1,622
Kings	4	180
Lake	8	110
Lassen	3	88
Los Angeles	1,466	36,555
Madera	19	300
Marin	53	1,881
Mariposa	1	20
Mendocino	16	217
Merced	34	492
Modoc	1	6
Mono	0	0
Monterey	63	1,511
Napa	41	713
Nevada	14	486
Orange	932	19,084

County Name	# of Facilities	# of Beds
Placer	136	2,041
Plumas	1	4
Riverside	523	9,011
Sacramento	476	7,266
San Benito	4	54
San Bernardino	251	5,441
San Diego	646	17,503
San Francisco	93	3,150
San Joaquin	98	2,738
San Luis Obispo	93	1,244
San Mateo	318	5,169
Santa Barbara	125	3,221
Santa Clara	367	8,266
Santa Cruz	32	1,153
Shasta	64	882
Sierra	0	0
Siskiyou	8	226
Solano	158	2,362
Sonoma	162	2,864
Stanislaus	79	2,455
Sutter	12	440
Tehama	9	174
Trinity	1	6
Tulare	53	1,048
Tuolumne	6	321
Ventura	198	4,868
Yolo	23	1,164
Yuba	6	164

Total Counties	Total Facilities	Total Beds
58	7,819	166,448

Community Care Licensing Case Reviews from EDRT

The following reviews are elder deaths that were associated with a Residential Care Facility for the Elderly.

During this review period, there were eight elder deaths reviewed in which the precipitating incident of the decedent's death occurred in a Residential Care Facility for the Elderly (RCFE). In each of the elder's deaths, the EDRT review found the facility failed to follow state regulations for Residential Care Facility for the Elderly licensure.

EDRT recommended during each of the following reviews that the licensing agency, California Department of Social Services Community Care Licensing Bureau (CCL), investigate the facility and if appropriate sanction the facility. The facilities involved were cited by CCL and in some cases the licensee's license to operate a Residential Care Facility for the Elderly was reversed.

Elders who are placed in a Residential Care Facility for the Elderly depend solely on the facility to provide them with an environment free of abuse and or neglect. The facility has regulations which are designed to provide a safe environment for our frail and vulnerable elders in Sacramento County. Oversight of these facilities and its ability to adhere to the licensure requirement has been addressed in this report.

Elder Death Review Team
CCL Case Review #1

Case Summary:	Decedent was a 94 year old Caucasian female who resided in a Residential Care Facility for the Elderly (RCFE). She had a history of dementia and hypertension. She was found unresponsive, kneeling on the floor with her head caught in the bed rail at 3:45 a.m. She was last seen alive at 2:45 a.m. The facility notified the next of kin prior to calling 911. The next of kin had a history of belligerent behavior toward the decedent and staff. The next of kin was alleged to be in charge of dispensing medication to the decedent while she was a resident of the RCFE.
Care Provider/ Relationship:	RCFE.
Why Was Case Referred to EDRT?	Public Administrator and Ombudsman had concerns. Aggressive/threatening behavior by next of kin toward decedent and caregivers.
Concerns Addressed By EDRT:	RCFE staff delayed calling 911 due to next of kin limiting facility actions. The next of kin administered medication in the RCFE.
Findings:	Toxicology performed on the decedent revealed a drug level consistent with twice the dose of medication prescribed to the decedent. The RCFE allowed the next of kin to administer the medication against licensing regulations.
Recommendations:	CCL to investigate RCFE for regulation violations and seek sanctions on facility, if applicable.

Elder Death Review Team
CCL Case Review #2

Case Summary:	Decedent was an 82 year old female who resided in a Residential Care Facility for the Elderly (RCFE). She had an unwitnessed fall from a wheelchair in a community room and was found convulsing on the floor with obvious facial injuries. 911 was called and decedent was transported to the hospital. The decedent received a CT scan, which revealed minor injuries to her brain and a facial fracture. She died 5 days later from complications of her injuries.
Care Provider/ Relationship:	RCFE
Why Was Case Referred To EDRT?	Fall at RCFE.
Concerns Addressed By EDRT:	Did the RCFE follow proper licensing procedures for the prevention and reporting of the fall?
Findings:	Residents left unattended in a community room. Unclear if death related to fall was reported to licensing.
Recommendations:	CCL to investigate RCFE for regulation violations regarding the prevention and reporting of the fall.

Elder Death Review Team
CCL Case Review #3

Case Summary:	Decedent was a 91 year old female residing in a Residential Care Facility for the Elderly (RCFE). She was considered independent and used a walker to ambulate. Decedent was found face down on the floor next to her bed with a cut on her nose. 911 was called and decedent was transported to the hospital. Decedent was diagnosed with facial fractures. The decedent was unable to eat and refused a feeding tube. She died a week later from complications of her injuries.
Care Provider/ Relationship:	RCFE
Why Was Case Referred To EDRT?	Fall in RCFE.
Concerns Addressed By EDRT:	Did the RCFE follow proper licensing procedures for the prevention and reporting of the fall?
Findings:	Unclear if death related to fall was reported to licensing.
Recommendations:	CCL to investigate RCFE for regulation violations.

Elder Death Review Team
CCL Case Review #4

Case Summary:	Decedent was a 75 year old female residing in a Residential Care Facility for the Elderly (RCFE). Decedent had a history of stroke, which caused swallowing problems requiring a special diet. RCFE was notified that all foods were to be pureed for the decedent because of a prior choking incident at a different facility. According to RCFE, on the day of the event, decedent was fed potato salad with soup and noodles and bread soaked in the soup. RCFE owner reported decedent's food was always pureed and she was never left alone while eating. When decedent started to choke, 911 was called, but no resuscitative efforts were performed by facility staff. Fire Department EMS reports removing several large pieces of food from airway prior to intubation. The food was described as potato, carrot and some type of food that was the size of "ice cubes."
Care Provider/ Relationship:	RCFE
Why Was Case Referred To EDRT?	Choking incident while being fed in RCFE. Heimlich maneuver and CPR not performed by staff prior to EMS arrival.
Concerns Addressed By EDRT:	Did the RCFE follow appropriate licensing procedures for the prevention and management of a choking episode in their facility?
Findings:	Facility failed to feed decedent special diet as prescribed and lied to investigator. Facility failed to perform resuscitative efforts prior to arrival of EMS.
Recommendations:	CCL to investigate RCFE for regulation violations and seek sanctions on facility, if applicable.

Elder Death Review Team
CCL Case Review #5

Case Summary:	Decedent was an 81 year old female residing in a Continuing Care Residential Community (CCRC) with her spouse who was her primary care provider. The decedent had a history of difficulty with swallowing due to esophageal reflux disease. She had a choking episode while dining with her husband. He performed the Heimlich maneuver and called CCRC staff for assistance. EMS was also called. Pieces of meat were removed from her airway.
Care Provider/ Relationship:	Spouse/CCRC
Why Was Case Referred To EDRT?	Choking incident at a CCRC
Concerns Addressed By EDRT:	Uncertain licensing status of the facility. Did the facility follow appropriate licensing procedures for the prevention and management of a choking episode in their facility?
Findings:	The facility is a licensed CCRC. The facility was unaware of the swallowing problem and did not provide a special diet for the decedent. The facility correctly administered CPR.
Recommendations:	CCL to investigate facility for regulation violations regarding choking incident.
Follow Up:	Allegations of negligence against the facility were determined to be unfounded. The family failed to disclose medical history and special needs requirements to the facility at the time of occupancy.

Elder Death Review Team
CCL Case Review #6

Case Summary:

A licensee of a Residential Care Facility for the Elderly (RCFE) owned four facilities--RCFE I, II, III and IV. Each was licensed for six clients. On November 26, 2006, RCFE I caught fire ultimately killing three of its clients. The fire started in a recliner chair that was originally located in a client's room. The chair caught fire from a lit cigarette the demented client had been smoking. After smoking the cigarette, the client went to bed. Two caregivers were on duty – a husband and wife team. The husband awoke when he heard the smoke alarm going off and found the recliner smoldering in the client's room. He pushed the chair outside onto a wooden patio through a patio door located in the decedent's room and doused it with a bowl of water prior to returning to bed.

Later, the smoke alarm went off again. The recliner had continued to smolder than ignited catching the wooden patio and ultimately the house on fire. The two caregivers tried to evacuate the five clients living in the home but could only remove three. Two clients perished in the fire. A third client died a week later from smoke inhalation. The two clients who perished in the fire were bedridden. One tried to get out but simply could not move. The other tried to get out but was stopped by a wheelchair that had been pushed in front of the bed and locked into place. The fire also caused damage to RCFE II next door but the damage was minimal. All the surviving clients were moved from RCFE I and II to RCFE III, RCFE IV and various other facilities.

Care Provider/ Relationship:

RCFE

Why Was Case Referred To EDRT?

Structural fire in an RCFE resulting in the death of its clients.

Concerns Addressed by EDRT:

Why was client allowed to smoke in her room? Was the facility fully equipped with appropriate fire safety equipment? Why didn't the caregiver use a fire extinguisher or call the fire department when he initially saw the chair on fire? Were there violations of licensing regulations regarding fire safety and evacuation of clients? What lessons could be learned from this tragedy?

Findings: The case was investigated by the Fire Department and by CCL. CCL determined that regulatory deficiencies were citable. CCL asked for and got revocation of the licenses for all four facilities, decertification of the administrators and exclusion of the licensee, the administrators and the caregivers. The Fire Department Investigator arrested the licensee, three administrators and two caregivers on manslaughter charges. The case is pending trial.

Recommendations: There has been a lot of discussion around the need for fire sprinklers in RCFEs. RCFE Associations have resisted legislative attempts to require the installation of fire sprinklers in RCFEs with fewer than seven beds due to the cost. Currently only RCFEs with seven+ non-ambulatory or bedridden clients are required to have sprinklers. An operational fire extinguisher is required at all facilities. The Residential Care Advisory Committee, under the State Department of Forestry and Fire Protection, plans to review the need for sprinklers in all RCFEs by establishing an ad-hoc committee in the next few months. EDRT plans to follow up on the committee's recommendation for fire prevention and safety in RCFEs and support the requirement of sprinklers in these types of facilities.

Elder Death Review Team

Case Reviews

The following five cases were chosen to illustrate the type of information reviewed by EDRT. (Names and other specific details have been deleted or generalized for confidentiality.)

Case Review #1

Case Summary: This case involves a 77-year-old female living at home with a number of nieces, nephews and a son. One of the nephews was a registered sex offender and there was a prior APS history for financial abuse. She was under the care of a niece. The client had multiple health problems including diabetes, dementia, hypothyroidism, hypertension and congestive heart failure. Client needed extensive assistance with domestic and personal care. The care provider was found to have neglected the client to the point where 24 stage IV pressure ulcers had developed. The ulcers were located on her back, legs, ankles, hips, coccyx and feet. Hospital staff at the time of admission stated that this was the worst case of neglect they had ever seen. Instead of seeking medical care earlier on, the care provider used an over-the-counter cream in an attempt to remedy the ulcers on her own. As a result, the decedent's health rapidly declined resulting in an admission to the hospital for sepsis. She died six months later at a skilled nursing facility from complications of the neglect.

Care Provider Relationship: The niece was the primary care provider.

Why Was Case Referred To EDRT? The case was opened with APS due to alleged neglect by care provider. There were elder abuse allegations by the treating hospital against the decedent's relatives.

Concerns Addressed By EDRT: Was this a case of a family being overwhelmed with the required care or was this deliberate? What can the community do to assist families with providing complicated care?

Findings: The care provider failed to provide care for her aunt, resulting in the physical decline in her health and ultimate death. The care provider used the client for financial gain. This care provider had also been the care provider on a prior EDRT case that was reviewed and included in the 2004 EDRT Report.

Recommendations: Law enforcement to refer case to District Attorney's Office for review.

Outcome: Upon review, based on the passage of time between the alleged neglect and the death, and the decedent's significant pre-existing health issues that contributed to her death, it was determined that it would be impossible to prove, with any reasonable certainty, to what degree, if at all, the care provider's conduct contributed to the decedent's death.

Case Review #2

Case Summary: This case involves a 57 year-old female who had a stroke in April 2006 which resulted in left-sided paralysis. At that time she was diagnosed with congestive heart failure and an automatic defibrillator was implanted. She was transferred from the hospital to a rehabilitation program, which subsequently discharged her home to the care of her daughter due to a loss of insurance benefits. The daughter became an IHSS care provider who looked after her mother for the next 1 ½ years. The client was last seen by her primary care doctor more than 10 months prior to her death. The client's health began to decline to the point where the client was bedbound and required a higher level of assistance. The daughter reported that the decedent's aggressive physical and verbal behavior made it difficult to provide basic care. Eventually the client developed diarrhea making it increasingly difficult to keep her clean. She arrived at the emergency room in septic shock 24 hours before her death. The hospital staff noticed multiple bedsores and reported the case to APS four days after the decedent's death. Law enforcement was not notified. An autopsy determined the cause of death was due to sepsis originating from an infected Stage III pressure ulcer over her sacrum.

Care Provider Relationship: Daughter became the decedent's IHSS provider in July 2006 following discharge from rehabilitation program.

Why Was Case Referred To EDRT? Suspicion of caregiver neglect based on the presence of large decubital ulcer at the time of the terminal hospitalization and no follow-up medical care for 10 months prior to death despite decline in health.

Concerns Addressed By EDRT: Could the bedsores have been addressed through regular medical monitoring? Hospital's delay in reporting suspicions of elder abuse/neglect to appropriate agency.

Findings: The primary caregiver was ill-equipped to provide care for a patient with difficult behaviors resulting in no medical monitoring and insufficient

care. The health system delayed reporting suspicion of neglect to APS. Law enforcement was never notified of death related to suspected neglect.

Recommendation: Care management services could have helped to monitor skin integrity, to insure that client attended medical appointments regularly, to monitor the level of care being provided by caregiver, and educate the caregiver on working with difficult patients. Hospital staff needs to be educated to report suspicions of elder abuse/neglect within 24 hours and to notify law enforcement when the abuse/neglect results in death.

Case Review #3

Case Summary: The client was a 79 year old female with psychiatric illness, hypertension, and diabetes living in a home with her daughter (on parole for fraud, assault, and drug-related offenses), son-in-law (a registered sex-offender), their two small children and another elderly man. APS was contacted in July 2006 by a women's shelter due to concerns of neglect. The family had been living in various hotels to escape the violent older son of the caregiver. The level of care for the client was so great that it exceeded what could be provided at an Adult Day Health Center. Family Services was providing emergency nutritional supplements, possibly indicating that the client was severely underweight and/or food was not being consumed in adequate quantities. After the decedent's death it was learned that the primary doctor was concerned with the lack of care being provided by the daughter and the cancellation of many medical appointments. The client was found dead by police after being left with no food, water, medications, or incontinence clean-up for 12 hours. Autopsy revealed cause of death due to sepsis originating from multiple infected stage III-IV pressure ulcers.

Care Provider/ Relationship: The client qualified for 222.9 IHSS hours; the daughter was the primary caregiver.

Why Was Case Referred To EDRT? Law enforcement concerns of criminal neglect by care provider.

Concerns Addressed By EDRT: Although there were other people in the house, the victim was not attended to for more than 12 hours on the day she died. Those left in the home were the caregiver's spouse, two small children and an elderly man. Medical attention or advice was never sought for the presence of bed sores. The primary physician did not report a suspicion of neglect for multiple missed doctor appointments.

Findings: As a "gatekeeper," the primary physician should have reported his/her initial suspicion of neglect to APS. It is not clear why Family Services was involved other than to provide food, but they should have reported the frequent moves and violent environment to APS.

Recommendation: Law enforcement to refer case to District Attorney's Office for review. Background checks and education for IHSS care providers. On-going medical and social care management could have assisted in monitoring care provided and safety in the home, attendance at regular medical appointments, evaluation of medical needs, caregiver education, etc.

Outcome: Upon review, DA declined to pursue charges of criminal neglect due to lack of evidence.

Case Review #4

Case Summary: Client was a 67 year old female who needed minimal assistance from a caregiver until the client suffered a stroke. After the stroke, the client was bed-ridden and non-verbal. She developed multiple stage II-IV bed sores while in residence at a Skilled Nursing Facility (SNF). The sores were treated at a hospital and she was released to a different SNF for wound management prior to being released to home care. About two weeks prior to the decedent's death, the decedent's son hired a caregiver to provide 24 hours assistance with her personal and wound care. The caregiver arranged for IHSS benefits for the decedent. The care provider photo documented the pressure wounds and took her to doctor appointments where she was evaluated based on the photos supplied by this care provider rather than conducting a physical exam on his own. The decedent became unresponsive at one of these visits and died shortly afterwards. Autopsy revealed a very large infected stage IV pressure ulcer that extended from the skin deep into her pelvis forming an abscess around her rectum.

Care Provider/ Relationship: The hired caregiver received IHSS payments for services performed by her employees. The care provider misrepresented herself as a certified nursing assistant and licensed vocational nurse. She also misrepresents herself as a licensed business operator with a home care aid business operating on referrals.

Why Was Case Referred To EDRT? Bed sores developed in a SNF. Case referred to licensing for investigation of neglect by SNF. The misrepresentation of home care provider's licensing status to family and possibly committing IHSS fraud.

Concerns Addressed By EDRT: For nearly five years this home care provider has had access to and solicits licensed facilities. The caregiver has numerous aliases and continues to provide care outside of the IHSS system. The development of multiple severe bed sores in a SNF.

Findings: Multiple facilities failed to recognize the depth and severity of the pressure sore developing over the sacrum. No medical documentation of wound care in the second SNF between the time of admission and discharge home. Home health care provider fraudulently misrepresented herself to family who hired her on good faith to care for their mother. Home care provider was not using appropriate medical care to treat the pressure ulcers. Primary physician inadequately evaluated patient by relying solely on photos provide by care provider.

Recommendation: Implementing an interactive county and state communication system within agencies dealing with elder abuse, neglect and death investigations so as to not duplicate effort and/or work and investigate more effectively and efficiently.

Educating those in care of elders the need to physically assess a patient to look for the development and progression of pressure sores. Ongoing case management services could have helped monitor skin integrity. Education of IHSS care providers to recognize and appropriately treat pressure ulcers.

Outcome: Based on the assessment of the case by multiple agency involvement, specifically IHSS Fraud Unit and Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) Agents, the home care provider was arrested and later convicted of a misdemeanor for impersonating an LVN, misdemeanor for impersonating a CNA and a misdemeanor for elder abuse under PC368(c). The provider received 60 days in county jail and 366 hours of community service.

Case Review #5

Case Summary: This case is that of a 92 year old female who lived at home with a live-in care provider for the last 5 years. The decedent was ambulatory with a walker until approximately 6 months prior to her death, when she became confined to either a wheelchair or bed. The decedent has an adult son who did not live with her. According to the son, who had power of attorney for health care, he first became aware of the decubitis ulcers, the size of quarters, in early May 2008. The live-in care provider was treating them with Bactine and Neosporin and dressing them with waterproof bandages.

The ulcers became larger after a bout of diarrhea. The son stated he did not believe the ulcers required medical attention.

When the decedent stopped eating and became very shaky, she was taken to the hospital for altered level of consciousness. She was diagnosed with sepsis and acute renal failure, thought to be secondary to advanced decubiti. She died three days later. Upon her admission to the hospital the decedent had multiple decubitis ulcers (one large stage IV on each hip and a large stage III over sacrum). Hospital medical staff reported the situation to APS and law enforcement for possible neglect. Autopsy revealed source of sepsis was a large segment of dead bowel caused by severe atherosclerosis. Decubital ulcers listed as a contributing factor.

Care Provider/ Relationship: Private-pay, 24-hour live-in care provider who claimed to be a nurse trained in Fiji.

Why Was Case Referred To EDRT? Concerns of care-giver neglect by private pay nurse and son.

Concerns Addressed By EDRT: The level of treatment provided to decedent by the live-in care provider. The son not seeking medical attention earlier for pressure sores.

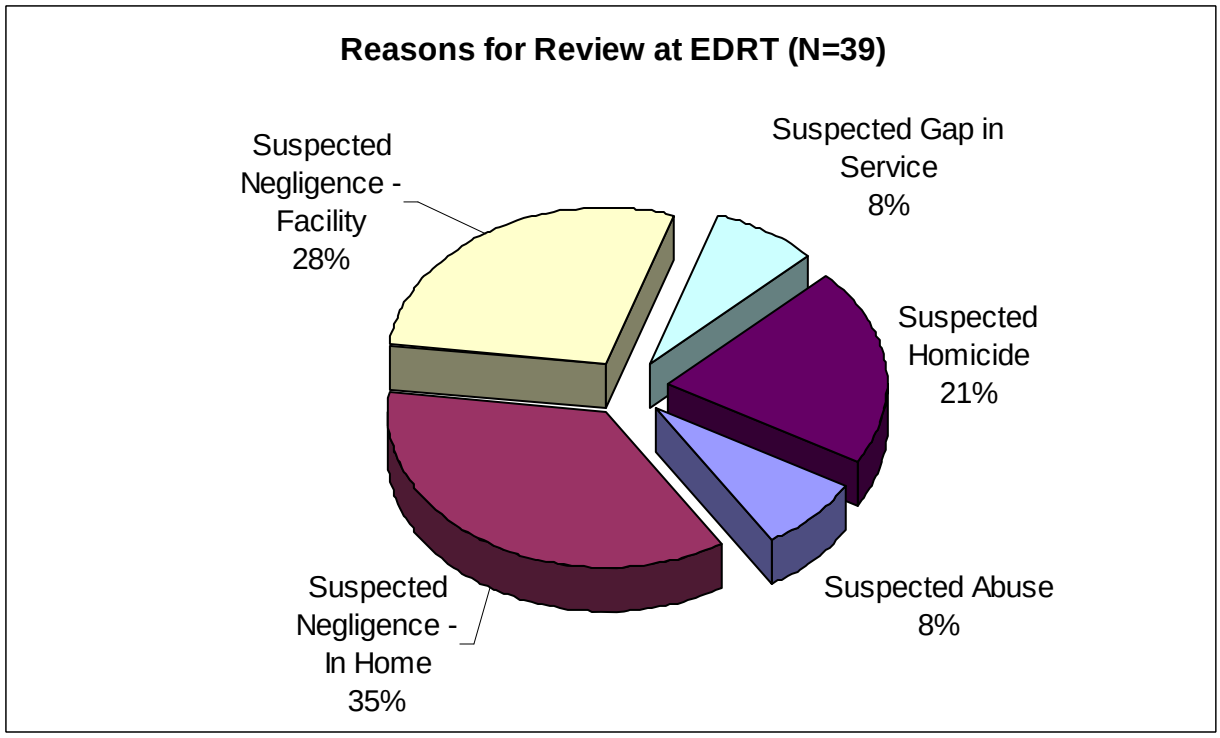
Findings: While the decubiti were not determined to be the source of the sepsis, they were without doubt quite painful. The treatment of the decubiti was below the standard of care that should have been provided. While the treatment was ultimately determined to be inadequate, it was not determined to rise to the level of criminal neglect.

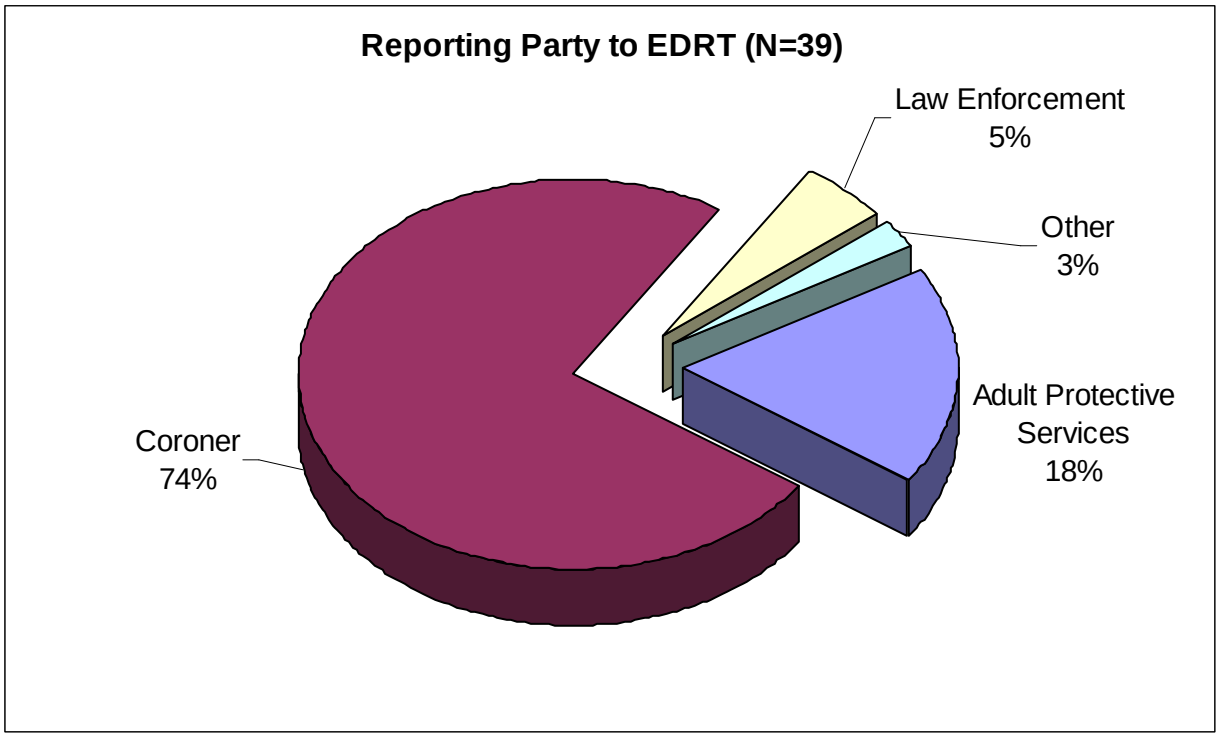
Recommendation: Training on bed sore treatment is needed for anyone providing care for the elderly and to anyone who has significant contact with the medically frail elderly.

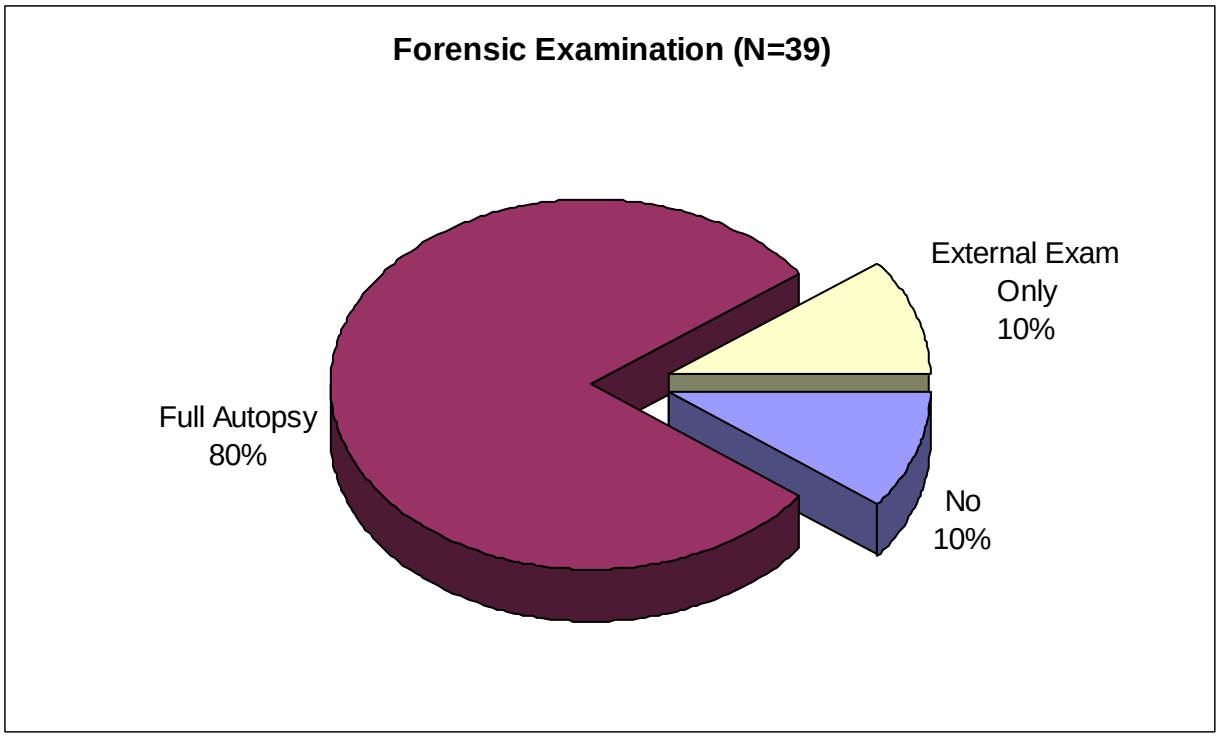
APPENDIX 1

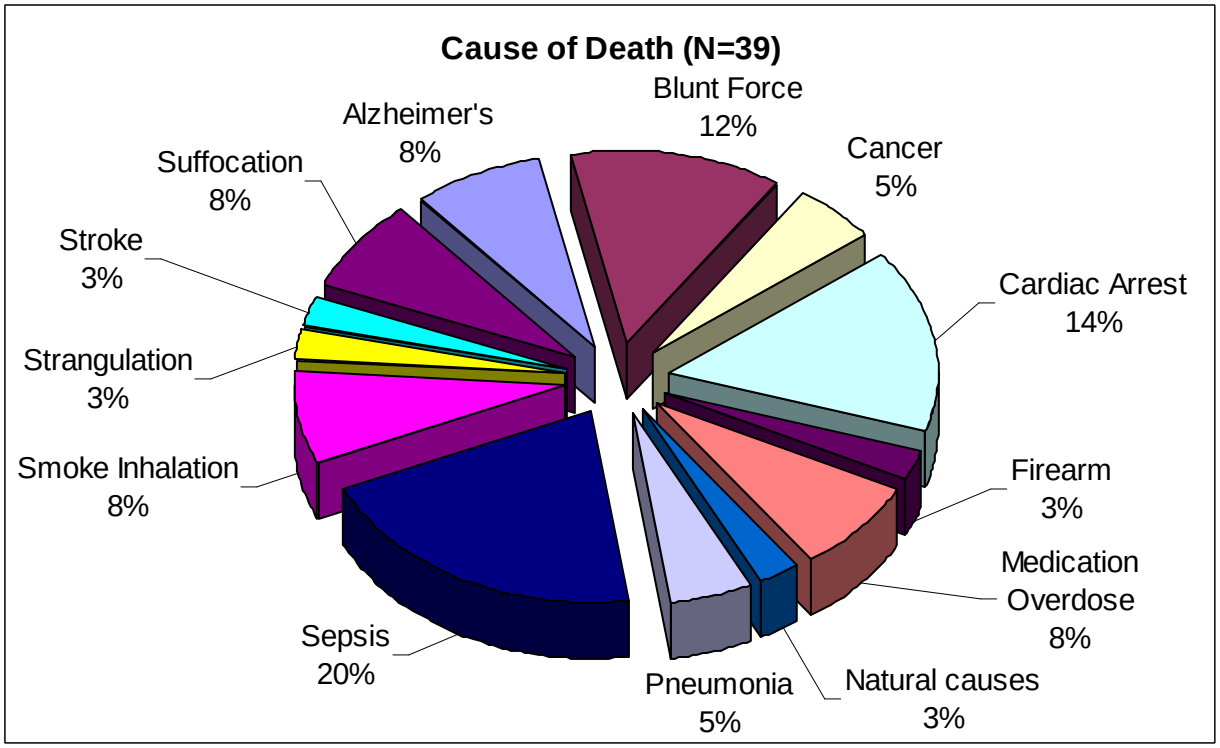
EDRT 2007/2008 Statistics

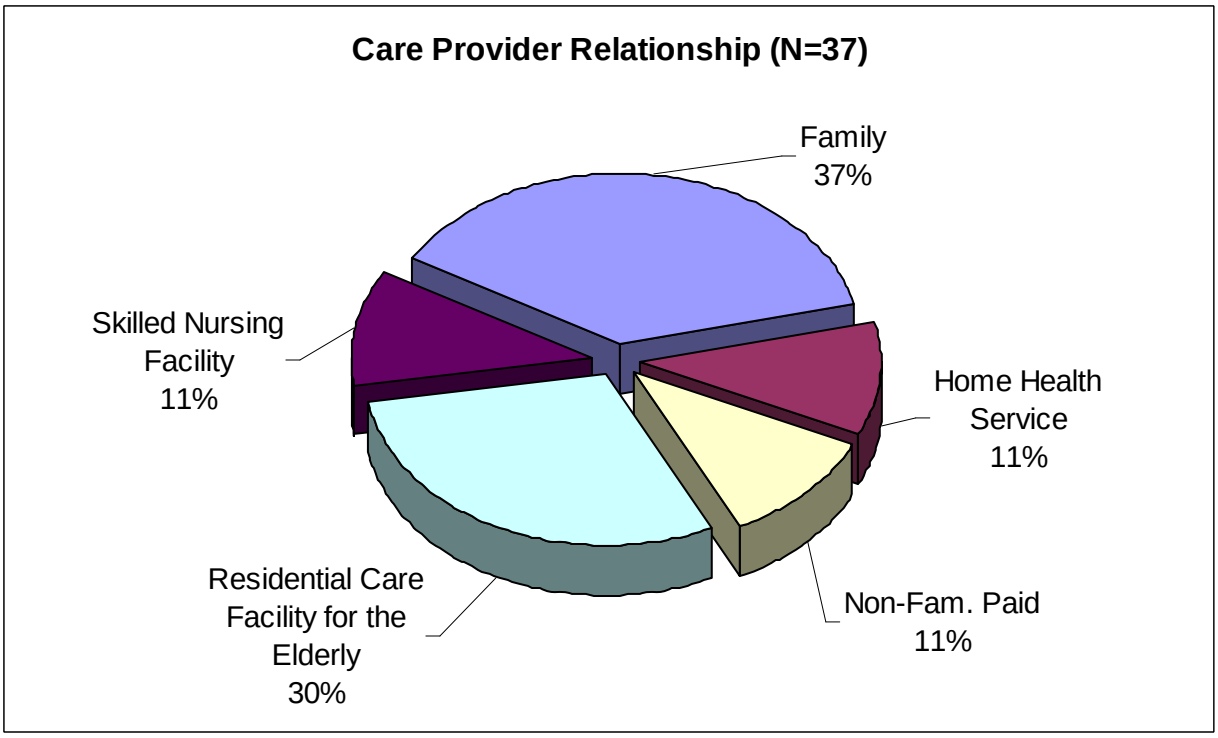
In 2007-20085 EDRT reviewed 39 cases and collected statistical data. Following is a breakdown of information regarding the data elements collected on the cases reviewed. Below each graph is the actual number of cases for each identified data element.


Reasons for Review at EDRT (N=39)
Suspected Negligence - Facility 28%
Suspected Gap in Service 8%
Suspected Homicide 21%
Suspected Abuse 8%
Suspected Negligence - In Home 35%

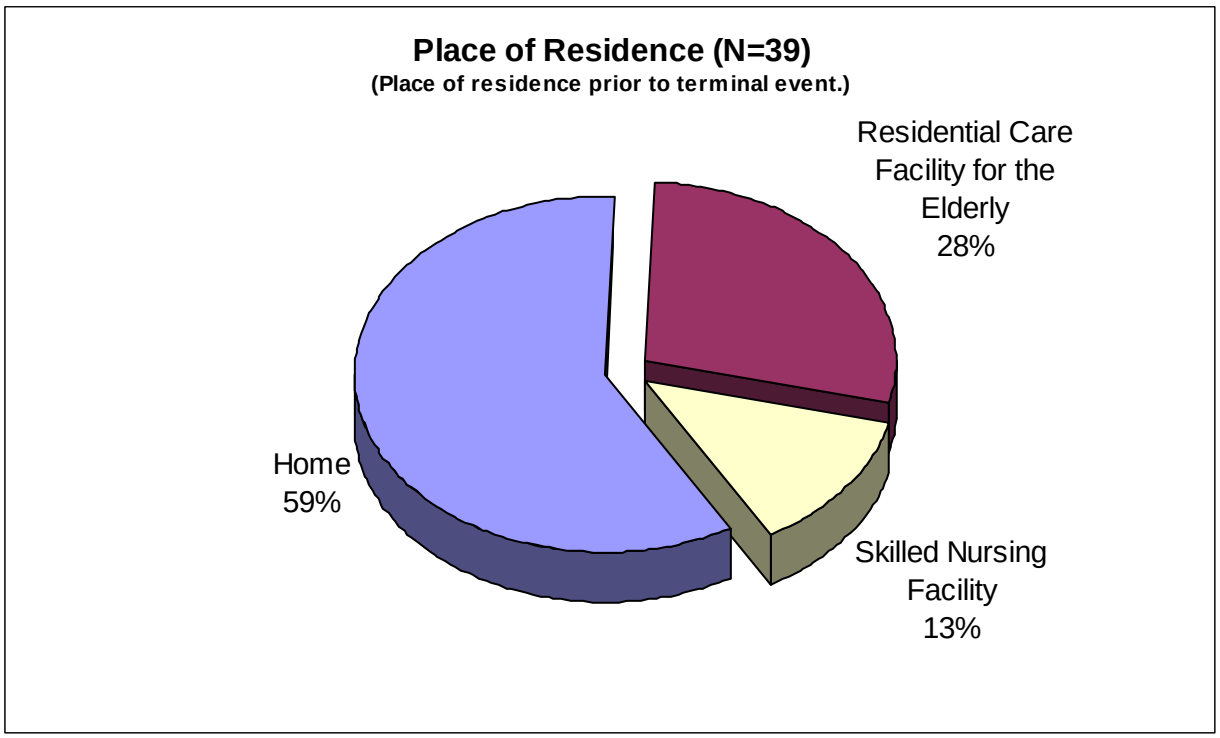

Reporting Party to EDRT (N=39)
Law Enforcement 5%
Other 3%
Adult Protective Services 18%
Coroner 74%

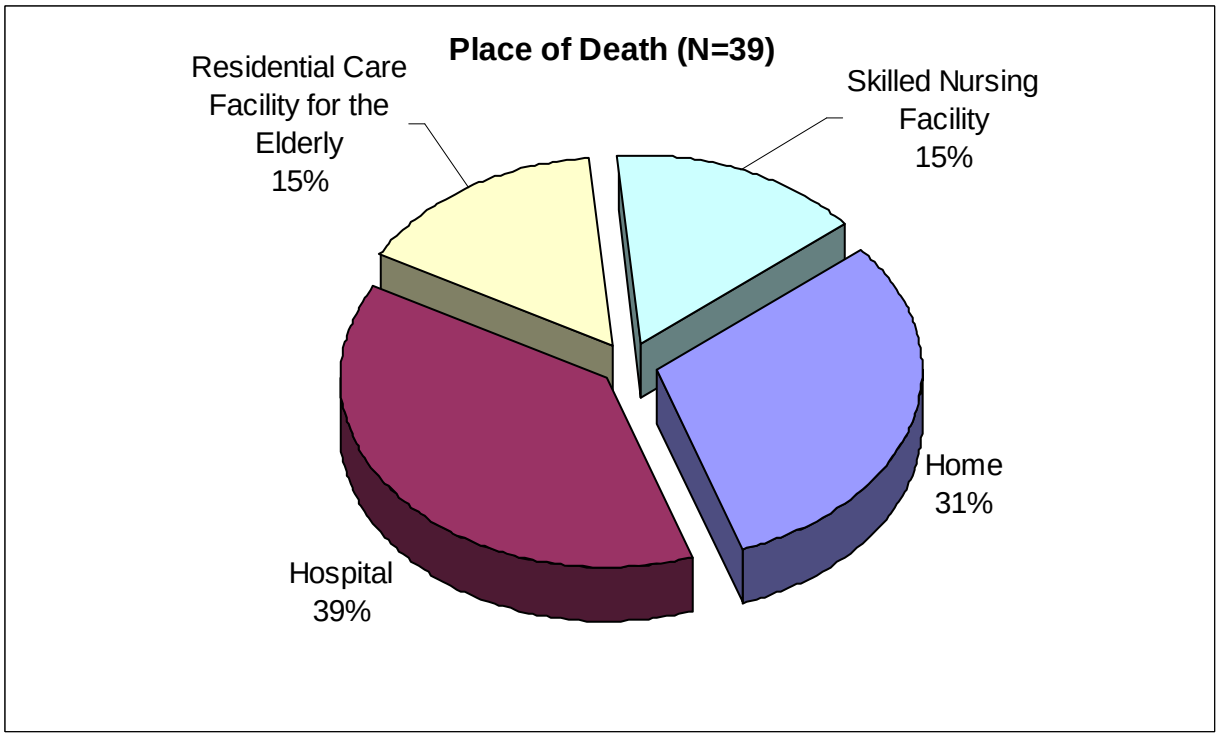

Forensic Examination (N=39)
External Exam Only 10%
Full Autopsy 80%
No 10%

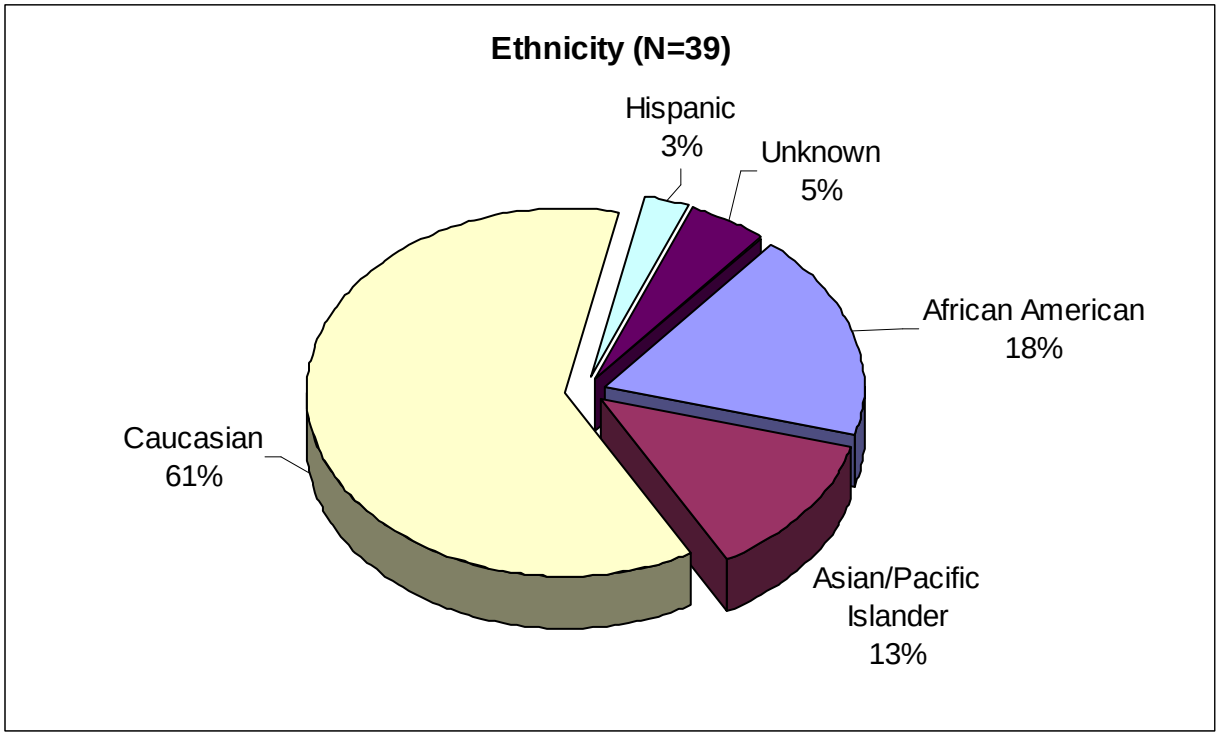

Cause of Death (N=39)
Blunt Force 12%
Alzheimer's 8%
Suffocation 8%
Cancer 5%
Stroke 3%
Cardiac Arrest 14%
Strangulation 3%
Smoke Inhalation 8%
Firearm 3%
Medication Overdose 8%
Sepsis 20%
Pneumonia 5%
Natural causes 3%

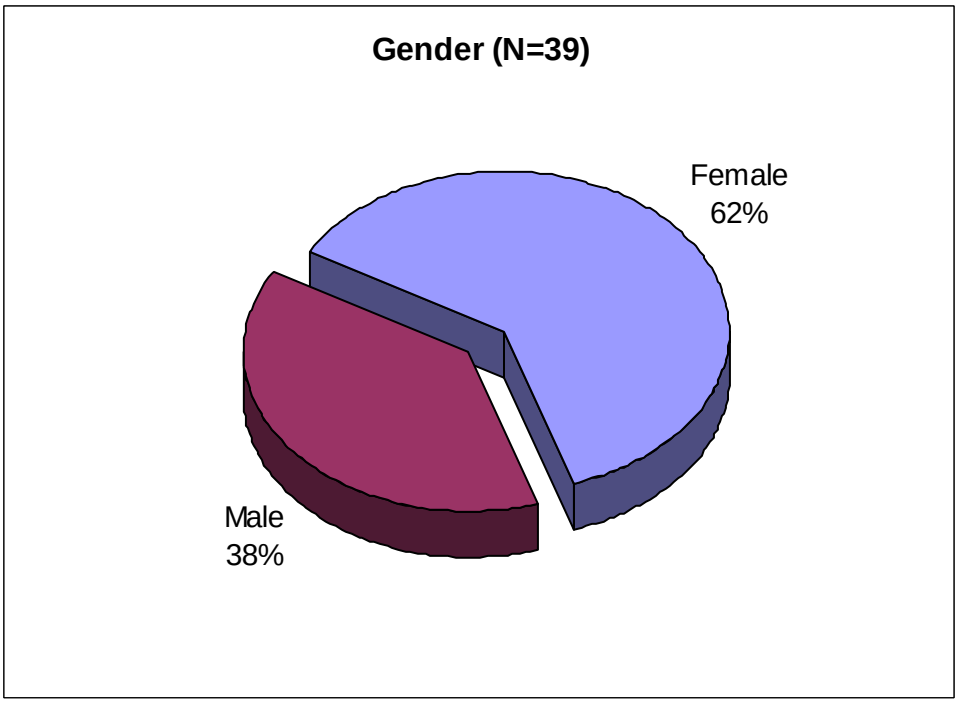


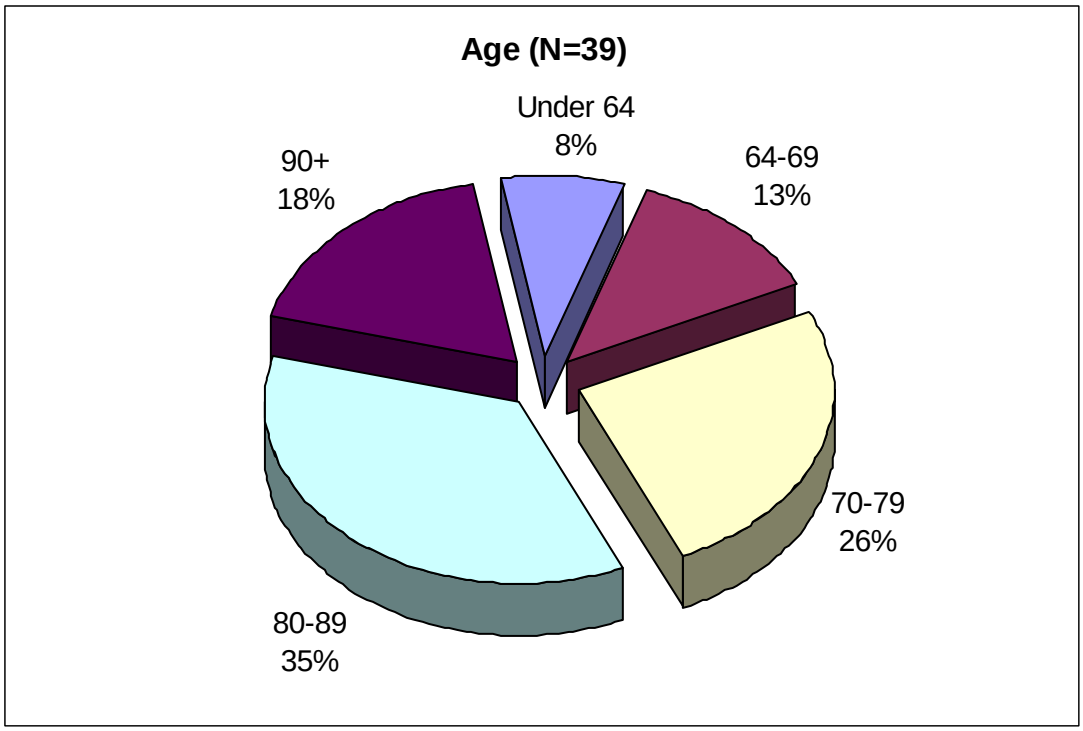
There was one case not included in the above chart because the victim was the care provider.




Place of Death (N=39)
Residential Care Facility for the Elderly 15%
Skilled Nursing Facility 15%
Home 31%
Hospital 39%


Ethnicity (N=39)
Hispanic 3%
Unknown 5%
African American 18%
Caucasian 61%
Asian/Pacific Islander 13%


Gender (N=39)
Female
62%
Male
38%


Age (N=39)
Under 64
8%
64-69
13%
70-79
26%
80-89
35%
90+
18%

APPENDIX 2

EDRT BROCHURE

Independent Living:
Resource Guide

IN-HOME SERVICES

- InfoLine Sacramento
  916-498-1000
- The Senior Connection - Eskaton
  916-334-1072
- www.Healthfinder.gov

For domestic and/or personal care to remain safely at home:

- Area 4 Agency on Aging
  916-486-1876
  www.a4aa.com
- In-Home Supportive Svcs., IHSS
  916-874-9471
- Sutter Senior Care
  916-424-8412
- U.C. Davis – Linkages / MSSP
  916-734-5432

HOME REPAIR

Home repair assistance for seniors and the disabled:

- Contractors State Licensing Board (license verification/problems with contractors) 1-800-321-2752
- Home Assistance/Repair for Seniors (and disabled) 916-264-1506 or tsater@shra.org
- Rebuilding Together
  916-455-1880
- Sacramento Housing & Redevelopment Agency
  916-264-1500

For heating or cooling problems:

- Sacramento Municipal Utility District, SMUD
  1-888-742-7683
- SMUD Energy Assistance Team
  916-874-0979 or seat@saccounty.net
- Pacific Gas & Electric, PG&E
  1-800-743-5002

OTHER AVAILABLE RESOURCES...

For help finding a residential or long term care facility:

- Older Adult Resource Center
  916-874-9492
  OARC@saccounty.net
- Community Care Licensing
  916-263-4700

For seniors over 59 who need food delivered:

- Senior Nutrition Services
  916-444-9533

For free specialized telephone equipment for disabled consumers of any age:

- 1-800-806-1191 Call Center
  1-800-806-4474 – TTY
- www.ddtp.org

To report suspected abuse of an elder or dependent adult:

- Adult Protective Services
  916-874-9377

If you suspect abuse or neglect at a long term care facility:

- Ombudsman Services of Northern CA
  916-376-8910 OR 1-800-231-4024
  www.osnc.net

Questions on conservator ships:

- Court Investigators Office
  916-875-3400

For transportation assistance:

- California Dept. of Developmental Svcs.
  916-654-2054 TTY OR 916-654-1690
- Regional Transit
  916-321-2877 OR 916-4834327 TDD
  www.sacrt.com
- South County Transit
  1-800-338-8676

For employment assistance:

- Sacramento Employment and Training Agency (SETA)
  916-263-3700 OR 1-800-735-2929 TTY
  www.seta.net

Low cost auto insurance for low income good drivers:

- 1-866-602-8861

To find out if a charity is legitimate:

- California Attorney General's Office
  (916) 322-3360
  www.ag.ca.gov/charities/

Find out if a sales person/company is legitimate before investing:

- Department of Corporations
  1-866-275-2677
  www.corp.ca.gov

Sacramento County
District Attorney's Office &
Department of Health & Human Services

Independent Living: Resource Guide

Service Categories:

- Medical
- Mental Health
- Financial
- Respite
- Legal
- In-Home Svcs
- Home Repair
- Other

IF THERE IS AN EMERGENCY CALL: 911

Provided by:
The Sacramento County
Elder Death Review Team
EDRTCoordinator@SacCounty.net

MEDICAL

For people without insurance:

- County Medically Indigent Services
  4600 Broadway
  Sacramento, CA 95820
  916-874-9238
  www.sacdhhs.com

- Folsom Family Clinic
  105 Dean Way
  Folsom, CA 95630
  916-983-3658
  www.mercysacramento.org

- Health for All
  420 I Street, Suite 7
  Sacramento, CA 95814
  916-441-2811
  www.health-forall.org

- White Rock Family Clinic
  10487 White Rock Road
  Rancho Cordova, CA 95670
  916-364-0724
  www.mercysacramento.org

- MAAP Community Health Center
  6950 65th Street
  Sacramento, CA. 95823
  916-422-5200

- Health Insurance Counseling and Advocacy Program
  1-800-434-0222

Questions about end of life care:

- California Medical Association
  916-444-5532
  www.cmanet.org

Questions about potential interactions with medications:

- www.drugdigest.org/DD/Home OR
- www.drugs.com/drug_interactions.html
- http://networkofcare.org/home.cfm

For help with buying prescriptions:

- 1-877-777-7815
  www.rxhelpforca.org

Grieving? Who to talk to when you have lost a loved one:

- Bereavement Network Resources of Sacramento, Inc.
  916-557-5882

MENTAL HEALTH

For elderly persons showing signs of depression, dementia, anxiety, or psychotic episodes:

- Geriatric Network
  916-648-2800
  www.medclinicmedgroup.org

- UCDMC – Geriatric Clinic
  916-734-3574 Appointments
  www.ucdmc.ucdavis.edu

- Kaiser Alzheimer / Dementia Program
  916-973-6165

For help with mental health issues:

- DHHS Division of Mental Health Adult Access Team
  875-1055 OR
  875-1000 (for an emergency)

FINANCIAL

For help with Medicare:

- Medicare
  1-800-MEDICARE
  www.medicare.gov

- Health Insurance Counseling Advocacy Program (HICAP)
  1-800-434-0222
  www.hicapservices.net

- CalMedicare.org
  916-376-8915
  www.calmedicare.org

Apply for MediCal:

- Department of Human Assistance
  916-874-2215
  www.dhaweb.saccounty.net

Apply for social security/disability:

- U.S. Social Security
  916-381-9410 OR 1-800-772-1213
  www.ssa.gov

For tax advice and basic tax preparation for seniors:

- Tax Counseling for the Elderly (TCE)
  916-974-5303
  www.irs.gov

Questions about reverse mortgages:

- U.S. HUD Sacramento Office
  916-498-5220 Ext. 221

To report reverse mortgage fraud:

- 1-888-827-5605
  www.hud.gov

RESPITE

For respite assistance:

- Cordova Senior Center
  916-366-3133

- Hart Senior Center
  916-808-5462

- Triple "R" Adult Day Program
  916-808-1591
  www.tripler.org/

- Del Oro
  916-971-0893 or
  http://www.deloro.org

LEGAL

For legal help:

- Legal Services of Northern California
  916-551-2150
  www.lsnc.net

- Superior California Legal Clinics, Inc.
  916-972-1188

- Voluntary Legal Services Program
  916-551-2102
  www.vlsp.org

- Superior Court Self Help Center
  916-875-3400

- McGeorge Community Legal Clinic
  916-340-6080