UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
LITTLE ROCK DIVISION

DISABILITY RIGHTS CENTER OF ARKANSAS, INC. PLAINTIFF

V. Case No. 4:13-CV-103 JLH

BAPTIST HEALTH DEFENDANT

COMPLAINT

Comes now the Plaintiff, Disability Rights Center of Arkansas, Inc., by and through its undersigned attorney, J. Paul Davidson, and for its Complaint against Defendant Baptist Health states:

1. The Disability Rights Center of Arkansas, Inc. (DRC) brings this action seeking declaratory and injunctive relief to compel Defendant Baptist Health to provide DRC with medical and related records pertaining to three (3) restraint related deaths that occurred in each of its facilities and more specifically, at Baptist Health Rehabilitation Institute on October 7, 2012; Baptist Health Medical Center-North Little Rock on October 29, 2012; and Baptist Medical Center-Little Rock on October 31, 2012.[1]

2. Pursuant to the Protection and Advocacy for Individual Rights Act (PAIR), 29 U.S.C. § 794e, DRC has a legal right to access the records regarding each individual's death.

JURISDICTION AND VENUE

3. This action arises under the PAIR Act and similar law analyzed below.

4. Jurisdiction is invoked pursuant to 28 U.S.C. 1331 as well as 28 U.S.C. § § 2201 and 2202.

[1] DRC does not know the identity of the three (3) deceased patients, but was notified of the deaths by the Center for Medicare and Medicaid Services. The identity of the individuals, however, is irrelevant to the remedies DRC seeks at this time, except to the extent the individuals had disabilities and thus eligible for DRC services. The Defendant is aware of the identity of the three individuals.

5. Venue is proper pursuant to 28 U.S.C. § 1391(b)(2) as a substantial part of the events or omissions giving rise to this claim occurred in the judicial district of this Court.

PARTIES

A. The Plaintiff

6. Plaintiff DRC is an independent and private non-profit corporation organized under the laws of the State of Arkansas, and at all times relevant, DRC has been the statewide Protection and Advocacy (P&A) system designated by the Governor of the State of Arkansas to protect and advocate for the legal and civil rights of those citizens in the State of Arkansas who have disabilities pursuant to the following: the Protection and Advocacy for Individual Rights Act (PAIR), 29 U.S.C. § 794e; the Developmental Disabilities Act (DDA), 42 U.S.C. § 15041, *et seq.*, the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. § 10801, *et seq.*, and the Protection for Individuals with Traumatic Brain Injuries (PATBI), 42 U.S.C. § 300d-53.

7. This complaint involves activities undertaken by DRC pursuant to its duties and authorities set forth in the PAIR Act. The PAIR Act specifically incorporates language, processes and procedures from the DDA. 29 U.S.C. § 794e(f)(2).

8. As the duly designated statewide P&A for individuals with disabilities in the State of Arkansas, DRC has the authority to pursue legal, administrative and other appropriate remedies to ensure the protection of and advocacy for the rights of individuals with disabilities within the State. 29 U.S.C. § 794e(f)(3).

9. DRC is authorized, for instance, to investigate allegations of abuse and neglect of individuals with disabilities such as the deaths that occurred at the Defendant's facilities if the incidents are reported to DRC or if there is probable cause to believe the individual has been subject to abuse and neglect. 29 U.S.C. § 794e(f)(2) (PAIR); 42 U.S.C. § 15043(a)(2)(B) (DDA).

10. DRC is authorized to have access to all records of an individual with a disability if that individual is unable to authorize the DRC to have such access, if the individual does not have a legal guardian, and if a complaint has been received by the system about the individual with regard to the status or treatment of the individual. 42 U.S.C. § 15043(a)(2)(I).

11. DRC is authorized to access all records of an individual with disability such as the ones referenced in this Complaint if that individual is unable to authorize DRC to have such access, if the individual does not have a legal guardian, and, as a result of monitoring or other activities, there is probable cause to believe such an individual has been subject to abuse or neglect. 42 U.S.C. § 15043(a)(2)(i)

12. The authorized investigation referred to in the previous paragraphs includes immediate access to the entire records of each individual referenced to herein, including any records received from other health care providers, all facility policies, procedures, and guidelines in effect during the individuals treatment at each respective facility owned and operated by the Defendant, including those in effect at the time of patients' deaths. 42 U.S.C. § 15043(c)

B. The Defendant

13. The Defendant, Baptist Health, is a non-profit healthcare corporation organized and existing under the laws of the State of Arkansas with its principal place of business in the judicial district of this Court.

14. The Defendant owns and operates the three (3) facilities where the deaths occurred, namely:

(1) Baptist Health Rehabilitation Institute located at 9601 Interstate 630, Exit 7, Little Rock, Arkansas, 72205;

(2) Baptist Health Medical Center located at 3333 Springhill Drive, North Little Rock, Arkansas 72117; and

(3) Baptist Medical Center located at 9601 Interstate 630, Exit 7, Little Rock, Arkansas 72205.

15. The Defendant has at all times relevant exercised general responsibility, supervision and oversight of promulgation and implementation of the policies and practices of each above facility, as well as the provision and coordination of all programs, treatment and services offered to the individuals referenced herein.

FACTS

16. In accordance with 42 CFR § 482.13(f)(7), health care facilities that receive federal funding, like the Defendant, are required to report restraint related deaths to the United States Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS). In turn, CMS is required to report restraint related deaths to the P&A in the state in which the death occurred.

17. On October 23, 2012, DRC received notification from the CMS that a "restraint associated death" had occurred at the Baptist Rehabilitation Institute on October 7, 2012. According to CMS, the type of restraint used on the deceased patient was an "enclosed bed." The CMS report did not disclose the identity of the patient to DRC, but indicated the patient's diagnosis was subdural hematomas. *See* a true and correct copy of the notification to DRC at Exhibit "A."

18. On November 5, 2012, DRC received notification from the CMS that a "restraint associated death" had occurred at Baptist Health Center-North Little Rock on October 29, 2012. According to the CMS report the type of restraint used on the deceased patient was an "enclosed bed." The CMS report did not disclose the identity of the patient to DRC, but indicated the patient's diagnosis was pneumonia. *See* a true and correct copy of the notification to DRC at Exhibit "B."

19. On November 5, 2012, DRC received notification from the CMS that a "restraint associated death" had occurred at the Baptist Health Center-Little Rock on October 31, 2012. According to the CMS report, the type of restraint used on the deceased patient was an "enclosed bed." The CMS report did not disclose the identity of the patient to DRC, but indicated the patient's diagnosis was chest pain. *See* a true and correct copy of the notification to DRC at Exhibit "C."

20. The Food and Drug Administration (FDA) has warned that certain enclosed beds, like some manufactured by Vail Products Inc., pose a health risk because patients can become entrapped in them and suffocate. Because of the suffocation risk, the FDA has advised hospitals, nursing homes and consumers who have a specific Vail enclosed bed system to stop using it and move the patient to an alternate bed.[2] Although DRC has not been able to confirm the specific enclosed bed the Defendant used on each patient, it appears that at least one of the deceased patients was restrained by a Vail or similar enclosed bed.

21. After receiving notice that three (3) deaths had occurred within three (3) weeks of one another and that all three (3) deaths involved an enclosed bed, DRC determined that probable cause existed that the three deaths may have been caused by abuse and neglect. DRC notified the Defendant through its administrator, Mr. Greg Cain, of the probable cause determination and requested documentation and information related to all three (3) deaths. *See* a true and correct copy of Jonathan Whipp's correspondence to Defendant's administrator regarding each death collectively at Exhibit "D."

22. The Defendant, by and through its legal counsel, initially informed DRC during a phone call that the Defendant would comply with DRC's written request. The Defendant, however, requested several additional weeks to gather the documents because the holidays were

[2] See http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications/ucm062025.htm

approaching.

23. After informing Defendant's counsel that a short extension would be given, but not the length of time requested by the Defendant, Defendant's counsel informed DRC that her client would not comply with the request after all because "none of the individuals had disabilities" and therefore, DRC did not have authority to review the requested materials.

24. After receiving this denial, DRC informed Defendant's counsel in writing that DRC would conduct an on-site review of the records at each facility. DRC provided counsel with DRC's authority to do so and provided counsel with the dates and times for the review.

25. Defendant's counsel met DRC's representative at each facility at the scheduled date and time, but Defendant's counsel refused DRC's representative requests to review the records and refused her requests to examine the "enclosed bed" associated with each death. During each visit, DRC representative provided Defendant's counsel with documentation concerning DRC's authority and relevant documentation supporting DRC's authorized access to the requested records. See a true and correct copy of the documentation provided by DRC's representative Dee Blakley collectively at Exhibit "E."

26. After DRC's attempt to conduct an on-site review of the records proved unsuccessful, DRC contacted Defendant's counsel by phone again to see if a reasonable agreement could be reached with respect to the records request. Unlike her previous defense, the Defendant's counsel argued *this time* that DRC did not have authority to access the records because the Defendant was a private hospital.

27. The law regarding DRC's authority to access records from a facility is clear. The P&A *shall have* reasonable unaccompanied access to *public and private* facilities which provide services, supports, and other assistance for individuals with disabilities in the State when necessary to conduct a full investigation of an incident of abuse or neglect under section

142(a)(2)(B) of the Act. See 29 U.S.C. 794e; 45 CFR § 1386.22(f). [Emphasis Supplied]

28. Although the Defendant has refused to provide any records or documentation relating to the deaths to date, DRC has received some documentation relating to the deaths from the Arkansas Department of Health and CMS. This additional documentation confirmed each individual had one or more disabilities and provided additional evidence that probable cause existed that the individuals were likely subject to abuse and neglect.

I. **Each patient had a disability**.

29. For purposes of the PAIR statute, a person is considered to have a "disability" if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment. 29 U.S.C. 705(9)(A-B). Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual task, and learning.

30. The additional documentation from the Arkansas Department of Health provided documentation that showed the individual who died at the Baptist Health Medical Center-Little Rock suffered not only from chest pains, but also suffered from pneumonia, chronic obstructive pulmonary disease and acute renal failure. *See* a true and correct copy of documentation from the Arkansas Department of Health at Exhibit "F."

31. The additional documentation from the Arkansas Department of Health provided documentation that demonstrated the individual who died at the Baptist Medical Center-North Little Rock suffered from pneumonia, but also suffered from lung cancer. See a true and correct copy of documentation from the Arkansas Department of Health at Exhibit "G."

32. The additional documentation from the Arkansas Department of Health provided documentation that demonstrated the individual who died at the Baptist Rehabilitation Institute suffered from subdural hematomas, but also suffered from hyperlipidemia, osteoarthritis, iron

deficiency anemia and benign prostatic hypertrophy. See a true and correct copy of documentation from the Arkansas Department of Health at Exhibit "H."

33. Based on the diagnosis of each deceased patient, all three (3) patients had a disability as each had a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarding as having such an impairment. *See* 29 U.S.C. § 705 (9)(A-B).

II. **There is probable cause to believe each individual was subject to abuse and neglect.**

34. Consent for release of such records to the P&A is not required following the death of an individual(s) where, as here, the manner of the death provides probable cause to suspect the potential for abuse or neglect and any guardianship which existed previously has been terminated by virtue of the individual's death. *See* 42 U.S.C. 15043 and 45 CFR 1386.22(c) (DDA) and 29 U.S.C. 794e (PAIR).

35. The facts supporting probable cause include, but are not limited to, the following:

(a) Three (3) restraint related deaths occurred at Defendant's facilities and the deaths occurred within three (3) weeks of one another;

(b) The Defendant restrained all three (3) patients with an enclosed bed;

(c) The Baptist Medical Center-Little Rock was investigated by the Arkansas Department of Health and was cited for deficiencies relating to the facility's monitoring of patients who were in enclosed beds. As a result of the Defendant's deficiencies, the Arkansas Department of Health recommended a plan of correction to the Defendant; and

(d) The enclosed beds pose an unreasonable risk of harm to patients which DRC believes may have contributed to the patients' deaths.

36. Despite multiple correspondence and attempts to obtain the requested

documentation in order to avoid litigation, the Defendant continues to refuse DRC access to the records or the facilities at issue. As a result, DRC cannot fulfill its federal mandate to conduct a full investigation into the abuse and neglect that may have occurred at Defendant's facilities.

37. The Defendant's refusal to comply with DRC's rights to access the requested documentation has caused irreparable harm to DRC and will continue to suffer irreparable harm unless this Court grants DRC's request for injunctive relief.

38. Pursuant to 29 U.S.C. § 794e and 42 U.S.C. § 15043 *et. seq.*, DRC has a right and legal duty to access documents relating to the three (3) restraint related deaths that occurred at the Defendant's facilities.

WHEREFORE, the Plaintiff, Disability Rights Center of Arkansas, Inc., prays the Court enter an Order granting Plaintiff the following:

(a) Immediate access to all medical records and documents relating to the three restraint related deaths identified herein;

(b) Immediate access to the three facilities to view the enclosed beds and for such other purposes as may be necessary to carry out an investigation;

(c) Reasonable attorney's fees and related costs for bringing this action; and

(d) Any other relief to which the Plaintiff is entitled.

Respectfully submitted,

DISABILITY RIGHTS CENTER
OF ARKANSAS, INC.
1100 N. University, Ste. 201
Little Rock, AR 72207
Phone: 501-296-1775
Facsimile: 501-296-1779
pauldavidson@arkdisabilityrights.org

J. Paul Davidson, ABN 2006291

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

Notice to Protection and Advocacy Organizations
Restraint/Seclusion Hospital Death Report
State Operations Manual 5140.4

To:
Arkansas - CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA
Address: Disability Rights Center of Arkansas
1100 North University, Suite 201
Little Rock, AR 72207
Phone: 501-296-1775 Voice/TDD \ 800-482-1174 (nationwide)
Fax: 501-296-1779
E-Mail: panda@arkdisabilityrights.org
Website: http://www.arkdisabilityrights.org

A restraint/seclusion death report was received by this office and an on-site survey was authorized as follows:

Hospital Name and Address: Baptist Health Rehabilitation Institute, 9601 Interstate 630 Exit 7, Little Rock, AR 72205

Date Restraint/Seclusion-associated death occurred: 10/07/2012

Patient's Diagnosis: Subdural hematomas

Types of restraint/seclusion used: Enclosed Bed

Regards,

Dorsey Sadongei

Health Insurance Specialist

EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

Notice to Protection and Advocacy Organizations
Restraint/Seclusion Hospital Death Report
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To:
Arkansas - CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA
Address: Disability Rights Center of Arkansas
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Little Rock, AR 72207
Phone: 501-296-1775 Voice/TDD \ 800-482-1174 (nationwide)
Fax: 501-296-1779
E-Mail: panda@arkdisabilityrights.org
Website: http://www.arkdisabilityrights.org

A restraint/seclusion death report was received by this office and an on-site survey was authorized as follows:

Hospital Name and Address: Baptist Health Medical Center North Little Rock, 3333 Springhill Drive, North Little Rock, AR 72117

Date Restraint/Seclusion-associated death occurred: 10/29/2012

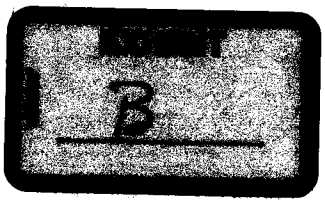
Patient's Diagnosis: Pneumonia

Types of restraint/seclusion used: Enclosed Bed

Regards,

Dorsey Sadongei

Health Insurance Specialist



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

Notice to Protection and Advocacy Organizations
Restraint/Seclusion Hospital Death Report
State Operations Manual 5140.4

To:
Arkansas - CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA
Address: Disability Rights Center of Arkansas
1100 North University, Suite 201
Little Rock, AR 72207
Phone: 501-296-1775 Voice/TDD \ 800-482-1174 (nationwide)
Fax: 501-296-1779
E-Mail: panda@arkdisabilityrights.org
Website: http://www.arkdisabilityrights.org

A restraint/seclusion death report was received by this office and an on-site survey was authorized as follows:

Hospital Name and Address: Baptist Health Medical Center-Little Rock, 9601 Interstate 630, Exit 7, Little Rock, AR 72205

Date Restraint/Seclusion-associated death occurred: 10/31/2012

Patient's Diagnosis: Chest Pain, Rule Out Myocardial Infarction

Types of restraint/seclusion used: Enclosed Bed

Regards,

Dorsey Sadongei

Health Insurance Specialist

EXHIBIT C

Dee Blakley

From:	Jonathan Whipps
Sent:	Thursday, November 08, 2012 12:54 PM
To:	Mike.perkins@baptist-health.org
Cc:	Dee Blakley; Stephanie Winstanley; Paul Davidson
Subject:	Request for information and documentation of death 10 07 2012
Attachments:	10 07 12 death.pdf

Disability Rights Center of Arkansas, Inc. (DRC) is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for people with disabilities in Arkansas. DRC is authorized by federal statute to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

Pursuant to federal law, the Centers for Medicare and Medicaid Services (CMS) notified DRC of a death related to the use of seclusion/restraint in your hospital on October 7, 2012. See attached letter from CMS to DRC.

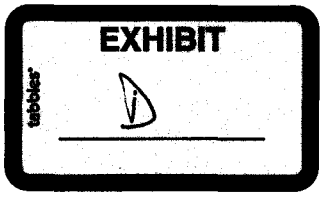
Pursuant to DRC's access authority under the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. §§ 15001, 15043]; the Protection and Advocacy for Individuals with Mental Illness Act [42 U.S.C. §§ 10801 et seq.; 42 C.F.R. Part 51]; and the Protection and Advocacy of Individual Rights of the Rehabilitation Act of 1973 [29 U.S.C. § 794e], we request access to the following information and documents, no later than close of business Wednesday, November 14, 2012:

Full identification of the patient, including demographic information (also includes any known disability);
the internal investigation report and any supporting documentation that goes along with said report;
any documentation of any action taken by the administrative review committee;
any personnel action taken;
any email correspondence between all staff concerning the incident;
your sentinel report submitted to The Joint Commission; and
any pictures that were taken of the patient and/or the location of death.

In the event any of the requested documentation is still in draft form, please note that the federal regulations governing our access authority provide for provision of such documents upon request, whether in draft or final form.

Please feel free to contact me with any questions.

Jonathan Whipps
Advocate/Investigator
Disability Rights Center of Arkansas
1100 North University Avenue
Suite 201
Little Rock, AR 72207
jonathanwhipps@arkdisabilityrights.org
(501) 296-1775/(800) 482-1174 V/TTY
(501) 296-1779 fax



Dee Blakley

From: Jonathan Whipps
Sent: Thursday, November 08, 2012 12:59 PM
To: Harrison.dean@baptist-health.org
Cc: Dee Blakley; Stephanie Winstanley; Paul Davidson
Subject: request for information
Attachments: 10 29 12 death.pdf

Disability Rights Center of Arkansas, Inc. (DRC) is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for people with disabilities in Arkansas. DRC is authorized by federal statute to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

Pursuant to federal law, the Centers for Medicare and Medicaid Services (CMS) notified DRC of a death related to the use of seclusion/restraint in your hospital on October 29, 2012. See attached letter from CMS to DRC.

Pursuant to DRC's access authority under the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. §§ 15001, 15043]; the Protection and Advocacy for Individuals with Mental Illness Act [42 U.S.C. §§ 10801 et seq.; 42 C.F.R. Part 51]; and the Protection and Advocacy of Individual Rights of the Rehabilitation Act of 1973 [29 U.S.C. § 794e], we request access to the following information and documents, no later than close of business Wednesday, November 14, 2012:

Full identification of the patient, including demographic information (also includes any known disability);
the internal investigation report and any supporting documentation that goes along with said report;
any documentation of any action taken by the administrative review committee;
any personnel action taken;
any email correspondence between all staff concerning the incident;
your sentinel report submitted to The Joint Commission; and
any pictures that were taken of the patient and/or the location of death.

In the event any of the requested documentation is still in draft form, please note that the federal regulations governing our access authority provide for provision of such documents upon request, whether in draft or final form.

Please feel free to contact me with any questions.

Jonathan Whipps
Advocate/Investigator
Disability Rights Center of Arkansas
1100 North University Avenue
Suite 201
Little Rock, AR 72207
jonathanwhipps@arkdisabilityrights.org
(501) 296-1775/(800) 482-1174 V/TTY
(501) 296-1779 fax

Dee Blakley

From: Jonathan Whipps
Sent: Thursday, November 08, 2012 1:00 PM
To: Greg.crain@baptist-health.org
Cc: Dee Blakley; Stephanie Winstanley; Paul Davidson
Subject: request for information
Attachments: 10 31 12 death.pdf

Disability Rights Center of Arkansas, Inc. (DRC) is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for people with disabilities in Arkansas. DRC is authorized by federal statute to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

Pursuant to federal law, the Centers for Medicare and Medicaid Services (CMS) notified DRC of a death related to the use of seclusion/restraint in your hospital on October 31, 2012. See attached letter from CMS to DRC.

Pursuant to DRC's access authority under the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. §§ 15001, 15043]; the Protection and Advocacy for Individuals with Mental Illness Act [42 U.S.C. §§ 10801 et seq.; 42 C.F.R. Part 51]; and the Protection and Advocacy of Individual Rights of the Rehabilitation Act of 1973 [29 U.S.C. § 794e], we request access to the following information and documents, no later than close of business Wednesday, November 14, 2012:

Full identification of the patient, including demographic information (also includes any known disability);
the internal investigation report and any supporting documentation that goes along with said report;
any documentation of any action taken by the administrative review committee;
any personnel action taken;
any email correspondence between all staff concerning the incident;
your sentinel report submitted to The Joint Commission; and
any pictures that were taken of the patient and/or the location of death.

In the event any of the requested documentation is still in draft form, please note that the federal regulations governing our access authority provide for provision of such documents upon request, whether in draft or final form.

Please feel free to contact me with any questions.

Jonathan Whipps
Advocate/Investigator
Disability Rights Center of Arkansas
1100 North University Avenue
Suite 201
Little Rock, AR 72207
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(501) 296-1775/(800) 482-1174 V/TTY
(501) 296-1779 fax

Dee Blakley

From: Lynda M. Johnson <LJohnson@fridayfirm.com>
Sent: Thursday, November 15, 2012 3:03 PM
To: Dee Blakley
Subject: RE: Follow-up to our meeting of this morning

Ms. Blakley-
This e-mail is in response to your e-mail which purports to summarize our meeting today. I will clarify below several statements from your e-mail:

1. To clarify our conversation concerning CMS, I told you that I had spoken with several officials from CMS with regard to our concerns about disclosing information to your agency. CMS shared my concerns and asked if I would submit my concerns in writing to the CMS Regional Office so that they could forward my concerns to CMS in Baltimore in hopes that the current process may be clarified. I plan to submit my concerns to the CMS Regional Office as soon as possible.

2. While you stated that you believe the failure on the part of Baptist Health Rehabilitation Institute to provide the information requested constitutes a violation of Federal law, I do not agree with your position. I did state that your agency is free to obtain documentation from CMS or from the Arkansas Department of Health which will demonstrate that none of the patient deaths at issue were a result of the use of restraints. Given the fact that both the Arkansas Department of Health and CMS have found that none of the patient deaths at issue were a result of the use of restraints or that the use of restraints contributed to the patient's death in any way, I do not agree that your agency has "probable cause to believe that the health or safety of all patients in all three (3) is in serious and immediate jeopardy."

I will be present at Baptist Health Springhill in the morning at 9 am and at Baptist Health Medical Center Little Rock at 9 am on Monday.

Lynda M. Johnson

LYNDA M. JOHNSON | ATTORNEY

FRIDAY | ELDREDGE & CLARK LLP
Client focused every day

LJohnson@fridayfirm.com | Direct: (501) 370-1553 | Fax (501) 244-5321
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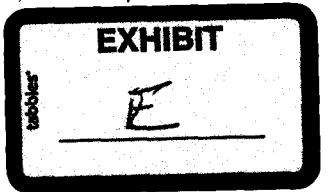
Little Rock, Arkansas 72201-3522 | www.FridayFirm.com



From: Dee Blakley [mailto:DeeBlakley@arkdisabilityrights.org]
Sent: Thursday, November 15, 2012 10:51 AM
To: Lynda M. Johnson
Cc: Paul Davidson; Jonathan Whipps
Subject: Follow-up to our meeting of this morning

Thanks for taking the time to meet with us.

I wanted to summarize our meeting of today.

I brought print copies of federal regulations defining DRC's access authority to you, pursuant to our federal grants under the Protection and Advocacy system for Developmental Disability; Protection and Advocacy system for Individuals with Mental Illness; and Protection and Advocacy for Individual Rights. I also provided you with a print copy of the FAQ from the United States Department of Health and Human Services, Office for Civil Rights (which enforces HIPAA) related to HIPAA and disclosures to Protection and Advocacy systems (P&As). (See http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_required_by_law/909.html)

In response to my question about your conversation with CMS yesterday, it is my understand that you are expecting correspondence from CMS clarifying when a covered entity must disclose PHI to a P&A (notwithstanding the seven (7) year old guidance posted on HHS' website).

You stated that DRC could obtain investigation reports on these deaths from the Arkansas Department of Health, and from CMS, both of whom have conducted investigations and found that the deaths were unrelated to the enclosed bed. I stated that failure of the three hospitals in the Baptist Health System to cooperate with DRC requests for access to information and documents previously requested was a violation of federal law. I also informed you that the three (3) deaths within the same hospital system, within three (3) weeks of each other with the manner of restraint described to DRC by CMS as "enclosed bed" gives us probable cause to believe that the health or safety of all patients in all three (3) is in serious and immediate jeopardy.

We disagreed that one or more of the decedents were people with disabilities.

Your stated position was that none of the three (3) hospitals would provide DRC with access to the previously requested information.

I stated that I would be at Baptist Springhill tomorrow morning at 9 a.m., and Baptist Medical Center on Monday at 9 a.m. You stated that you would be there also, and in response to my question, you said that I should come to the administrative office of each hospital.

I stated that unless your position changed overnight, the next two meetings would be for the purpose of having our access denied at each hospital, and these meetings were for the purpose of making a record.

I will bring you one of my business cards tomorrow when we meet at Baptist Springhill.

I look forward to seeing you.

Dee Blakley
Disability Rights Center of Arkansas, Inc.

Dee Blakley

From: Dee Blakley
Sent: Friday, November 16, 2012 10:17 AM
To: LJohnson@fridayfirm.com
Cc: Paul Davidson
Subject: To recap our brief meeting of this morning

Tracking:

Recipient	Delivery
LJohnson@fridayfirm.com	
Paul Davidson	Delivered: 11/16/2012 10:17 AM
Susan Pierce	Delivered: 11/16/2012 10:17 AM

Thank you for meeting with me at Baptist Health Medical Center (Springhill) in North Little Rock.

I asked if your position was still to deny DRC access to the information and documents originally requested by DRC in our November 8, 2012 email to you client, and further to deny DRC access to conduct an investigation of a death which occurred on October 29, 2012 in your client's hospital. We were informed of the death in an enclosed bed by the Centers for Medicare and Medicaid Services (CMS).

You said your position to deny access had not changed.

You also stated that your position was that DRC did not have jurisdiction to request records or conduct an investigation. You stated that the decedent was not a person with a disability, and that investigations conducted by the Arkansas Department of Health (ADH) and CMS had determined that the death was not related to the use of the enclosed bed. You stated further that DRC could obtain those investigations from ADH and CMS.

I stated that our position for the record was that DRC's statutory and regulatory access authority to documents and information generated by and in the custody of your client was not predicated on the existence of documents created by another entity. Nor was our access authority predicated on any finding by those entities or your client that the death was unrelated to the use of the enclosed bed. I said otherwise, a provider could simply deny DRC access by saying an allegation was unfounded, and further, that you would not be able to find regulations or case law which would support that position.

You asked if I intended to be at Baptist Health Medical Center in Little Rock on Monday, November 19, 2012. I said yes. You said you would also be there.

I look forward to meeting with you at 9 a.m. on Monday.

Dee Blakley
Disability Rights Center of Arkansas, Inc.

Dee Blakley

From: Lynda M. Johnson <LJohnson@fridayfirm.com>
Sent: Monday, November 19, 2012 10:22 AM
To: Dee Blakley
Cc: greg.graham@baptist-health.org; greg.crain@baptist-health.org
Subject: RE: Thank you for meeting with me this morning

Ms. Blakley-
Our position has remained the same. The Disability Rights Center of Arkansas, Inc. is not entitled to receive the documents that have been requested and does not have jurisdiction in this matter to receive documents nor to conduct an investigation.
I will be sending our written concerns to CMS Regional Office in Dallas next week.
I hope you have a Happy Thanksgiving as well.
Lynda

LYNDA M. JOHNSON | ATTORNEY

FRIDAY | ELDREDGE & CLARK LLP
Client focused every day

LJohnson@fridayfirm.com | Direct: (501) 370-1553 | Fax (501) 244-5321
400 West Capitol Avenue, Suite 2000
Little Rock, Arkansas 72201-3522 | www.FridayFirm.com

From: Dee Blakley [mailto:DeeBlakley@arkdisabilityrights.org]
Sent: Monday, November 19, 2012 10:14 AM
To: Lynda M. Johnson
Cc: Paul Davidson
Subject: Thank you for meeting with me this morning

At Baptist Health Medical Center in Little Rock.

I asked if it was still your position to deny DRC access to the information and documents originally requested via email on November 8, 2012 and to access by DRC to conduct an investigation into a death which occurred in an "enclosed bed" at BMC on October 31, 2012 reported to DRC by CMS.

You stated that yes, that was still your position, and further, it was your position that DRC had no jurisdiction to receive documents and information or to investigate the death.

You further stated that you would be sending correspondence to CMS in Dallas noting your concerns about notification to DRC of deaths until they had been investigated by CMS, and that it was your understanding that the Dallas Regional Office (RO) of CMS would forward those concerns to CMS in Baltimore. You stated that you would send that correspondence after the upcoming holiday.

Wishing you a happy Thanksgiving holiday.

Dee Blakley
Disability Rights Center of Arkansas, Inc.

Arkansas Department of Health

Health Facility Services
5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204-1704 • Telephone (501) 661-2201
Governor Mike Beebe
Paul K. Halverson, DrPH, FACHE, Director and State Health Officer

November 15, 2012

Greg Crain, Administrator
Baptist Health Medical Center-Little Rock
9601 Interstate 630, Exit 7
Little Rock, AR 72205

RE: Licensure Hospital Complaint Investigation
Conducted 11/13/2012

Dear Mr. Crain:

Baptist Health Medical Center-Little Rock is considered to be in compliance with applicable provisions of the Rules and Regulations for Hospitals and Related Institutions in Arkansas. We appreciate the cooperation of the facility staff during the complaint investigation.

If you have any questions, please call (501) 661-2201.

Sincerely,

Doug Gordon, Program Manager
Health Facility Services
Arkansas Department of Health

/sm

EXHIBIT
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COMPLAINT INVESTIGATION

DATE: November 14, 2012

RE: Baptist Medical Center
9601 Interstate 630, Exit 7
Little Rock, AR 72205
Administrator: Greg Crain
Telephone #: 501-202-2000

SUBJECT: State Agency Control #13-020

The complaint was investigated on 11/13/12. An entrance conference was conducted with Facility Representatives at 0805. The Representatives were informed the purpose of the visit was to conduct a complaint investigation. The complaint was reviewed at that time.

The complaint was a reported death in restraints. The patient was admitted to the facility on October 13, 2012, with chest pain, coronary artery disease and renal failure. On October 31, 2012, the patient died within 24 hours of being in an enclosure bed.

The following Condition of Participation was reviewed:

482.13 Patient Rights

The Condition of Participation was considered met. No deficiencies were cited.

The following Section was reviewed:

13 Restraints

The Section was considered met. No deficiencies were cited.

The following information was reviewed:
Patient Rights Statement provided on admission
Incidents/Occurrences/Accidents for 3 full months
List of Patients admitted to the hospital in the last 6 months
Patient/Complaint/Grievance Policy and Resolution Policy
Patient Abuse/Harassment/Investigation Policy
Complaints/Grievances Log and Responses for previous 3 months
Advance Directives P & P
Use of Restraint/Seclusion Policy
Restraint/Seclusion Log
Patient's Death While in Restraints P & P
Death in Restraint Log

Soft Wrist Restraint Death Log
Evidence of On-going education in the use of Restraints
List of employees hired in the last month
The above met regulatory requirements.

The Complainant was identified as Patient #1. Review of the physician #1's progress notes timed and dated 0511 on 10/21/12 revealed Patient #1 fell while getting to the bathroom. Family was present at the time. CT Scan revealed a small right parietal epidural bleed from the fall. Review of same physician progress notes revealed Patient #1 was moved from the Telemetry Unit to the Intensive Care Unit (ICU) for closer monitoring, assessment and evaluation. Patient #1 was transferred back to the Telemetry Floor on 10/22/12.

Review of physician's orders timed and dated 2102 on 10/22/12 revealed orders to place Patient #1 into an enclosure bed to ensure safety due to Patient #1's confusion, agitation and trying to get out of bed. Patient #1 remained in the enclosure bed until 1000 on 10/31/12 when she was transferred to CT.

Review of physician #1's progress note timed 1337 and dated 10/30/12 revealed "Spoke with (NAMED - daughter) about kidney biopsy risks and benefits including bleeding, infection, loss of kidney, need of blood transfusion, need of surgery, biopsy of adjacent organs, death etc. She understands the risks well and wants to proceed with biopsy. Will get consent signed and have IR do kidney biopsy in am."

Review of Physician #2's progress note timed and dated 1318 on 10/31/12 revealed the following:
Renal bx (biopsy) performed
Following bx, pt. became hypotensive and developed cardiopulmonary arrest
Code was initiated and Drs. (Physician #3 and #1) informed.
Patient would initially respond to pressors, but would become hypotensive subsequently
Patient intubated and resuscitation continued.
Patient was brought to Interventional Radiology Suite and embolization of rt (right) renal artery performed.
Patient's BP remained labile and was subsequently transferred to CCU (Coronary Care Unit)
During resuscitation attempt bilateral femoral CVLs (central venous line) were placed
Dr. (Physician #3) present with patient in CCU

Review of the nurses' notes dated 10/31/12 revealed Patient #1 expired at 1245 on 10/31/12.

Patient #11 was in a safety enclosure bed on the 7A Unit on the day of survey. The 7A Unit was toured at 1135. All four side rails were observed to be up, the manufacturer's guidelines were attached to the bed and the bed was in the low position.

Patient #11's primary nurse was RN #1. During an interview with RN #1 at 1150 on 11/13/12, she was asked how many side rails were supposed to be up on an enclosure bed, how often the

patient was to be checked, offered oral intake and toileting, how often physician's orders were obtained, who could initiate restraints and discontinue restraints and what documentation was mandated per Facility policy. RN #1 answered every question correctly.

Review of 11 clinical records included six open records and five closed records. Nine of the eleven clinical records were restraint patients. Of the six open records, three had been in restraints during this hospitalization and one was currently in restraints. All records met regulatory requirements.

The complaint was not substantiated in that the safety enclosure bed had nothing to do with the Patient death. State Agency recommends no further action.

An exit conference was held with Facility Representatives at 1435 on 11/13/12. No deficiencies were cited. The State Agency recommends no action.

STAFF IDENTIFIER LIST

Provider No. 040114 *Facility Name* Bapt Med Ctr

Jill Massiet RN	CNO
Stefana Loyd RN	VP (Assist) Nursing
Greg Crain	VP + Admin
Phyllis Derrough RN	Pt Safety Officer
Michelle McFaul RN	Director Med Surg
Glenn Rusby RN	Pt Care Coord
Damaris Ross RN	ER Unit Manager
Fakhar Ijaz MD	Renal-Medical Doctor #1
Clinton Fuller MD	Radiologist - " " #2
Randell Minton MD	" " #3
Natalie Carter RN	Staff RN #1

HFS- 41 06/06/07

PATIENT IDENTIFIER LIST

Provider Number _____ *Facility* Baptist Medical Center

01 [redacted]		49	73
02		50	74
03		51	75
04		52	76
05		53	77
06		54	78
07		55	79
08		56	80
09		57	81
10		58	82
11		59	83
12	36	60	84
13	37	61	85
14	38	62	86
15	39	63	87
16	40	64	88
17	41	65	89
18	42	66	90
19	43	67	91
20	44	68	92
21	45	69	93
22	46	70	94
23	47	71	95
24	48	72	96

HFS - 40 06/06/07

• → active pt

– restraint pt

Printed: 11/16/2012
Due Date: 11/07/2012
Priority: IJ

INTAKE INFORMATION

Intake Number: AR00015095
Facility ID: HSPT0030
Provider Number:

PROVIDER INFORMATION:

Name: BAPTIST HEALTH MEDICAL CENTER-LITTLE ROCK
Address: 9601 INTERSTATE 630, EXIT 7
City/State/Zip/County: LITTLE ROCK, AR, 72205, PULASKI
Telephone: (501) 202-2200

License #:
Type: HOSPITAL
Medicaid #:
Administrator: GREG CRAIN

INTAKE INFORMATION:

Intake Number: AR00015095
Taken by - Staff: MARTIN, SHARON
Location Received: HFS HOSPITAL COMPLAINT TEAM
Intake Type: Complaint
Intake Subtype: State-only, licensure
SA Contact:
RO Contact:
Responsible Team: HFS HOSPITAL COMPLAINT TEAM
Source: Entity Self-Reported

Received Start: 11/05/2012 At 13:08
Received End: 11/05/2012 At 13:08
Received by:
State Complaint ID: 13-020
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Work Phone	Home Phone	Cell Phone
[redacted]	BAPTIST HEALTH MC LITTLE ROCK, AR 72205	[redacted]		

Confidentiality Requested : Y
Link ID: 08J0BQ

RESIDENTS/PATIENTS/CLIENTS:

Name	Admitted	Location	Discharged	Room	Link ID
[redacted]					2471701

INTAKE DETAIL:

Date of Alleged Event: Time: Shift:
Standard Notes: Death in restraints, patient was in an enclosure bed.
Extended RO Notes:
Extended CO Notes:

ALLEGATIONS:

Category: Resident/Patient/Client Rights
Sub-category:
Seriousness:
Details:

SURVEY INFORMATION:

Event ID	Start Date	Exit Date	Team Members
8LL211	11/13/12	11/13/12	MORRIS, DEBI

ACTIVITIES:

Type	Sent	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	11/13/2012	11/13/2012	11/13/2012	MORRIS, DEBI

END OF INTAKE INFORMATION

SURVEY/CONSTRUCTION ATTENDANCE

DATE: Dec. 13, 2012

FACILITY: Bapt. Med Ctr

FACILITY LEAD: Jill Massiet
JILL MASSIET
Printed Name

Signature

TELEPHONE NUMBER: _____

ADH SURVEY TEAM: D.H. Morris RN

_____

_____

_____

_____

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_____

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_____

Arkansas Department of Health

Health Facility Services
5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204-1704 • Telephone (501) 661-2201
Governor Mike Beebe
Paul K. Halverson, DrPH, FACHE, Director and State Health Officer

November 16, 2012

Harrison Dean, Administrator
Baptist Health Medical Center - North Little Rock
3333 Springhill Drive
North Little Rock, AR 72117

RE: Licensure Hospital Complaint Investigation
Conducted 11/13/2012

Dear Mr. Dean:

The following deficiencies were identified by the survey team of the Arkansas Department of Health during their visit on 11/13/2012.

RESTRAINTS
SECTION 13.B.

Based on clinical record review and interview, it was determined the facility failed to ensure three (#1, #2 and #3) of ten (#1-#10) patients in restraints had daily orders for those restraints. The failed practice created the potential for unnecessary restraint use and could affect any patient admitted to the facility. See CMS 2567

SECTION 13.E.

Based on review of policy and procedures, interview and clinical record review, it was determined the facility failed to ensure five (#1, #2, #3, #4 and #10) of 10 (#1-#10) patients in restraints were monitored every two hours according to facility policy. The failed practice created the potential for patient injury or death and did not allow the patient to be assessed and released from restraints as early as safely possible and could affect any patient in restraints. See CMS 2567

The above shall be corrected at the earliest possible date in order to provide maximum care and/or safety to the patients in your facility. Your response on the above should be forwarded to this office within ten calendar days of receipt of this correspondence. Such comments should include any corrective action, taken or proposed, the person responsible for correction and the date of correction.

If we may be of assistance at any time, please call (501) 661-2201.

EXHIBIT
tabbies
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Sincerely,

Doug Gordon, Program Manager
Health Facility Services
Arkansas Department of Health

COMPLAINT INVESTIGATION

DATE: November 15, 2012

RE: Provider #: 040036
Baptist Health Medical Center
3333 Springhill Drive
North Little Rock, AR 72117
Administrator: Harrison Dean
Telephone #: (501) 202-3000

SUBJECT: State Agency Control # 13-021

The complaint was investigated on November 13, 2012. An entrance conference was conducted with Facility Representatives at 0825. The Representatives were informed the purpose of the visit was to conduct a death in restraints investigation.

The patient was admitted to the facility on 10/16/12 with altered mental status and weight loss. The patient died on 10/29/12 within 24 hours of being removed from an enclosure bed. Cause of death was listed as lung cancer.

The following Condition of Participation was reviewed:

482.13 Patient Rights

The Condition of Participation was considered met. Deficiencies were cited.

The following Section was reviewed:

Section 13: Restraints

The Section was considered met. Deficiencies were cited.

The following information was reviewed:
Incidents/Occurrences/Accidents
Patient/Complaint/Grievance Policy and Resolution Policy
Patient Abuse/Harassment/Investigation Policy
Restraint/Seclusion Log
Patient's Death While in Restraints
Complaints/Grievances and Responses
Advance Directives Policy and Procedure
Use of Restraint/Seclusion Policy
The above met regulatory requirements.

When asked on 11/13/12 at 0905 if any current patients were in enclosure beds, the

Director of Quality stated no patients were in enclosure beds at this time. She also stated that very rarely do they use an enclosure bed and other alternatives were always tried first.

Review of the policy titled "Restraints/Seclusion" effective September 2012 stated, "4.3 Acute Care Restraint Orders must be renewed daily".

A total of 10 clinical records were reviewed to include two closed records of patients who had been in enclosure beds and eight current records of patients who had been in wrist restraints. Patient #1 was the patient named in the complaint.

Review of Orders revealed Patient #1 was in restraints 11 out of 14 days during his admission. Six (10/18/12, 10/19/12, 10/20/12, 10/21/12, 10/25/12 and 10/28/12) of 11 days did not have an order for restraints

Regarding restraint monitoring, the Restraint/Seclusion policy also stated, "6.1. Observe the patient's physical and mental status a minimum of every two (2) hours and more frequently as condition warrants. 6.2. Offer fluids and toileting at least every two (2) hours while awake. 6.3. Release restraints, perform range of motion for any restrained joints and physical assessment at least every two (2) hours".

On the days Patient #1 was in restraints, monitoring was not documented at the following times:
10/19/12 from 0300 through 2000;
10/20/12 from 0400 through 0715 and from 1100 through 1500;
from 1700 on 10/20/12 through 0745 on 10/21/12;
from 1800 on 10/21/12 through 0900 on 10/22/12;
10/23/12 from 0400 through 1413 and from 1413 through 1900;
from 2300 on 10/23/12 through 1800 on 10/24/12; and
from 1518 through 1800 on 10/27/12.

Progress note written by Physician #3 on 10/18/12 at 0936 stated, "He (Patient #1) was very aggressive and agitated this am, per nursing staff. He got Haldol and Ativan and was placed in restraints. He is now calm and sleeping."

Progress note written by Physician #2 on 10/22/12 at 1735 stated, "Pt (Patient) with et (metastatic) lung CA (cancer) - needs power port - plan to do Wed. (Wednesday). Pt currently is restrained and moderately confused, although appears to understand what I'm saying and the risks. Will plan surgery on Wed." Note written on 10/23/12 at 0810 stated, "Patient is sedated and in a veil bed. I discussed with his wife is in the room about his port tomorrow. Surgery will be tomorrow."

Progress note written by RN #1 on 10/23/12 at 1344 stated, "Patient found on floor in bathroom. Patient had no apparent injuries. Patient assisted back to bed and enclosure bed reinstated." Note written on 10/23/12 at 1417 stated, "Patient vail bed not zipped. Patient not attempting to get out

of bed unassisted. Family member in room."

Review of Complex Assessments revealed Patient #1 was documented as having "poor safety awareness" and/or "poor judgment" a total of 48 times during the course of his admission.

Progress note written by Physician #1 on 10/28/12 at 1427 stated, "The patient was found unresponsive and code blue was called. The nurse had been in his room within the last 5 min (minutes). And he was awake and alert. During intubation it was apparent that he may have aspirated. He was resuscitated following ACLS protocol. He had episodes of ventricular fibrillation and required cardioversion several times. Eventually we were able to reestablish a heart rhythm but had difficulty obtaining a blood pressure. He has received fluid resuscitation and is now on a dopamine and norepinephrine drip. Even with this his blood pressure is 70 systolic. His heart rate is stable at 115. His left pupil is larger than his right pupil. He is on the ventilator and does not appear to be assisting the ventilator. He was resuscitated for over one hour."

Progress note written by RN #2 on 10/29/12 at 0325 stated, "Unable to get consistently accurate BPs (blood pressure) this shift. Have tried both arms and legs, changed BP cuff. Also unable to obtain pox (pulse oximetry), nail beds dusky, extremities very cool. Cont (continue) on 100% FIO2 (fraction of inspired oxygen). Temp at beginning of shift low 90s and Bair Hugger placed, this brought temp up, currently 96.6."

Progress note written by Physician #4 on 10/29/12 at 0409 stated, "Patient developed PEA (Pulseless Electrical Activity). ACLS (Advanced Cardiovascular Life Support) protocol followed. Emergency medications and chest compressions given. Patient went into asystole. Code was called and patient expired."

Discharge Summary written by Physician #1 on 10/29/12 at 0620 stated, "He was found to be remarkably hypercalcemia and was treated with IV fluids and then pamidronate. He was found to have a long mass and underwent a CTI that needle biopsy which demonstrated non-small cell lung cancer. His calcium was corrected but he continued to be confused and disoriented. It was felt that this was most likely alcohol withdrawal. He was being treated appropriately. Yesterday he was found unresponsive and code blue was called he was resuscitated with IV fluids and placed on the dopamine and norepinephrine. He remained profoundly hypotensive. During the night he developed PEA and code blue was called once again. He was aggressively treated according to a ACLS protocol but eventually was pronounced dead at 4:06 AM."

An exit conference was conducted with Facility Representatives on 11/13/12 at 1430. The Representatives were informed deficiencies were cited and were given an opportunity to present additional information. No further information was presented at that time. The complaint was substantiated in that Patient #1 died within 24 hours of being in an enclosure bed. The State Agency recommends a plan of correction.

SURVEY/CONSTRUCTION ATTENDANCE

DATE: 11/13/12

FACILITY: BHMC-NLR

FACILITY LEAD: Kathy Martin **Printed Name**

Kathy Martin **Signature**

TELEPHONE NUMBER: 202-3461

ADH SURVEY TEAM: Liz Weaver MS, RD, LD

Printed: 11/16/2012
Due Date: 11/10/2012
Priority: Non-IJ Medium

INTAKE INFORMATION

Intake Number: AR00015098
Facility ID: HSPT0031
Provider Number:

PROVIDER INFORMATION:

Name: BAPTIST HEALTH MEDICAL CENTER - NORTH LITTLE
Address: 3333 SPRINGHILL DRIVE
City/State/Zip/County: NO LITTLE ROCK, AR, 72117, PULASKI
Telephone: (501) 202-3000
License #:
Type: HOSPITAL
Medicaid #:
Administrator: HARRISON DEAN

INTAKE INFORMATION:

Intake Number: AR00015098
Taken by - Staff: MARTIN, SHARON
Location Received: HFS HOSPITAL COMPLAINT TEAM
Intake Type: Complaint
Intake Subtype: State-only, licensure
SA Contact:
RO Contact:
Responsible Team: HFS HOSPITAL COMPLAINT TEAM
Source: Other Health Provider
Received Start: 11/05/2012 At 13:06
Received End: 11/05/2012 At 13:06
Received by:
State Complaint ID: 13-021
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Work Phone	Home Phone	Cell Phone
[redacted]		[redacted]		

Confidentiality Requested : Y
Link ID: 08TEZZ

RESIDENTS/PATIENTS/CLIENTS:

Name	Admitted	Location	Discharged	Room	Link ID
RICHARD JACKSON					2471759

INTAKE DETAIL:

Date of Alleged Event: Time: Shift:
Standard Notes: Death in Restraints
Extended RO Notes:
Extended CO Notes:

ALLEGATIONS:

Category: Resident/Patient/Client Rights
Sub-category:
Seriousness:
Details:

SURVEY INFORMATION:

Event ID	Start Date	Exit Date	Team Members
NTWC11	11/13/12	11/13/12	WEAVER, LIZ

ACTIVITIES:

Type	Sent	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	11/13/2012	11/13/2012	11/13/2012	WEAVER, LIZ

END OF INTAKE INFORMATION

Arkansas Department of Health

Health Facility Services
5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204-1704 • Telephone (501) 661-2201
Governor Mike Beebe
Paul K. Halverson, DrPH, FACHE, Director and State Health Officer

November 13, 2012

Lee Gentry, Administrator
Baptist Health Rehabilitation Institute
9601 Inerstate 630, Exit 7
Little Rock, AR 72205

RE: Licensure HospitalComplaint Investigation
Conducted 10/25/2012

Dear Mr.: Gentry:

Baptist Health Rehabilitation Institute is considered to be in compliance with applicable provisions of the Rules and Regulations for Hospitals and Related Institutions in Arkansas. We appreciate the cooperation of the facility staff during the complaint investigation.

If you have any questions, please call (501) 661-2201.

If we may be of assistance at any time, please call (501) 661-2201.

Sincerely,

Doug Gordon

Doug Gordon, Program Manager
Health Facility Services
Arkansas Department of Health

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EXHIBIT
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COMPLAINT INVESTIGATION

DATE: October 26, 2012

RE: Provider #: 043026
Baptist Health and Rehabilitation Institute
9601 Interstate 630, Exit 7
Little Rock, AR 72205
Administrator: Lee Gentry
Telephone: 501-202-7008

SUBJECT: State Agency Control # 13-014

The complaint was investigated on October 25, 2012. An entrance conference was conducted with Facility Representatives at 0830. At that time the self reported death in restraint complaint was reviewed.

The following Condition of Participation was reviewed:

482.13: Patient's Rights

The Condition of Participation was considered met. No deficiencies were cited.

The following Section was reviewed:

Section #13: Restraints

The Section was considered met. No deficiencies were cited.

The restraint log for the facility was requested and reviewed. The Second floor of the facility did not have any patients in restraint at the time of the survey. The 3rd Floor census was 22 patients and 8 were restrained. All eight patients in restraint at the time of the survey were selected for review and two discharged patients who had been in restraint were selected. Patient #1 was the record of the patient in the complainant and was hospitalized on the third floor of the facility.

The third floor of the facility was for patients who had a Neurological or Brain Injury. A copy of the Admission criteria was reviewed and included the absence of acute medical problems that interfered with therapy, required the services of at least two of the rehabilitation components and be able to participate in three hours of therapy per day within 10 days of admission. Patients are admitted to the floor and services are comprised of three clinical practice foci: Brain injury, CVA (Cerebrovascular Accident) and Comprehensive Rehabilitation. Admissions occurred through the admissions office after a reservation was made by the attending physician.

The Complainant entered the facility on 09/17/12. Review of the record revealed a discrepancy from the reported date of birth (04/20/1959) to the clinical record date of birth which was 04/20/1929. The Quality Director reviewed the documentation and stated the reported date of birth of 04/20/1959 was incorrect. A correction was submitted.

Review of the discharge summary on 10/07/12 revealed Patient #1 had an admission diagnosis of subdural hematoma and a secondary Diagnosis of: Question of myocardial infarction versus pulmonary embolus. Other diagnosis included Hyperlipidemia, Cataracts, osteoarthritis, Iron deficiency anemia and benign prostatic hypertrophy. Consultations were obtained for physical therapy, occupation therapy, speech therapy, thereaputic recreation, medical social work and medical nutrition. The procedures the patient underwent were a follow-up non-contrast CT of the brain during his hospital stay. The patient received five days of intravenous vancomycin due to a resistant staph in his urine with a positive urinalysis.

The patient history included a frontal pariental subdural evacuation on 08/27/12 at another facility and a left sided frontal pariental craniotomy (09/05/12). The discharge summary stated "He was on tube feeding for a short time and continued to slowly improve with his level of alertness and began therapy. He was evaluated and admitted then to the facility on 09/17/12." The discharge summary defined his hospital course as "making slow progress in all areas. He was still requiring assistance with all of his ADLs (Activities of Daily Living), transfers, ambulation, memory and problem solving. We were in the process of arranging for him to be transferred to a skilled nursing facility."

On the morning of 10/07/12, the patient developed shortness of breath and was placed on nasal oxygen. His saturations rapidly improved from 88 - 96% on 4 liters of oxygen by nasal cannula. His blood was checked for cardiac enzyme levels, complete blood count, electrolytes, BUN (Blood Urea Nitrogen) and creatinine. An Electrocardiogram was ordered. The patient was pronounced dead at 0939 after resusicitation efforts were not effective.

The history and physical dated 09/18/12 revealed the physician statement "Clinical complications certainly include significant risk for falls. Will exercise fall safety precautions with all of our therapies and on the floor. He is certainly at risk for further seizures. We will continue his current seizure medicines and institute seizure precautions as well." The plan was stated "Will exercise cardiac, fall safety and seizure precautions with all of our therapies and on the floor. I spoke with the family and at this point we will put him in a safety enclosure bed to avoid falls as he has been very impulsive."

Physician progress notes were reviewed and revealed on 09/30/12 the patient's neurologic status was described as oriented to self and place with decreased short term memory. .
Restraint orders were reviewed from 09/17/12 - 10/07/12 and noted daily. The care plan was reviewed and revealed patient education and safety guidelines were documented. The documentation included risk for falls and fall prevention interventions. Documentation revealed the patient was checked every two hours while in restraints and on the day the patient expired. Vital signs were documented at 0300 on 10/07/12 (temp) 99.4, (pulse 93) blood pressure,

152/76, Vital signs were documented at 0630 on 10/07/12 as blood pressure 93/60 and SpO2 reading of 88%. At 0634 the SpO2 was 90%, 0700 94% on 4 liters of oxygen. The patient expired at 0939.

The facility QA(Quality Assurance) was reviewed related to the use of restraints. There were no injuries reported while the patient was in restraint. The facility determined the patient least restrictive restraint was the enclosure bed due to short term memory loss and impulsiveness. The wheelchair safety belt was utilized when he was up for therapy.

A tour was conducted of the third floor and each of the enclosure beds were observed. Licensed Practical Nurse #1 was interviewed on 10/25/12 at 1600. He verbalized training, alternatives to restraints and the monitoring required. An interview was conducted with Patient Technician #1 and she verbalized what monitoring, safety concerns, abuse neglect recognition and prevention.

An exit conference was conducted with Facility Representatives on 10/25/12 at 1630. The findings of the investigation were reviewed. No deficiencies were cited. The State Agency recommends no further action.

Baptist Health
REHABILITATION INSTITUTE

9601 Interstate 630, Exit 7
Little Rock, AR 72205-7299
501 202-7000

FACSIMILE TRANSMITTAL SHEET

DATE: October 25, 2012

TO: Dorsey Sudorgei

FAX NUMBER: 214-767-0270

FROM: Phyllis Dorrough

FAX NUMBER: (501) 202-7693

NUMBER OF PAGES, INCLUDING THIS TRANSMITTAL SHEET

3 **LETTER** **(8 1/2 X 11)**

COMMENTS:

Please note: This document is a CORRECTED form for [redacted]. The original form had a birth year of 1959, which is incorrect. The correct year of his birth is 1929. See correction on the form please.

If you are not receiving this transmission clearly, or you do not receive all pages, please call the operator below. Thank you.

Phyllis Dorrough 501-202-7296
Operator **Phone Number**

Hospital Restraint/Seclusion Death Report Worksheet

For provider use only

Check one:

Initial report	
Update	

Fax 443-380-8869 or e-mail to RODALDSC@cms.hhs.gov
no later than the close of business the next business day following knowledge of the death.
For questions call the Dallas coordinator, Dorsey Sadongei, at 214-767-3570.

A. Hospital Information:

Hospital Name: Baptist Health Medical Center – LR CCN: 043026

Address: 9601 Interstate 630, Exit 7, Little Rock, AR 72205

Contact Person: Phyllis Dorrough Phone: 501-202-1276

B. Patient Information:

Name: [redacted] Date of Birth: April 20[redacted]

Admitting Diagnosis: *Subdural Hematomas* Date of Admission: September 17, 2012

Cause of Death: Possible myocardial infarction versus pulmonary embolism

Date & Time of Death: October 7, 2012 9:39 AM

Patient died: *(check one only)*

X	While in restraint, seclusion, or both
	Within 24 hours of removal
	Within 1 week, if restraint or seclusion contributed to patient's death

Type: *(check all that apply)*

x	Physical Restraint
	Seclusion
	Drug used as restraint Drug/dosage_____

If Physical Restraint, select Type(s):

_____01 Side Rails
_____02 Two Point, Soft Wrist
_____03 Two Point, Hard Wrist
_____04 Four Point, Soft Restraints
_____05 Four Point, Hard Restraints
_____06 Forced Medication Holds
_____07 Therapeutic Holds
_____08 Take-downs
_____09 Other Physical Holds
__X__10 Enclosed Beds
_____11 Vest Restraints
_____12 Elbow Immobilizers
_____13 Law Enforcement Restraints
_____14 Other Type Physical Restraint

Was a Soft Wrist Restraint used alone, without seclusion or any other type of restraint? Yes____ No X

If YES, stop here. No further information is required. If NO, complete Section C below.

C. Additional Information:

1. Reason(s) for Restraint/Seclusion Use: Inability to follow directions, confused, unsteady gait
2. Circumstances Surrounding the Death: Developed respiratory distress (gradual onset) leading to respiratory arrest
3. Restraint/Seclusion Order Details:
   a. Date/Time Restraint/Seclusion Applied: October 6, 2012 0955
   b. Date/Time Last Monitored: October 7, 2012 0800
   c. Total Time in Restraint/Seclusion: 20 hours
4. Was restraint/seclusion used to manage violent or self-destructive behavior? Yes___ No X *(If NO, stop here.)*
   a. *If YES, was 1 hour face-to-face evaluation documented? Yes___ No___*
   b. Date/Time of Last Face-to-face Evaluation: _____
   c. Was the order renewed at appropriate intervals based on patient's age? Yes____ No____

Note: Orders may be renewed at the following intervals for up to 24 hours:

> 18 years of age	*every 4 hours*
9 – 17 years of age	*every 2 hours*
< 9 years of age	*every hour*

Printed: 11/16/2012
Due Date: 12/07/2012
Priority: Non-IJ Medium

INTAKE INFORMATION

Intake Number: AR00015082
Facility ID: HSPT0060
Provider Number:

PROVIDER INFORMATION:

Name: BAPTIST HEALTH REHABILITATION INSTITUTE
Address: 9601 INERSTATE 630, EXIT 7
City/State/Zip/County: LITTLE ROCK, AR, 72205, PULASKI
Telephone: (501) 202-7578
License #:
Type: HOSPITAL
Medicaid #:
Administrator: LEE GENTRY

INTAKE INFORMATION:

Intake Number: AR00015082
Taken by - Staff: MARTIN, SHARON
Location Received: HFS HOSPITAL COMPLAINT TEAM
Intake Type: Complaint
Intake Subtype: State-only, licensure
SA Contact:
RO Contact:
Responsible Team: HFS HOSPITAL COMPLAINT TEAM
Source: Other Health Provider
Received Start: 10/23/2012 At 09:42
Received End: 10/23/2012 At 09:42
Received by:
State Complaint ID: 13-014
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Work Phone	Home Phone	Cell Phone
[redacted]		[redacted]		

Confidentiality Requested : Y
Link ID: 084Y40

RESIDENTS/PATIENTS/CLIENTS:

Name	Admitted	Location	Discharged	Room	Link ID
[redacted]					2478537

INTAKE DETAIL:

Date of Alleged Event: Time: Shift:
Standard Notes: Death in restraints
Extended RO Notes:
Extended CO Notes:

ALLEGATIONS:

Category: Other
Sub-category:
Seriousness:
Details:

SURVEY INFORMATION:

Event ID	Start Date	Exit Date	Team Members
4HPK11	10/25/12	10/25/12	LAWSON, ANGELA A.

ACTIVITIES:

Type	Sent	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	10/25/2012	10/25/2012	10/25/2012	LAWSON, ANGELA A.

END OF INTAKE INFORMATION

SURVEY/CONSTRUCTION ATTENDANCE

DATE: 10/25/12

FACILITY: Baptist Health Rehab Institute

FACILITY LEAD: Lee Gentry **Printed Name**

Lee Gentry **Signature**

TELEPHONE NUMBER:

ADH SURVEY TEAM: Angela Lawson, RN