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ARKANSAS STATE CLAIMS COMMISSION
JUN 04 2013
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BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss Brett Renoudet Mize, as Special Administrator of the Estate of Brenda Mize, Deceased, Claimant

vs.

State of Arkansas, Respondent

DHS/Developmental Disabilities Svs.

Do Not Write in These Spaces
Claim No. 13-0865-CC
Date Filed June 4, 2013 (Month) (Day) (Year)
Amount of Claim $ 1,000,000.00
Fund DHS/DDS
Mental Anguish, Pain & Suffering, Wrongful Death, Negligence, Failure to Follow Procedure Refund of Expenses

COMPLAINT

Brett Renoudet Mize, as Special Administrator of the Estate of Brenda Mize, Deceased (Name) the above named Claimant, of 11136 Cobblestone Dr, Bentonville (Street or R.F.D. & No.) (City) Arkansas, 72712 (State) (Zip Code) 479-290-3493 (Daytime Phone No.) County of Benton represented by M. Darren O'Quinn (Legal Counsel, if any, for Claim) of 415 N. McKinley Ste 1000, Little Rock, AR 72205 (Street and No.) (City) (State) (Zip Code) 501-975-2442 (Phone No.) 501-975-2443 (Fax No.) says:

State agency involved: AR DHS (Arkadelphia Human Development Center) Amount sought: $1,000,000.00

Month, day, year and place of incident or service: February 9, 2013 Arkadelphia Human Development Center

Explanation: Brenda Mize, age 47, choked to death at the Arkadelphia Human Development Center on February 9, 2013. Brenda, who had a diagnosis of an intellectual disability, emotional disorder, and swallowing problems, was a client of the Center. She was supposed to be supervised while eating because she was a known choking risk. Despite this, however, Brenda was allowed to wander into the kitchen unsupervised and rummage through the cabinets and refrigerator. She found a food item and sat down at the kitchen table to eat it. A staff member came in and told Brenda to leave the kitchen -- yet allowed her to continue eating the food unsupervised and alone in her room.

(Continued on page 2)

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? No (Yes or No); when? (Month) (Day) (Year); to whom? (Department); and that the following action was taken thereon:

and that $ was paid thereon: (2) Has any third person or corporation an interest in this claim? No; if so, state name and address (Name) (Street or R.F.D. & No.) (City) (State) (Zip Code) and that the nature thereof is as follows:

; and was acquired on , in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

M. Darren O'Quinn
(Print Claimant/Representative Name)

M. Darren O'Quinn
(Signature of Claimant/Representative)

HILARY [illegible]
Arkansas - Pulaski County
Notary Public - Commission 12368421
My Commission Expires Mar 31, 2018
(SEAL)

SWORN TO and subscribed before me at Little Rock (City) AR (State) on this 30 (Date) day of May (Month) 2013 (Year)

(Notary Public)

My Commission Expires: March 31, 2018 (Month) (Day) (Year)

SF1- R7/99

In fact, Brenda is seen on the Center's video system getting up and taking the food with her to her room. A minute later she is seen on the video coming unsteadily out of her room and collapsing on the floor in front of the staff member who allowed her to have the food. The Center, however, did not have the proper equipment or staff training for cardiopulmonary resuscitation and emergency life saving measures so that correct emergency interventions for choking were utilized. Although the staff called 911 for an ambulance service from the local hospital in Arkadelphia, this took 10 very valuable minutes. When the ambulance did finally arrive, Brenda was transported to the local hospital where resuscitation efforts continued. There, she was diagnosed with "cardiac Arrest [due to] asphyxiation." Brenda still had some blood pressure and heart rate so she was transferred to critical care at Baptist Hospital in Little Rock. Tragically, however, too much damage had been done and she died the next day.

The Office of Long Term Care, Intermediate Care Facilities for the Mentally Retarded, surveyors were sent on February 12, 2013 to conduct an unannounced complaint investigation concerning this incident. They confirmed the above facts. ***See Office of Long Term Care Complaint Report appended as Exhibit A hereto and incorporated herein by reference.*** The surveyors found that Brenda had "severe deficits in intellectual functioning, profound deficits in adaptive behavior functioning, a choking risk assessment score of 70% (increased risk), required supervision and cueing to chew food well and eat or drink at a slow pace and was served a regular mechanical soft diet with gravy/sauce to moisten food." In other words, the staff knew Brenda was a choking risk while eating and needed supervision to eat safely.

Staff interviews were conducted by the surveyors and confirmed the following:

> Staff #4 stated the living unit staff told her Brenda had gotten into a "Danish" in the living unit kitchen, and *staff have to be with Brenda to ensure safety from choking*. She stated Brenda roams the home and *will go into the kitchen when staff are not watching her*. Brenda gets in a hurry when eating and can choke on food. Staff #2 RCT, stated *it was common for Brenda to sneak into the living unit kitchen*. Staff #1, RCT, stated Brenda was a part of Staff #2's group assignment. *She stated that after she had Brenda leave the kitchen and go to her room, she was in the back of the living unit folding clothes*. She stated when Brenda came out of her room [choking] "I panicked and screamed for help."

This complaint was "substantiated" by the surveyors and resulted in the Center being cited for ***immediately jeopardizing the health and safety of 60 clients who required supervision for eating by putting them at risk for serious***

harm, injury, or death. See Department of Health and Human Services CMS-2567 appended as Exhibit B hereto and incorporated herein by reference. Specifically, the surveyors found that the facility:

1. Failed to ensure all direct care staff were trained and certified with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions (CPR, airway clearing, Heimlich, and defibrillator) were utilized for choking victims and assure that at least one such staff member works in each home, every shift (24/7);

2. Failed to ensure supervision was provided during eating to prevent choking and nursing interventions were implemented during eating to prevent choking and assure that staff trained in the supervision of eating will work in each home, every shift (24/7)

Id.

Unfortunately, prior to Brenda's horrific death this very preventable tragedy had already occurred at other Human Development Centers controlled by the Arkansas Department of Human Services. ***See Estate of Michael Fornell v. State of Arkansas, Claims Commission No. 11-0698-CC.*** If DHS will simply accept responsibility for it deficient practices in this case, as found by its very own investigators, and then actually correct these deficiencies throughout its Human Development Centers (which very sadly was evidently *not* done after the ***Fornell*** case put DHS on notice of this danger) the chances of this tragedy being continually repeated to the harm of other helpless victims will be drastically reduced.

Choking to death is obviously a most unpleasant way to die, with a substantial period of extreme distress, the simulation of which has even been used as a method of torture. The State of Arkansas must immediately move to protect the very sick, debilitated, and fragile clients in our Human Development Centers who are totally dependent on the staff for their health and safety.

The Special Administrator, Brett Mize, brings this claim on behalf of Brenda Mize, her estate, and her statutory wrongful death beneficiaries due to the above negligent equipping, staffing, training, supervision, care, and treatment against the State of Arkansas, Arkansas Department of Human Services, Arkadelphia Human Development Center, and their employees and agents for all damages allowable under ***AMI (Civil) 2216.*** These include, but are not limited to, Brenda's loss of life,

the reasonable value of her funeral expenses, her conscious pain and suffering prior to her death, medical expenses attributable to her fatal injury, and any scars, disfigurement, or visible results of the injury sustained by her prior to her death, as well as the mental anguish, such as grief and despair associated with the loss of their loved one, suffered and reasonably probable to be suffered in the future by Brenda's wrongful death beneficiaries: Harold Mize, Brett Mize, Randall Mize, and Susan Maddie.

The attached exhibits are as follows:

Exhibit A: Copy of Office of Long Term Care Complaint Report
Exhibit B: Copy of Department of Health and Human Services CMS-2567
Exhibit C: Copy of Brenda's Death Certificate
Exhibit D: Copy of the Order Appointing Special Administrator

COPY

ARKANSAS STATE CLAIMS COMMISSION
NON VEHICLE PROPERTY DAMAGE/PERSONAL INJURY INCIDENT REPORT FORM

SECTION 1
CLAIMANT Brett Renoudet Mize, as Special Administrator of the Estate of Brenda Mize, Deceased ADDRESS 11136 Cobblestone Dr

CITY & STATE Bentonville, Arkansas ZIP CODE 72712

DATE OF INCIDENT: February 9, 2013 TIME

Give a brief description of incident, showing how incident happened, exact loss and extent of damage to property and/or injury to person:

Ms. Mize was supposed to be supervised with food at the Arkadelphia Human Development Center because she was a known choking risk. Despite this, however, Brenda was allowed to wander into the kitchen unsupervised where she found a food item on which she later choked to death.

(If personal injury claim only, move on to Section IV)

****

SECTION II

Has this property been repaired? Yes ( ) No ( ) If repairs have been made, give the following information: Amount: $_____ Have you paid for the repairs? Yes ( ) No ( )

NOTE: Attach a copy of repair bill.

If repairs have not been made, list three estimates below and **attach copies** of each of them.

	NAME	ADDRESS	AMOUNT
1.			$
2.			$
3.			$

****

SECTION III

Was property covered by insurance? Yes ( ) No ( )
If yes, what is the deductible? $_____

NAME OF INSURANCE CARRIER ADDRESS

****

SECTION IV

Is injured covered by medical insurance? Yes ( ) No (x)

If yes, what is the deductible? $_____

NAME OF INSURANCE CARRIER ADDRESS

N/A

****

SECTION V

If incident was investigated by the police or by some other agency, give name and title of officer/person making the investigation: Arkansas Department of Human Services

****

SECTION VI

The undersigned states on oath that he/she is familiar with the matters and things set forth in the above statement, and that he/she verily believes that they are true.

Signature of Claimant

(Notary Seal)

Sworn to and subscribed before me at Little Rock, Arkansas
City & State

on this 30 day of May, 2013.
day month year

My Commission Expires March 31, 2018.

HILARY SHRUM
Arkansas - Pulaski County
Notary Public - Comm# 12365421
My Commission Expires Mar 31, 2018

Signature of Notary Public

Arkansas Department of Human Services

Office of Long Term Care

Complaint Report

Complaint No.: 18109 Date of Visit: 2/12-13/2013

Facility Name: Arkadelphia Human Development Center

Mailing Address: #1 Prator Drive

City, State and Zip: Arkadelphia, Arkansas 71923

Date of Exit: 2/13/2013 Attachments: Yes

Name & Title of Persons at Exit: Les o'Neal RN

See exit conference sheet

Les O'Neal RN 2/19/2013

Surveyor Date Complaint Section Date

Complaint Findings

Item No. 1

☒ Substantiated (with deficiency ☒; without deficiency ☐) ☐ Unsubstantiated

Narrative: On February 9, 2013 client #1 went into the kitchen and rummaged through the kitchen cabinets and the refrigerator. The client got a food item and sat down at the kitchen table to unwrap the item and started eating it when a staff member came in and told the client to leave the kitchen. Client is seen on video getting up and taking food item with her to her

EXHIBIT A

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room. A minute later she came out of her room unsteady and collapsed on the floor in front of a staff member. The staff yelled for help and there were 2 additional staff who happened to be in the home; a supervisor and the medication nurse. Immediately the staff started assessing the client and attempted a Heimlich maneuver and mouth sweeps, realized the client was choking and another staff meember called for more help and called 911 to summons an ambulance service from the local hospital in Arkadelphia. The ambulance service personnel arrived about 10 minutes after being called and transported the client to the local hospital in Arkadelphia where resutation efforts continued client did have some blood pressure and heart rate and was transferred to critical care at Baptist Hospital in Little Rock and expired the next day.

The Office of Long Term Care, Intermediate Care Facilities for the Mentally Retarded surveyors, were sent on 2/12/2013 to conduct an unannounced complaint investigation concerning this incident.

Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder and Dysphagia, oral phase.

The Dysphagia Disorders Survey completed on 1/10/13 documented, "[Client #1] exhibited the following symptoms of feeding and swallowing disorder in the oral preparation and oral initiation stages of swallowing: decreased biting, decreased chewing, ... [Client #1] ate and drank at a rapid pace... was cued to slow down... The Choking Risk Assessment (CRA) was completed to assess the risk of choking as a result of dysphagia. [Client #1] received a score of 70% which indicates that she is at increased risk for choking based on this screening... Recommendations:... Staff should cue [Client #1] to chew food well. Staff should cue [Client #1] to eat and drink at a slower pace..."

The Individual Program Plan (IPP) dated 1/16/13 documented the client had severe deficits in intellectual functioning and profound deficits in adaptive behavior functioning.

The Department of Human Services (DHS) Incident Report dated 2/11/13 documented, " Subject: [Client #1] ...Date of Incident: 2/9/13 ...Type of Incident Death Choking ...Narrative Description On February 9, 2013 at 7:20 p.m. [Client #1] went into the [living unit] kitchen [of 290 Pine where she resides]. [Client #1] rummaged through the kitchen cabinets and the refrigerator. [Client #1] got a food item out of the refrigerator, sat at the kitchen table, unwrapped the item and was eating the item when [Staff #1] entered the kitchen. [Staff #1] asked [Client #1] to leave the kitchen.[Client #1] had shoved the item in her mouth ...[Client #1] left the kitchen and went to her bedroom. A few minutes later, [Staff #1] was sitting in the back hallway folding clothes when [Client #1] came out of her room and collapsed in the hallway. [Staff #1] called for assistance. [Staff #4 RCSS (Resident Care Shift Supervisor)], [Staff #3 LPN (Licensed Practical Nurse)] and [Staff #2 RCT (Resident Care Technician)] ran to assist [Client #1]. [Client #1] was choking. The three staff cleaned food out of [Client #1's] mouth and throat, preformed [performed] the Heimlich maneuver and performed CPR [cardiopulmonary resuscitation]. Medical Emergency was called. 911 was called. The ambulance arrived and transported [Client #1] to the [hospital #1] ER [emergency room]. Later [Client #1] was transported to [hospital #2] in [city] where she died at 3:15 p.m. on February 10, 2013."

The [hospital #1] Emergency Room Treatment Record dated 2/9/12 documented, "Diagnosis: cardiac Arrest [due to] asphyxiation."

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The hospital #1 Emergency Department (ER) History and Physical documented, "Date of Service: 02/09/13 Chief Complaint- Cardiac Arrest History of present illness- The patient is a 47-year-old female from the human development center that was found asphyxiating on food. The patient was unresponsive and apneic for 5-10 minutes before EMS [emergency medical services] arrived. According to EMS, they were able to remove unknown food substance from upper airway with a finger sweep, and then they were able to establish an airway, CPR was started. The patient was in asystole for approximately 15 minutes prior to arrival while ACLS [advanced cardiac life saving] was being performed by EMS. On arrival, the patient is in asystole... patient is not awake ...pupils are fixed and dilated Assessment and Plan: 1. Cardiac arrest. We were able to achieve a heart rate ...2. Post cardiac arrest. Because the patient will likely need a bronchoscopy, we will be transferring to [medical center #2] for a higher level of care."

The facility's Video #1 (living unit kitchen) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entered the kitchen alone at 7:20 p.m., looked through the kitchen cabinets, opened the refrigerator and retrieved an unidentified food item, sat at the nearest dining room table at 7:22 p.m. and ate the food item. There was no staff member in the kitchen or dining room. At 7:23 p.m., Staff #1 entered the kitchen/dining room and the client left the dining room followed by this staff.

The facility's Video #2 (hallway near the client's bedroom door) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entering the hallway from the kitchen/dining room at 7:23 p.m., going down the hall to her room, (Clients room out of camera view) with Staff #1 seated in the hallway folding laundry. At 7:24 p.m., Client #1 walked toward Staff #1 in the hallway and collapsed onto the floor. Staff #1 went to the resident and Staff #4 entered the hallway and attempted a mouth sweep. At 7:25 p.m., Staff #3 (LPN) entered, partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth and sling something onto the floor. At 7:26 p.m., Staff #3 again partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth again and sling something onto the floor then placed the client flat on the floor on her back. At 7:26:55 p.m., Staff #4 delivered 13 compressions to the client's mid-torso area and stopped compressions at 7:27:09 p.m. At 7:27:17 p.m., Staff #4 delivered 12 consecutive compression motions and stopped again at 7:27:25 p.m. At 7:27:29 p.m., Staff #4 delivered 20 consecutive compression motions and stopped again at 7:27:39 p.m. Staff continued this cycle, delivering varying numbers of consecutive compressions including 27, 16, 28, 23, 32, 85 and 69.

Staff stopped CPR for longer intervals than required to deliver 2 breaths and then resumed CPR as follows:

At 7:30:23 p.m., staff stopped CPR and resumed CPR at 7:31:12 p.m., a period of 49 seconds.

At 7:31:29 p.m., staff stopped CPR and resumed CPR at 7:31:45 p.m., a period of 24 seconds.

At 7:31:57 p.m., staff stopped CPR and resumed CPR at 7:32:29 p.m., a period of 32 seconds.

At 7:33:08 p.m., staff stopped CPR and resumed CPR at 7:33:39 p.m., a period of 31 seconds.

At 7:34:47 p.m., staff stopped CPR and resumed CPR at 7:35:17 p.m., a period of 30 seconds.

At 7:37:07 p.m., staff stopped CPR and resumed CPR at 7:37:49 p.m., a period of 42 seconds.

At 7:41 p.m. EMS arrived and the staff stopped CPR.

Staff Interviews were conducted:

On 2/13/2013 at 10:00 a.m., Staff #4 stated the living unit staff told her Client #1 had gotten into a "Danish" in the living unit kitchen, and staff have to be with Client #1 to ensure safety from choking. She stated Client #1 roams the home and will go into the kitchen when staff are not watching her. Client #1 gets in a hurry when eating and can choke on food.

On 2/13/2013 at 10:16 a.m., Staff #3, LPN, stated she was in 290 Pine passing medications when staff screamed for her to come to help Client #1, who was on the floor choking. Staff #3 told other staff to call 911.

On 2/13/2013 at 10:31 a.m., Staff #2 RCT, stated it was common for the client to sneak into the living unit kitchen.

On 2/13/2013 at 10:43 a.m., Staff #1, RCT, stated Client #1 was a part of Staff #2's group assignment. She stated that after she had Client #1 leave the kitchen and go to her room, she was in the back of the living unit folding clothes. She stated when Client #1 came out of her room [choking] "I panicked and screamed for help."

This complaint was Substantiated, all or in part, with deficient practices cited at W158 the Condition of Participation (CoP) for Facility Staffing; with subsequent standard level tags at W189 (The failure to provide each employee with current, continuing, emergency life saving training that enables each employee to perform their duties, effectively, efficiently and competently); and W192 (The failure to provide employees with current skills and competencies, directed towards client's current emergent emergency health needs).

The CoP at W318 Health Care Services was also cited, with subsequent standard level tags at W331 (The failure to provide correct nursing services in accordance with emergent, emergency client needs and W339 (The failure to provide employees with current skills and competencies, directed towards client's current emergent, emergency health care needs.

Item No. 2

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 3

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 4

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 5

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 6

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 7

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

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Item No. 8

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 9

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 10

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 11

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

Item No. 12

☐ Substantiated (with deficiency ☐; without deficiency ☐) ☐ Unsubstantiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A complaint survey was conducted from 2/12 - 2/13/13. Complaint #18109 was substantiated, all or in part, with deficiencies cited at W158, W189, W192, W318, W331 and W339.	W 000		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to meet the requirements of the Condition of Participation (CoP) for Facility Staffing (W158) as evidenced by the facility's failure to ensure all direct care staff were trained and certified as competent with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions were utilized for choking	W 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EXHIBIT B

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 158	Continued From page 1 for 1 (Client #1) of 5 (Clients #1 - #5) sampled clients, who required staff supervision while eating. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death for Client #1 who suffered respiratory distress after eating with no staff supervision and had the potential to cause more than minimal harm for 60 clients residing at the facility who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. The facility failed to meet the Standards at W189 and W192 as evidenced by the facility's failure to ensure all direct care staff were trained and certified as competent with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions were utilized after a choking incident for 1 of 1 sampled (Client #1) who choked on food and went into respiratory distress. Refer to W180 and W192 2. The facility removed the Immediate Jeopardy on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7).	W 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 158	Continued From page 2 In addition, Arkadelphia Human Development Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current in this training. Twenty Direct Care staff completed the training today and the training will continue every day until all Direct Care staff are current in CPR and the above listed skills."	W 158		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure all direct care staff were trained and certified as competent with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions were utilized after a choking incident for 1 of 1 sampled (Client #1) who choked on food and went into respiratory distress. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 3 for Client #1, who suffered respiratory distress after choking on food and had the potential to cause more than minimal harm for 60 clients who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder and Dysphagia, oral phase. a. The Individual Program Plan (IPP) dated 1/16/13 documented the client had severe deficits in intellectual functioning, profound deficits in adaptive behavior functioning, a choking risk assessment score of 70% (increased risk), required supervision and cueing to chew food well and eat and drink at a slow pace and was served a regular mechanical soft diet with gravy/sauce to moisten food. b. The Department of Human Services (DHS) Incident Report dated 2/11/13 documented, " Subject: [Client #1] ...Date of Incident: 2/9/13 ...Type of Incident Death Choking ...Narrative Description On February 9, 2013 at 7:20 p.m. [Client #1] went into the [living unit] kitchen [of 290 Pine where she resides]. [Client #1] rummaged through the kitchen cabinets and the refrigerator. [Client #1] got a food item out of the refrigerator, sat at the kitchen table, unwrapped the item and was eating the item when [Staff #1] entered the kitchen. [Staff #1] asked [Client #1] to leave the kitchen. [Client #1] had shoved the item in her mouth ...[Client #1] left the kitchen and went to her bedroom. A few minutes later, [Staff #1] was sitting in the back hallway folding clothes when [Client #1] came out of her room and	W 189		

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collapsed in the hallway. [Staff #1] called for assistance. [Staff #4 RCSS (Resident Care Shift Supervisor)], [Staff #3 LPN (Licensed Practical Nurse)] and [Staff #2 RCT (Resident Care Technician)] ran to assist [Client #1]. [Client #1] was choking. The three staff cleaned food out of [Client #1's] mouth and throat, preformed [performed] the Heimlich maneuver and performed CPR [cardiopulmonary resuscitation]. Medical Emergency was called. 911 was called. The ambulance arrived and transported [Client #1] to the [hospital #1] ER [emergency room]. Later [Client #1] was transported to [hospital #2] in [city] where she died at 3:15 p.m. on February 10, 2013."

c. The [hospital #1] Emergency Room Treatment Record dated 2/9/12 documented, "Diagnosis: cardiac Arrest [due to] asphyxiation."

The hospital #1 Emergency Department (ER) History and Physical documented, "Date of Service: 02/09/13 Chief Complaint- Cardiac Arrest History of present illness- The patient is a 47-year-old female from the human development center that was found asphyxiating on food. The patient was unresponsive and apneic for 5-10 minutes before EMS [emergency medical services] arrived. According to EMS, they were able to remove unknown food substance from upper airway with a finger sweep, and then they were able to establish an airway, CPR was started. The patient was in asystole for approximately 15 minutes prior to arrival while ACLS [advanced cardiac life saving] was being performed by EMS. On arrival, the patient is in asystole... patient is not awake ...pupils are fixed and dilated Assessment and Plan: 1. Cardiac

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W 189	Continued From page 5 arrest. We were able to achieve a heart rate ...2. Post cardiac arrest. Because the patient will likely need a bronchoscopy, we will be transferring to [medical center #2] for a higher level of care." d. The facility's Video #1 (living unit kitchen) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entered the kitchen alone at 7:20 p.m., looked through the kitchen cabinets, opened the refrigerator and retrieved an unidentified food item, sat at the nearest dining room table at 7:22 p.m. and ate the food item. There was no staff member in the kitchen or dining room. At 7:23 p.m., Staff #1 entered the kitchen/dining room and the client left the dining room followed by this staff. The facility's Video #2 (hallway near the client's bedroom door) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entering the hallway from the kitchen/dining room at 7:23 p.m., going down the hall to her room, (Clients room out of camera view) with Staff #1 seated in the hallway folding laundry. At 7:24 p.m., Client #1 walked toward Staff #1 in the hallway and collapsed onto the floor. Staff #1 went to the resident and Staff #4 entered the hallway and attempted a mouth sweep. At 7:25 p.m., Staff #3 (LPN) entered, partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth and sling something onto the floor. At 7:26 p.m., Staff #3 again partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth again	W 189		

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and sling something onto the floor then placed the client flat on the floor on her back. At 7:26:55 p.m., Staff #4 delivered 13 compressions to the client's mid-torso area and stopped compressions at 7:27:09 p.m. At 7:27:17 p.m., Staff #4 delivered 12 consecutive compression motions and stopped again at 7:27:25 p.m. At 7:27:29 p.m., Staff #4 delivered 20 consecutive compression motions and stopped again at 7:27:39 p.m. Staff continued this cycle, delivering varying numbers of consecutive compressions including 27, 16, 28, 23, 32, 85 and 69, instead of pausing for 2 breaths only after consistently delivering 30 consecutive compressions per standards of practice. (The camera was blocked by staff so breaths could not be visualized during the pauses).

Staff stopped CPR for longer intervals than required to deliver 2 breaths and then resumed CPR as follows:

At 7:30:23 p.m., staff stopped CPR and resumed CPR at 7:31:12 p.m., a period of 49 seconds.

At 7:31:29 p.m., staff stopped CPR and resumed CPR at 7:31:45 p.m., a period of 24 seconds.

At 7:31:57 p.m., staff stopped CPR and resumed CPR at 7:32:29 p.m., a period of 32 seconds.

At 7:33:08 p.m., staff stopped CPR and resumed CPR at 7:33:39 p.m., a period of 31 seconds.

At 7:34:47 p.m., staff stopped CPR and resumed CPR at 7:35:17 p.m., a period of 30 seconds.

At 7:37:07 p.m., staff stopped CPR and resumed

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W 189	Continued From page 7 CPR at 7:37:49 p.m., a period of 42 seconds. At 7:41 p.m. EMS arrived and the staff stopped CPR. e. Staff Interviews: 1) On 2/13/2013 at 10:00 a.m., Staff #4, Shift Supervisor, stated there was not an AED in living unit 290 Pine and Medical personnel brought one when Client #1 had her choking incident. She stated this was the first time she had performed CPR. She stated she thought her CPR had expired, but was unsure. She stated to her knowledge she had not been rescheduled for CPR training. She also stated they could not get Client #1 up for the Heimlich maneuver. 2) On 2/13/2013 at 10:16 a.m., Staff #3, LPN, stated she was in 290 Pine passing medications when staff screamed for her to come to help Client #1, who was on the floor choking. Staff #3 told other staff to call 911. Staff #3 started cleaning Client #1's mouth out and kept sweeping and sweeping. Staff #4 began compressions, as Staff #3 watched the client's mouth. She stated there was not an Ambu Bag there for her to use. [Unidentified staff name] started using a "mouth piece." Staff #3 was unsure whether a suction machine was located in this living unit. Another staff brought in an AED. The AED only said "Check airway." Staff #3 stated she had received CPR training here on campus, but AED training was not a part of her training per her recall. 3) On 2/13/2013 at 10:31 a.m., Staff #2, RCT, stated she did not think her CPR training was current and thought it expired around 9/11. She	W 189		

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has not received word to get updated CPR training yet. She further stated she participated in delivering compression to Client #1.

4) On 2/13/2013 at 10:43 a.m., Staff #1, RCT, stated Client #1 was a part of Staff #2's group assignment. Staff #1 stated she had CPR training in 2012 and also went over the AED. She could not recall the ratio of compressions/breaths from her CPR training. She stated when Client #1 came out of her room [choking] "I panicked and screamed for help." She stated this was her first experience with this.

f. The facility's job description titled "Resident Care Technician", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations."

g. The facility's job description titled "Resident Care Assistant", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations."

h. The facility's job description titled "LPN (Licensed Practical Nurse)", provided by the Administrative Assistant on 2/13/13, documented, "... Responds to emergency situations, assess the condition of the persons served, administers first aid... "

i. The facility's job description titled "Resident Care Supervisor", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations ...

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W 189	Continued From page 9 administers First Aid and/or CPR in emergency situations;... " j. The facility's job description titled "Residential Care Program Coordinator (Program Supervisor)", provided by the Administrative Assistant on 2/13/13, documented, "... must be able to maintain CPR certification and to use techniques taught in these classes in emergency situations." k. The facility's memorandum from the Staff Development Coordinator dated 2/12/13, provided by the Administrative Assistant on 2/12/13 at 4:05 p.m., documented, "We currently do not have a policy on CPR. We follow the guidelines of the American heart Association ... " l) The American Heart Association current standards of practice titled "Choking in an Adult" documented, "Choking is when food or another object gets stuck in the airway in the throat. The object stops air from getting into the lungs. Some choking is mild and some is severe. If it's severe, act fast. Get the object out so the person can breathe ...When someone has severe choking, give thrusts slightly above the belly button. These thrusts are sometimes called the Heimlich maneuver ... Like a cough, each thrust pushes air from the lungs. This can help remove an object that is blocking the airway ... give thrusts until the object is forced out and [the victim] can breathe, cough, or talk, or until [the victim] stops responding ...if the person stops responding, follow these steps: 1. Check if he needs CPR, give it if needed and if you know how. If you don't know how, give Hands-only CPR. 2. Continue CPR until [the victim] speaks, moves, or breathes	W 189		

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W 189	Continued From page 10 or until someone with more advanced training arrives and takes over ... " 2) The American Heart Association current standards of practice titled "CPR" documented the rate of chest compressions to breaths during CPR was 30:2. I. On 2/13/13 at 12:15 p.m., the surveyor asked the Administrative Assistant how many facility staff did not have current CPR certification. She stated, "We have 261 staff and 57 of them are not current on their CPR certifications." 2. The facility removed the Immediate Jeopardy on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7). In addition, Arkadelphia Human Development Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current	W 189		

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W 189	Continued From page 11 in this training. Twenty Direct Care staff completed the training today and the training will continue every day until all Direct Care staff are current in CPR and the above listed skills."	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure direct care staff had current and focused training directed towards client health needs by not ensuring all direct care staff were trained and certified as competent with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions were utilized after a choking incident for 1 of 1 sampled (Client #1) who choked on food and went into respiratory distress. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death for Client #1, who suffered respiratory distress after choking on food and had the potential to cause more than minimal harm for 60 clients who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. Client #1 had diagnoses of Severe Mental	W 192		

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W 192	Continued From page 12 Retardation, Bipolar Disorder and Dysphagia, oral phase. a. The Individual Program Plan (IPP) dated 1/16/13 documented the client had severe deficits in intellectual functioning, profound deficits in adaptive behavior functioning, a choking risk assessment score of 70% (increased risk), required supervision and cueing to chew food well and eat and drink at a slow pace and was served a regular mechanical soft diet with gravy/sauce to moisten food. b. The Department of Human Services (DHS) Incident Report dated 2/11/13 documented, " Subject: [Client #1] ...Date of Incident: 2/9/13 ...Type of Incident Death Choking ...Narrative Description On February 9, 2013 at 7:20 p.m. [Client #1] went into the [living unit] kitchen [of 290 Pine where she resides]. [Client #1] rummaged through the kitchen cabinets and the refrigerator. [Client #1] got a food item out of the refrigerator, sat at the kitchen table, unwrapped the item and was eating the item when [Staff #1] entered the kitchen. [Staff #1] asked [Client #1] to leave the kitchen. [Client #1] had shoved the item in her mouth ...[Client #1] left the kitchen and went to her bedroom. A few minutes later, [Staff #1] was sitting in the back hallway folding clothes when [Client #1] came out of her room and collapsed in the hallway. [Staff #1] called for assistance. [Staff #4 RCSS (Resident Care Shift Supervisor)], [Staff #3 LPN (Licensed Practical Nurse)] and [Staff #2 RCT (Resident Care Technician)] ran to assist [Client #1]. [Client #1] was choking. The three staff cleaned food out of [Client #1's] mouth and throat, preformed [performed] the Heimlich maneuver and	W 192		

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W 192	Continued From page 13 performed CPR [cardiopulmonary resuscitation]. Medical Emergency was called. 911 was called. The ambulance arrived and transported [Client #1] to the [hospital #1] ER [emergency room]. Later [Client #1] was transported to [hospital #2] in [city] where she died at 3:15 p.m. on February 10, 2013." c. The [hospital #1] Emergency Room Treatment Record dated 2/9/12 documented, "Diagnosis: cardiac Arrest [due to] asphyxiation." The hospital #1 Emergency Department (ER) History and Physical documented, "Date of Service: 02/09/13 Chief Complaint- Cardiac Arrest History of present illness- The patient is a 47-year-old female from the human development center that was found asphyxiating on food. The patient was unresponsive and apneic for 5-10 minutes before EMS [emergency medical services] arrived. According to EMS, they were able to remove unknown food substance from upper airway with a finger sweep, and then they were able to establish an airway, CPR was started. The patient was in asystole for approximately 15 minutes prior to arrival while ACLS [advanced cardiac life saving] was being performed by EMS. On arrival, the patient is in asystole... patient is not awake ...pupils are fixed and dilated Assessment and Plan: 1. Cardiac arrest. We were able to achieve a heart rate ...2. Post cardiac arrest. Because the patient will likely need a bronchoscopy, we will be transferring to [medical center #2] for a higher level of care." d. The facility's Video #1 (living unit kitchen) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entered	W 192		

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W 192	Continued From page 14 the kitchen alone at 7:20 p.m., looked through the kitchen cabinets, opened the refrigerator and retrieved an unidentified food item, sat at the nearest dining room table at 7:22 p.m. and ate the food item. There was no staff member in the kitchen or dining room. At 7:23 p.m., Staff #1 entered the kitchen/dining room and the client left the dining room followed by this staff. The facility's Video #2 (hallway near the client's bedroom door) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entering the hallway from the kitchen/dining room at 7:23 p.m., going down the hall to her room, (Clients room out of camera view) with Staff #1 seated in the hallway folding laundry. At 7:24 p.m., Client #1 walked toward Staff #1 in the hallway and collapsed onto the floor. Staff #1 went to the resident and Staff #4 entered the hallway and attempted a mouth sweep. At 7:25 p.m., Staff #3 (LPN) entered, partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth and sling something onto the floor. At 7:26 p.m., Staff #3 again partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth again and sling something onto the floor then placed the client flat on the floor on her back. At 7:26:55 p.m., Staff #4 delivered 13 compressions to the client's mid-torso area and stopped compressions at 7:27:09 p.m. At 7:27:17 p.m., Staff #4 delivered 12 consecutive compression motions and stopped again at 7:27:25 p.m. At 7:27:29 p.m., Staff #4 delivered 20 consecutive	W 192		

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W 192	Continued From page 15	W 192		

compression motions and stopped again at 7:27:39 p.m. Staff continued this cycle, delivering varying numbers of consecutive compressions including 27, 16, 28, 23, 32, 85 and 69, instead of pausing for 2 breaths only after consistently delivering 30 consecutive compressions per standards of practice. (The camera was blocked by staff so breaths could not be visualized during the pauses).

Staff stopped CPR for longer intervals than required to deliver 2 breaths and then resumed CPR as follows:

At 7:30:23 p.m., staff stopped CPR and resumed CPR at 7:31:12 p.m., a period of 49 seconds.

At 7:31:29 p.m., staff stopped CPR and resumed CPR at 7:31:45 p.m., a period of 24 seconds.

At 7:31:57 p.m., staff stopped CPR and resumed CPR at 7:32:29 p.m., a period of 32 seconds.

At 7:33:08 p.m., staff stopped CPR and resumed CPR at 7:33:39 p.m., a period of 31 seconds.

At 7:34:47 p.m., staff stopped CPR and resumed CPR at 7:35:17 p.m., a period of 30 seconds.

At 7:37:07 p.m., staff stopped CPR and resumed CPR at 7:37:49 p.m., a period of 42 seconds.

At 7:41 p.m. EMS arrived and the staff stopped CPR.

e. Staff Interviews:

1) On 2/13/2013 at 10:00 a.m., Staff #4, Shift

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ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 16 Supervisor, stated there was not an AED in living unit 290 Pine and Medical personnel brought one when Client #1 had her choking incident. She stated this was the first time she had performed CPR. She stated she thought her CPR had expired, but was unsure. She stated to her knowledge she had not been rescheduled for CPR training. She also stated they could not get Client #1 up for the Heimlich maneuver. 2) On 2/13/2013 at 10:16 a.m., Staff #3, LPN, stated she was in 290 Pine passing medications when staff screamed for her to come to help Client #1, who was on the floor choking. Staff #3 told other staff to call 911. Staff #3 started cleaning Client #1's mouth out and kept sweeping and sweeping. Staff #4 began compressions, as Staff #3 watched the client's mouth. She stated there was not an Ambu Bag there for her to use. [Unidentified staff name] started using a "mouth piece." Staff #3 was unsure whether a suction machine was located in this living unit. Another staff brought in an AED. The AED only said "Check airway." Staff #3 stated she had received CPR training here on campus, but AED training was not a part of her training per her recall. 3) On 2/13/2013 at 10:31 a.m., Staff #2, RCT, stated she did not think her CPR training was current and thought it expired around 9/11. She has not received word to get updated CPR training yet. She further stated she participated in delivering compression to Client #1. 4) On 2/13/2013 at 10:43 a.m., Staff #1, RCT, stated Client #1 was a part of Staff #2's group assignment. Staff #1 stated she had CPR training in 2012 and also went over the AED. She could	W 192		

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W 192	Continued From page 17 not recall the ratio of compressions/breaths from her CPR training. She stated when Client #1 came out of her room [choking] "I panicked and screamed for help". She stated this was her first experience with this. f. The facility's job description titled "Resident Care Technician", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations." g. The facility's job description titled "Resident Care Assistant", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations." h. The facility's job description titled "LPN (Licensed Practical Nurse)", provided by the Administrative Assistant on 2/13/13, documented, "... Responds to emergency situations, assess the condition of the persons served, administers first aid... " i. The facility's job description titled "Resident Care Supervisor", provided by the Administrative Assistant on 2/13/13, documented, "... required to maintain CPR certification and to use techniques taught in these classes in emergency situations ... administers First Aid and/or CPR in emergency situations;... " j. The facility's job description titled "Residential Care Program Coordinator (Program Supervisor)", provided by the Administrative Assistant on 2/13/13, documented, "... must be able to maintain CPR certification and to use	W 192		

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W 192	Continued From page 18 techniques taught in these classes in emergency situations." k. The facility's memorandum from the Staff Development Coordinator dated 2/12/13, provided by the Administrative Assistant on 2/12/13 at 4:05 p.m., documented, "We currently do not have a policy on CPR. We follow the guidelines of the American heart Association ... " l) The American Heart Association current standards of practice titled "Choking in an Adult" documented, "Choking is when food or another object gets stuck in the airway in the throat. The object stops air from getting into the lungs. Some choking is mild and some is severe. If it's severe, act fast. Get the object out so the person can breathe ...When someone has severe choking, give thrusts slightly above the belly button. These thrusts are sometimes called the Heimlich maneuver ... Like a cough, each thrust pushes air from the lungs. This can help remove an object that is blocking the airway ... give thrusts until the object is forced out and [the victim] can breathe, cough, or talk, or until [the victim] stops responding ...if the person stops responding, follow these steps: 1. Check if he needs CPR, give it if needed and if you know how. If you don't know how, give Hands-only CPR. 2. Continue CPR until [the victim] speaks, moves, or breathes or until someone with more advanced training arrives and takes over ... " 2) The American Heart Association current standards of practice titled "CPR" documented the rate of chest compressions to breaths during CPR was 30:2.	W 192		

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W 192	Continued From page 19 I. On 2/13/13 at 12:15 p.m., the surveyor asked the Administrative Assistant how many facility staff did not have current CPR certification. She stated, "We have 261 staff and 57 of them are not current on their CPR certifications." 2. The facility removed the Immediate Jeopardy on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7). In addition, Arkadelphia Human Development Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current in this training. Twenty Direct Care staff completed the training today and the training will continue every day until all Direct Care staff are current in CPR and the above listed skills."	W 192		
W 318	483.460 HEALTH CARE SERVICES	W 318		

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W 318	Continued From page 20 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to meet the Condition of Participation (CoP) for Health Care Services (W318) as evidenced by the facility's failure to ensure supervision was provided during eating to prevent choking and nursing interventions were implemented during eating to prevent choking for 1 (Client #1) of 5 (Clients #1 - #5) sampled clients who required staff supervision while eating. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death for Client #1, who suffered respiratory distress after eating with no supervision and had the potential to cause more than minimal harm for 60 clients who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. The facility failed to meet the Standard at W331 as evidenced by the facility's failure to ensure supervision was provided during eating to prevent choking. Refer to W331 2. The facility failed to meet the Standard at W339 as evidenced by the facility's failure to ensure nursing interventions were implemented during eating to prevent choking. Refer to W339 3. The facility removed the Immediate Jeopardy	W 318		

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W 318	Continued From page 21 on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7). In addition, Arkadelphia Human Development Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current in this training. Twenty Direct Care staff completed the training today and the training will continue every day until all Direct Care staff are current in CPR and the above listed skills."	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings:	W 331		

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W 331	Continued From page 22 Based on record review and interview, the facility failed to ensure supervision was provided during eating to prevent choking for 1 (Client #1) of 5 (Clients #1 - #5) sampled clients who required staff supervision while eating. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death for Client #1, who suffered respiratory distress after choking on food and had the potential to cause more than minimal harm for 60 clients who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder and Dysphagia, oral phase. a. The Dysphagia Disorders Survey completed on 1/10/13 documented, "[Client #1] exhibited the following symptoms of feeding and swallowing disorder in the oral preparation and oral initiation stages of swallowing: decreased biting, decreased chewing, ... [Client #1] ate and drank at a rapid pace... was cued to slow down... The Choking Risk Assessment (CRA) was completed to assess the risk of choking as a result of dysphagia. [Client #1] received a score of 70% which indicates that she is at increased risk for choking based on this screening... Recommendations:... Staff should cue [Client #1] to chew food well. Staff should cue [Client #1] to eat and drink at a slower pace..." b. The Individual Program Plan (IPP) dated 1/16/13 documented the client had severe deficits in intellectual functioning and profound deficits in	W 331		

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W 331	Continued From page 23 adaptive behavior functioning. c. The Department of Human Services (DHS) Incident Report dated 2/11/13 documented, " Subject: [Client #1] ...Date of Incident: 2/9/13 ...Type of Incident Death Choking ...Narrative Description On February 9, 2013 at 7:20 p.m. [Client #1] went into the [living unit] kitchen [of 290 Pine where she resides]. [Client #1] rummaged through the kitchen cabinets and the refrigerator. [Client #1] got a food item out of the refrigerator, sat at the kitchen table, unwrapped the item and was eating the item when [Staff #1] entered the kitchen. [Staff #1] asked [Client #1] to leave the kitchen.[Client #1] had shoved the item in her mouth ...[Client #1] left the kitchen and went to her bedroom. A few minutes later, [Staff #1] was sitting in the back hallway folding clothes when [Client #1] came out of her room and collapsed in the hallway. [Staff #1] called for assistance. [Staff #4 RCSS (Resident Care Shift Supervisor)], [Staff #3 LPN (Licensed Practical Nurse)] and [Staff #2 RCT (Resident Care Technician)] ran to assist [Client #1]. [Client #1] was choking. The three staff cleaned food out of [Client #1's] mouth and throat, preformed [performed] the Heimlich maneuver and performed CPR [cardiopulmonary resuscitation]. Medical Emergency was called. 911 was called. The ambulance arrived and transported [Client #1] to the [hospital #1] ER [emergency room]. Later [Client #1] was transported to [hospital #2] in [city] where she died at 3:15 p.m. on February 10, 2013." d. The [hospital #1] Emergency Room Treatment Record dated 2/9/12 documented, "Diagnosis: cardiac Arrest [due to] asphyxiation."	W 331		

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W 331	Continued From page 24 The hospital #1 Emergency Department (ER) History and Physical documented, "Date of Service: 02/09/13 Chief Complaint- Cardiac Arrest History of present illness- The patient is a 47-year-old female from the human development center that was found asphyxiating on food. The patient was unresponsive and apneic for 5-10 minutes before EMS [emergency medical services] arrived. According to EMS, they were able to remove unknown food substance from upper airway with a finger sweep, and then they were able to establish an airway, CPR was started. The patient was in asystole for approximately 15 minutes prior to arrival while ACLS [advanced cardiac life saving] was being performed by EMS. On arrival, the patient is in asystole... patient is not awake ...pupils are fixed and dilated Assessment and Plan: 1. Cardiac arrest. We were able to achieve a heart rate ...2. Post cardiac arrest. Because the patient will likely need a bronchoscopy, we will be transferring to [medical center #2] for a higher level of care." e. The facility's Video #1 (living unit kitchen) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entered the kitchen alone at 7:20 p.m., looked through the kitchen cabinets, opened the refrigerator and retrieved an unidentified food item, sat at the nearest dining room table at 7:22 p.m. and ate the food item. There was no staff member in the kitchen or dining room. At 7:23 p.m., Staff #1 entered the kitchen/dining room and the client left the dining room followed by this staff. The facility's Video #2 (hallway near the client's bedroom door) dated 2/9/13, provided by the	W 331		

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W 331	Continued From page 25 Administrative Assistant on 2/12/13, showed the client entering the hallway from the kitchen/dining room at 7:23 p.m., going down the hall to her room, (Clients room out of camera view) with Staff #1 seated in the hallway folding laundry. At 7:24 p.m., Client #1 walked toward Staff #1 in the hallway and collapsed onto the floor. Staff #1 went to the resident and Staff #4 entered the hallway and attempted a mouth sweep. At 7:25 p.m., Staff #3 (LPN) entered, partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth and sling something onto the floor. At 7:26 p.m., Staff #3 again partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth again and sling something onto the floor then placed the client flat on the floor on her back. At 7:26:55 p.m., Staff #4 delivered 13 compressions to the client's mid-torso area and stopped compressions at 7:27:09 p.m. At 7:27:17 p.m., Staff #4 delivered 12 consecutive compression motions and stopped again at 7:27:25 p.m. At 7:27:29 p.m., Staff #4 delivered 20 consecutive compression motions and stopped again at 7:27:39 p.m. Staff continued this cycle, delivering varying numbers of consecutive compressions including 27, 16, 28, 23, 32, 85 and 69. Staff stopped CPR for longer intervals than required to deliver 2 breaths and then resumed CPR as follows: At 7:30:23 p.m., staff stopped CPR and resumed CPR at 7:31:12 p.m., a period of 49 seconds.	W 331		

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W 331	Continued From page 26 At 7:31:29 p.m., staff stopped CPR and resumed CPR at 7:31:45 p.m., a period of 24 seconds. At 7:31:57 p.m., staff stopped CPR and resumed CPR at 7:32:29 p.m., a period of 32 seconds. At 7:33:08 p.m., staff stopped CPR and resumed CPR at 7:33:39 p.m., a period of 31 seconds. At 7:34:47 p.m., staff stopped CPR and resumed CPR at 7:35:17 p.m., a period of 30 seconds. At 7:37:07 p.m., staff stopped CPR and resumed CPR at 7:37:49 p.m., a period of 42 seconds. At 7:41 p.m. EMS arrived and the staff stopped CPR. f. Staff Interviews: 1) On 2/13/2013 at 10:00 a.m., Staff #4 stated the living unit staff told her Client #1 had gotten into a "Danish" in the living unit kitchen, and staff have to be with Client #1 to ensure safety from choking. She stated Client #1 roams the home and will go into the kitchen when staff are not watching her. Client #1 gets in a hurry when eating and can choke on food. 2) On 2/13/2013 at 10:16 a.m., Staff #3, LPN, stated she was in 290 Pine passing medications when staff screamed for her to come to help Client #1, who was on the floor choking. Staff #3 told other staff to call 911. 3) On 2/13/2013 at 10:31 a.m., Staff #2 RCT, stated it was common for the client to sneak into	W 331		

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W 331	Continued From page 27 the living unit kitchen. 4) On 2/13/2013 at 10:43 a.m., Staff #1, RCT, stated Client #1 was a part of Staff #2's group assignment. She stated that after she had Client #1 leave the kitchen and go to her room, she was in the back of the living unit folding clothes. She stated when Client #1 came out of her room [choking] "I panicked and screamed for help." 2. The facility removed the Immediate Jeopardy on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7). In addition, Arkadelphia Human Development Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current in this training. Twenty Direct Care staff completed the training today and the training will continue every day until	W 331		

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W 331	Continued From page 28 all Direct Care staff are current in CPR and the above listed skills."	W 331		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Complaint #18109 was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure nursing interventions were implemented during eating to prevent choking for 1 (Client #1) of 5 (Clients #1 - #5) sampled clients who required staff supervision while eating. This failed practice resulted in Immediate Jeopardy, which caused or could have caused, serious harm, injury or death for Client #1, who suffered respiratory distress after choking on food and had the potential to cause more than minimal harm for 60 clients who required supervision for eating. The facility was notified of the Immediate Jeopardy on 2/13/13 at 1:55 p.m. The findings are: 1. Client #1 had diagnoses of Severe Mental Retardation, Bipolar Disorder and Dysphagia, oral phase. a. The Dysphagia Disorders Survey completed on 1/10/13 documented, "[Client #1] exhibited the following symptoms of feeding and swallowing disorder in the oral preparation and oral initiation stages of swallowing: decreased biting, decreased chewing, ... [Client #1] ate and drank	W 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 30 [Client #1's] mouth and throat, preformed [performed] the Heimlich maneuver and performed CPR [cardiopulmonary resuscitation]. Medical Emergency was called. 911 was called. The ambulance arrived and transported [Client #1] to the [hospital #1] ER [emergency room]. Later [Client #1] was transported to [hospital #2] in [city] where she died at 3:15 p.m. on February 10, 2013." d. The [hospital #1] Emergency Room Treatment Record dated 2/9/12 documented, "Diagnosis: cardiac Arrest [due to] asphyxiation." The hospital #1 Emergency Department (ER) History and Physical documented, "Date of Service: 02/09/13 Chief Complaint- Cardiac Arrest History of present illness- The patient is a 47-year-old female from the human development center that was found asphyxiating on food. The patient was unresponsive and apneic for 5-10 minutes before EMS [emergency medical services] arrived. According to EMS, they were able to remove unknown food substance from upper airway with a finger sweep, and then they were able to establish an airway, CPR was started. The patient was in asystole for approximately 15 minutes prior to arrival while ACLS [advanced cardiac life saving] was being performed by EMS. On arrival, the patient is in asystole... patient is not awake ...pupils are fixed and dilated Assessment and Plan: 1. Cardiac arrest. We were able to achieve a heart rate ...2. Post cardiac arrest. Because the patient will likely need a bronchoscopy, we will be transferring to [medical center #2] for a higher level of care." e. The facility's Video #1 (living unit kitchen)	W 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

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W 339	Continued From page 31 dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entered the kitchen alone at 7:20 p.m., looked through the kitchen cabinets, opened the refrigerator and retrieved an unidentified food item, sat at the nearest dining room table at 7:22 p.m. and ate the food item. There was no staff member in the kitchen or dining room. At 7:23 p.m., Staff #1 entered the kitchen/dining room and the client left the dining room followed by this staff. The facility's Video #2 (hallway near the client's bedroom door) dated 2/9/13, provided by the Administrative Assistant on 2/12/13, showed the client entering the hallway from the kitchen/dining room at 7:23 p.m., going down the hall to her room, (Clients room out of camera view) with Staff #1 seated in the hallway folding laundry. At 7:24 p.m., Client #1 walked toward Staff #1 in the hallway and collapsed onto the floor. Staff #1 went to the resident and Staff #4 entered the hallway and attempted a mouth sweep. At 7:25 p.m., Staff #3 (LPN) entered, partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth and sling something onto the floor. At 7:26 p.m., Staff #3 again partially raised the client's shoulders from behind her, placed her arms under the client's axillae, pulled upward at the level of the client's breasts and appeared to sweep the client's mouth again and sling something onto the floor then placed the client flat on the floor on her back. At 7:26:55 p.m., Staff #4 delivered 13 compressions to the client's mid-torso area and stopped compressions at 7:27:09 p.m. At 7:27:17 p.m., Staff #4 delivered 12 consecutive compression motions and	W 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 32	W 339		

stopped again at 7:27:25 p.m. At 7:27:29 p.m., Staff #4 delivered 20 consecutive compression motions and stopped again at 7:27:39 p.m. Staff continued this cycle, delivering varying numbers of consecutive compressions including 27, 16, 28, 23, 32, 85 and 69.

Staff stopped CPR for longer intervals than required to deliver 2 breaths and then resumed CPR as follows:

At 7:30:23 p.m., staff stopped CPR and resumed CPR at 7:31:12 p.m., a period of 49 seconds.

At 7:31:29 p.m., staff stopped CPR and resumed CPR at 7:31:45 p.m., a period of 24 seconds.

At 7:31:57 p.m., staff stopped CPR and resumed CPR at 7:32:29 p.m., a period of 32 seconds.

At 7:33:08 p.m., staff stopped CPR and resumed CPR at 7:33:39 p.m., a period of 31 seconds.

At 7:34:47 p.m., staff stopped CPR and resumed CPR at 7:35:17 p.m., a period of 30 seconds.

At 7:37:07 p.m., staff stopped CPR and resumed CPR at 7:37:49 p.m., a period of 42 seconds.

At 7:41 p.m. EMS arrived and the staff stopped CPR.

f. Staff Interviews:

1) On 2/13/2013 at 10:00 a.m., Staff #4 stated the living unit staff told her Client #1 had gotten into a "Danish" in the living unit kitchen, and staff have to be with Client #1 to ensure safety from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 33 choking. She stated Client #1 roams the home and will go into the kitchen when staff are not watching her. Client #1 gets in a hurry when eating and can choke on food. 2) On 2/13/2013 at 10:16 a.m., Staff #3, LPN, stated she was in 290 Pine passing medications when staff screamed for her to come to help Client #1, who was on the floor choking. Staff #3 told other staff to call 911. 3) On 2/13/2013 at 10:31 a.m., Staff #2 RCT, stated it was common for the client to sneak into the living unit kitchen. 4) On 2/13/2013 at 10:43 a.m., Staff #1, RCT, stated Client #1 was a part of Staff #2's group assignment. She stated that after she had Client #1 leave the kitchen and go to her room, she was in the back of the living unit folding clothes. She stated when Client #1 came out of her room [choking] "I panicked and screamed for help." 2. The facility removed the Immediate Jeopardy on 2/13/13 at 2:50 p.m. when the following plan of removal was implemented: Arkadelphia Human Development Center will immediately identify Direct Care staff that have current CPR [Cardiopulmonary Resuscitation] certification, to include air way clearing, Heimlich maneuver and AED [Automatic External Defibrillator] use. Arkadelphia Human Development Center will adjust all schedules to assure that at least one such staff member will work in each home; every shift, (24-7). In addition, Arkadelphia Human Development	W 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 34 Center will immediately identify direct care staff who have current training in supervision of eating and adjust all schedules to assure that at least one such staff member will work in each home, every shift (24-7). CPR Refresher Training including air way clearing, Heimlich maneuver and AED use was started today for all Direct Care staff not current in this training. Twenty Direct Care staff completed the training today and the training will continue every day until all Direct Care staff are current in CPR and the above listed skills."	W 339		

The Law Offices Of

DARREN O'QUINN PLLC

I, M. Darren O'Quinn, certify that the attached Death Certificate of Brenda Mize is a true and correct color copy of the original Death Certificate of Brenda Mize contained in our firm for this case.

DATED this 30th day of May, 2013.

M. Darren O'Quinn, #87-125
LAW OFFICES OF DARREN O'QUINN PLLC
Plaza West Building
415 N. McKinley, Suite 1000
Little Rock, AR 72205
(501) 975-2442 telephone
(501) 975-2443 facsimile
Darren@DarrenOQuinn.com email

STATE OF Arkansas)
) ss
COUNTY OF Pulaski)

SUBSCRIBED and SWORN to before me, a Notary Public, the 30 day of May, 2013.

NOTARY PUBLIC

My Commission expires:
March 31, 2018

HILARY SHRUM
Arkansas - Pulaski County
Notary Public - Comm# 12368421
My Commission Expires Mar 31, 2018

EXHIBIT C

STATE OF ARKANSAS

TYPE / PRINT IN PERMANENT BLACK INK. SEE INSTRUCTIONS

ARKANSAS DEPARTMENT OF HEALTH
Vital Records
CERTIFICATE OF DEATH

To Be Completed / Verified by FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix): Brenda Kimberly Mize
2. SEX: Female
3a. DATE OF DEATH (Mo/Day/Yr): February 10, 2013
3b. TIME OF DEATH: 6:39 ☐ AM ☒ PM
4. SOCIAL SECURITY NO.:
5a. AGE – Last Birthday (Years): 47
5b. IF UNDER 1 YEAR: Months / Days
5c. IF UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo/Day/Yr): May 9, 1965
7. BIRTHPLACE (City and State or Foreign Country): Lubbock, Texas
8a. RESIDENCE STATE or FOREIGN COUNTRY: Arkansas
8b. COUNTY: Clark
8c. CITY OR TOWN: Arkadelphia
8d. NUMBER AND STREET: 1 Prator Drive
8e. APT. NO.:
8f. ZIP CODE: 71923
8g. INSIDE CITY LIMITS? ☒ Yes ☐ No
9. EVER IN US ARMED FORCES? ☐ Yes ☒ No
10. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Widowed ☒ Never Married ☐ Married, but Separated ☐ Divorced ☐ Unknown
11. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage.): None
12a. IF DEATH OCCURRED IN A HOSPITAL: ☒ Inpatient ☐ Emergency Room / Outpatient ☐ Dead on Arrival
12b. IF DEATH OCCURRED ELSEWHERE THAN A HOSPITAL: ☐ Decedent's Home ☒ Hospice Facility ☐ Nursing Home / Long Term Care Facility ☐ Other (Specify)
12c. COUNTY OF DEATH: Pulaski
12d. FACILITY NAME (If not institution, give street address): Baptist Health Medical Center
12e. CITY OR TOWN: Little Rock
12f. ZIP CODE: 72205
13. FATHER'S NAME (First, Middle, Last): Harold L. Mize
14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Marie Renoudet
15a. INFORMANT'S NAME: Brett Mize
15b. RELATIONSHIP TO DECEDENT: Brother
15c. MAILING ADDRESS (Number and Street or P.O. Box, City, State, Zip Code): 11136 Cobblestone Drive, Bentonville, AR 72712
16a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
16b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Lake Lawn Park
16c. LOCATION – CITY, TOWN, AND STATE: New Orleans, Louisiana
17a. EMBALMER'S NAME: Bobbie Lance ☐ Not Embalmed
17b. EMBALMER'S LICENSE #: 2182
17c. LICENSEE OR OTHER AGENT: Bobbie Lance
17d. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Lake Lawn Metairie Funeral Home, 5100 Pontchartrain Blvd, New Orleans, Louisiana 70124
17e. LICENSE #: 2745

NAME OF DECEDENT (For use by funeral director)

18a. DATE PRONOUNCED DEAD (Mo/Day/Yr): February 10, 2013
18b. TIME PRONOUNCED DEAD: 6:39 ☐ AM ☒ PM
18c. NAME AND TITLE OF PERSON PRONOUNCING DEATH (Print / Type): James Muller, M.D.
19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☒ Yes ☐ No

To Be Completed / Verified by MEDICAL CERTIFIER

CAUSE OF DEATH

20. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line.

		APPROXIMATE INTERVAL: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Anoxic Brain Injury	~ 72 hrs.
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (Disease or injury that initiated the events resulting in death) LAST.	b. Due to (or as a consequence of): Choking	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

21a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No
21b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

22. MANNER OF DEATH: ☐ Natural ☒ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined

23. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown

24. IF FEMALE: ☒ Not pregnant within past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Unknown if pregnant within last year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant 43 days to 1 year before death

25a. DATE OF INJURY (Mo/Day/Yr): February 10, 2013
25b. TIME OF INJURY: Unknown ☐ AM ☒ PM
26a. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area): Decedent's Home
26b. INJURY AT WORK? ☐ Yes ☒ No
26c. LOCATION OF INJURY (Number, Street, Apartment No., City, State, Zip Code): 1 Prator Drive, Arkadelphia, Arkansas 71923
27. DESCRIBE HOW INJURY OCCURRED: Patient reportedly choked on some food.
28a. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver / Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

29a. CERTIFIER (Check only one)
☒ Certifying Physician – To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying Physician – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Coroner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Hospice [illegible], death occurred due to the cause(s) and manner stated.

29b. SIGNATURE: [signature] TITLE: MD PhD DATE: 3/7/13 (Mo/Day/Yr)
29c. NAME AND COMPLETE MAILING ADDRESS OF PERSON SIGNING ITEM 29a. (Type / Print): Joel Dwoskin, M.D., 500 South University #214, Little Rock, Arkansas 72205
29d. LICENSE #: E-4077
30. SIGNATURE OF REGISTRAR: Israelyn Brewster, Deputy Registrar
31. FOR REGISTRAR ONLY - DATE FILED (Mo/Day/Yr): March 8, 2013

ARKANSAS DEPARTMENT OF HEALTH SEAL LITTLE ROCK, ARK.

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THE ARKANSAS DEPARTMENT OF HEALTH.

MAR 08 2013

Paul W. Johnson
State Registrar

WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE ARKANSAS DEPARTMENT OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.

3626017

VR-112

IN THE CIRCUIT COURT OF CLARK COUNTY, ARKANSAS
PROBATE DIVISION

In the Matter of the Estate of
BRENDA MIZE, Deceased

No. PR-13-28

ORDER APPOINTING SPECIAL ADMINISTRATOR

NOW BEFORE THE COURT is the Petition of Brett Renoudet Mize for the appointment of a Special Administrator of the Estate of Brenda Mize, Deceased, for the purpose of pursuing claims related to the Decedent's wrongful death claim against the parties responsible. The Court, having reviewed the Petition and Exhibits A and B attached thereto and other matters of proof before the Court, finds that the need exists for the appointment of a Special Administrator for the reasons stated.

It is, therefore, **ORDERED, CONSIDERED** and **ADJUDGED** that Brett Renoudet Mize be, and is hereby, appointed Special Administrator of the Estate of Brenda Mize, Deceased, for a period of time necessary to pursue all claims related to the wrongful death of Brenda Mize, deceased, during which time he is empowered to, and shall, perform all duties and acts required to pursue such claims and upon termination of the duties set forth hereinabove or upon completion of the term of his appointment hereunder, whichever shall first occur, he shall immediately make a full and complete

Filed on the 22 day of April 20 13
Rhonda L. Cole
COUNTY CLERK, CLARK COUNTY
BY Johnson DC

EXHIBIT D

report of his actions and condition and affairs of the estate to this Court; that no bond shall be required; and that Letters of Administration shall be issued to said Special Administrator upon filing of the Acceptance of Appointment.

It is further **ORDERED, CONSIDERED** and **ADJUDGED** that Robert Renoudet Mize be, and is hereby, authorized to retain legal counsel identified in his Petition and that the contract for legal services, as set forth in Exhibit B, shall be approved in its entirety.

Honorable Robert McCallum

4-22-13
Date

PREPARED BY:
M. Darren O'Quinn
Law Offices of Darren O'Quinn, PLLC
Plaza West Building
415 N. McKinley, Suite 1000
Little Rock, AR 72205
(501) 975-2442 telephone
(501) 975-2443 facsimile

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**BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS**

**BRETT RENOUDET MIZE,
as SPECIAL ADMINISTRATOR
of the ESTATE of BRENDA MIZE, DECEASED** **CLAIMANT**

VS. **CLAIM #13-0865-CC**

**STATE OF ARKANSAS,
DEPARTMENT OF HUMAN SERVICES,
DIVISION OF DEVELPOMENTAL
DISABILITIES SERVICES** **RESPONDENT**

ANSWER

Comes on Respondent, the State of Arkansas, Department of Human Services, Division of Developmental Disabilities Services ("DDS"), and for the Answer to the Complaint states:

1. Respondent denies liability in the above referenced claim. Account information is:

Agency Number:	0710
Cost Center	419220
Internal Order #	HMKX01XX
Fund	PWP5500
Fund Center	896

2. DDS denies liability on this claim. DDS disputes the issues of negligence, liability, causation, foreseeability and damages with regard to the death of Ms. Brenda Mize.

3. The death of Ms. Mize was not proximately caused by any claimed action or inaction of Respondent, its agents or employees. Ms. Mize lived in a group cottage at the Arkadelphia Human Development Center ("HDC"). In accordance with Ms. Mize's individual plan of care, she was free to move about her home independently without any specialized supervision. Ms. Mize was not restricted in her movements. Ms. Mize's plan of care did not

require one-to-one supervision by HDC personnel or any enhanced supervision except during mealtime. The choking incident complained of did not occur during mealtime. In other words, Ms. Mize did not choke on any food during mealtime or while she was in the kitchen, as alleged in the Complaint. Instead, the alleged choking incident happened after Ms. Mize left the kitchen and returned to her room.

4. Under Ms. Mize's plan of care, there was no *duty* to supervise Ms. Mize at time of the incident.[1] The law of negligence requires the plaintiff in a lawsuit to establish that a duty was owed by the defendant. *Kowalski v. Rose Drugs,* __ Ark. __, 376 S.W.3d 109 (2011). Without a duty to provide special supervision at the time of the choking incident, whether it be one-on-one or enhanced supervision, there was no negligence by HDC staff for the alleged failure to provide supervision of Ms. Mize as asserted in the Complaint. Instead, Ms. Mize, who was free to move about the cottage unrestricted, entered to the kitchen, took out a snack and ate the snack all without incident. Once HDC staff observed Ms. Mize in the kitchen, staff then redirected her and Ms. Mize left the kitchen. At no time did Ms. Mize choke on food while in the kitchen or while leaving the kitchen. The asserted choking event did not occur in the kitchen. Instead, Ms. Mize exited the kitchen, walked down the hallway to her room, and entered her bedroom. Video evidence demonstrates that the alleged choking incident happened while Ms. Mize was either in her room or while walking down the hallway after exiting her room. It is unknown exactly what happened to Ms. Mize in her room or while in the hallway.

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[1] It should be noted Claimant inappropriately references a claim against a *different facility* made in another case where, unlike the facts of that prior claim, there was no enhanced or one on one supervision requirement here. Moreover, there is no legitimate purpose to reference a prior, unrelated incident.

5. Because no special supervision of Ms. Mize was required by staff at the time of the claimed choking incident in her room, the incident was not proximately caused by the lack of staff supervision. Proximate cause in Arkansas means a cause which, in a natural and continuous sequence, produces damage and without which the damage would not have occurred. *Schubert v. Target Stores, Inc.*, 2010 WL 4910126 (Dec. 2, 2010). Before an act can be said to be the proximate cause of an injury, the injury must be the probable and natural consequence of that act. *Gathright v. Lincoln Ins. Co.*, 286 Ark. 16, 688 S.W.2d 931(1985). Consequently, the claimed failure to provide special supervision was not the proximate cause of death here.

6. No autopsy was performed on Ms. Mize in order to determine the actual cause of death.

WHEREFORE, Respondent prays this Commission discharge Respondent from any liability herein.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
Division of Developmental Disabilities Services

By: Richard Rosen

Richard Rosen, AR Bar #97164
Office of Policy and Legal Services
P.O. Box 1437, Slot S260
Little Rock, Arkansas 72203
Telephone # (501) 320-6334
rich.rosen@arkansas.gov

CERTIFICATE OF SERVICE

This is to certify that I mailed a copy of the foregoing Answer, postage prepaid, this 20th day of June, 2013 to:

Darren O'Quinn, Esquire
415 North McKinley, Suite 1000
Little Rock, AR 72205

Richard Rosen

Rich Rosen
Attorney

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

BRETT RENOUDET MIZE,
as SPECIAL ADMINISTRATOR OF
THE ESTATE OF BRENDA MIZE,
DECEASED

CLAIMANT

vs.

CLAIM #13-0865-CC

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES,
DIVISION OF DEVELOPMENTAL DISABILITIES
SERVICES

RESPONDENT

CLAIMANT'S HEARING BRIEF

Claimant, Brett Mize, on behalf of the Estate of Brenda Mize and its wrongful death beneficiaries, by his attorneys and for his Brief, states:

Introduction

This is a wrongful death case against the Arkadelphia Human Development Center (AHDC). Brenda Mize was a resident there and a known choking risk while eating. She was supposed to be supervised while eating, but choked to death after being allowed to eat unsupervised in the kitchen.

Facts

Brenda Mize choked to death at the AHDC on February 9, 2013. She was forty-seven years old and was a known choking risk while eating.

Therefore, her Individual Program Plan ("IPP") mandated that she have someone with her at all times when she was in the kitchen. Despite this, however, she was allowed to wander into the kitchen and eat unsupervised. When discovered, she was ordered out of the kitchen without an assessment. When she began choking about one minute later, her resuscitation was improperly done. All of this is documented in records discovered in this case and captured on video (The video is attached hereto as ***Exhibit "A"***).

On the day in question Brenda Mize was supposed to be supervised by Alicia House. ***Deposition of Amber Hubbard at p. 13.*** Ms. House, however, was in the office with the door closed filing out paperwork on another resident. ***Deposition of Alicia House at p. 23*** and ***Hubbard at p. 13.*** Ms. House states that she turned Brenda's supervision over to Amber Hubbard so that she could fill out paperwork, but Ms. Hubbard denies this. ***House at p. 23*** and ***Hubbard at p. 14.*** What is not disputed is that during this confusion over who was supposed to supervise Brenda, she wandered into the kitchen and hurriedly ate a Danish pastry. ***Hubbard at p. 31.*** It took another developmentally disabled resident to sound the alarm. ***House at p. 23.***

Brenda simply was not supposed to be in the kitchen unsupervised. This is evidenced by her IPP, which was a roadmap to the care Brenda was supposed to receive, and which had required since 2011 that she have "enhanced supervision" meaning "a staff member will be right with [Brenda] at all times when [she was] in the kitchen." ***Deposition of Cheryl MacKay***

at pp. 68-69 and ***IPP at p.13*** (The IPP is attached hereto as ***Exhibit "B"***). This requirement for such close supervision was due to Brenda's risk for choking while eating due to her tendency to take large bites of snack items, eat to fast, and swallow without adequate chewing. ***Id.*** Indeed, even the other disabled residents in the facility knew this and that is why one of them sounded the alarm. ***House at p. 23.***

Ms. Hubbard responded to this known danger by going into the kitchen and "rudely" telling Brenda to "get out of here." ***Amber Hubbard Notice of Disciplinary Action at p. 2 (Exhibit "C").*** The standard of care, however, was to assess Brenda to determine whether she had taken small bites, offered her liquids to help with swallowing, speak with her to determine whether she was all right and still had food in her mouth, and observe her to be sure she was not going to choke on what she had already quickly eaten. ***Id. at pp. 2-3.***

Indeed, Ms. Hubbard had been trained on Brenda's IPP only days earlier, on February 4, and had three other documented training sessions on Brenda's risk for choking and the level of supervision and monitoring that she required when eating. ***Id. at p. 3.*** Ms. Hubbard was terminated for "maltreatment/neglect" for these very reasons. ***Id. at p. 4.***

AHDC still had one last opportunity to prevent Brenda's death. The staff could have performed a proper resuscitation when Brenda began choking on the Danish. The staff failed Brenda again, however, when they did not perform a proper resuscitation.

Specifically, Brenda is seen on the video about a minute after being run out of the kitchen coming out of her room and collapsing on the floor in front of the Ms. Hubbard. Ms. Hubbard has testified that Brenda was clearly choking and blue in the face at that time. ***Hubbard at p. 25.***

AHDC, however, did not have the equipment or staff training for proper cardiopulmonary resuscitation and emergency life saving measures so that correct emergency interventions for choking were utilized. Although the staff called 911 for an ambulance service from the local hospital in Arkadelphia, this took three minutes. ***Deposition of Karen McGowan at p. 67.*** Moreover, while waiting on the ambulance the staff did not start chest compressions (to help dislodge the food and circulate oxygen) for three very valuable minutes and thereafter did not perform them at the required ratio of 100 per minute for two minute cycles, with only a fifteen second pause in between for the Automated External Defibrillator ("AED") to evaluate the heart. ***Id.*** and ***Deposition of Russell Tarr at pp. 18-21.***

When the ambulance did finally arrive, the paramedic, using proper resuscitation procedures, was able to immediately clear the "red, cake substance" in Brenda's airway and easily ventilate her. ***Deposition of Melina Jenkins at* pp. 12-14** By this time, however, Brenda had been without oxygen for some ten minutes. ***Id. at p. 9.***

Brenda was transported to the local hospital where resuscitation efforts continued. She was diagnosed with a cardiac arrest due to

asphyxiation on a pink, cake-like substance. ***Deposition of Joe David May at pp. 6-13.*** In short, she choked to death. ***Id. at p. 10.*** Brenda did, however, have some blood pressure and a heart rate so she was transferred to critical care at Baptist Hospital in Little Rock. Tragically, too much damage had been done and she was brain dead. All heroic efforts were stopped, her ventilator was turned off, and she died the next day. ***Baptist Health Medical Center – Little Rock Medical Records (Exhibit "D").***

The Commission does not have to rely solely on the above overwhelming evidence. The Commission can also look to AHDC's own investigation into Ms. Hubbard's conduct to confirm the substandard care in this case. ***Amber Hubbard Notice of Disciplinary Action (Exhibit "C").*** It confirms the above facts and that Ms. Hubbard was terminated for "maltreatment and neglect" in her supervision, assessment, and resuscitation of Brenda. ***Id.***

Moreover, the Office of Long Term Care ("OLTC"), per its statutory duty, investigated the facility. It also confirmed the above facts and cited AHDC for "immediate jeopardy" deficiencies for its failures in the supervision, assessment, and resuscitation of Brenda. This confirms AHDC caused serious injury and death to Brenda and had the potential to do so to sixty other residents at the facility who needed supervision while eating and possible resuscitation. ***Department of Health and Human Services CMS-2567 (Exhibit "E").***

Specifically, this Immediate Jeopardy related to deficient facility staffing related to insufficient supervision of eating and insufficient training in cardiopulmonary resuscitation and emergency life saving measures. These very serious citations related to Deficiency **Tags W 158** (deficient facility staffing resulting in the danger of harm to Brenda and 60 other facility clients), **189** (failure to ensure that all direct care staff were trained and certified as competent in cardiopulmonary resuscitation and emergency life saving measures so that correct emergency life saving measures were utilized after Brenda began choking on her food and went into respiratory arrest), **192** (failure to ensure that all direct care staff were trained and certified as competent in cardiopulmonary resuscitation and emergency life saving measures so that correct emergency life saving measures interventions were utilized after Brenda began choking on her food and went into respiratory arrest), **318** (failure to meet the Conditions of Participation for Health Care Services **(W318)** by failing to ensure supervision was provided during eating to prevent choking and nursing interventions were implemented during eating to prevent choking for Brenda and clients like her), **331** (failure to provide supervision while eating to prevent choking for Brenda and clients like her), and **339** (failure to ensure nursing interventions were implemented while eating to prevent choking by Brenda and clients like her).

Notably, the OLTC inspectors found that Brenda had:

> "severe deficits in intellectual functioning, profound deficits in adaptive behavior functioning, a choking risk assessment score of 70% (increased risk), required supervision and cueing to chew food well and eat or drink at a slow pace and was served a regular mechanical soft diet with gravy/sauce to moisten food."

Id.

In other words, the staff knew Brenda was a choking risk while eating and needed supervision to eat safely. The inspectors also conducted staff interviews and confirmed the following events:

> Staff #4 stated the living unit staff told her Brenda had gotten into a "Danish" in the living unit kitchen, and *staff have to be with Brenda to ensure safety from choking*. She stated Brenda roams the home and *will go into the kitchen when staff are not watching her*. Brenda gets in a hurry when eating and can choke on food. Staff #2 RCT, stated *it was common for Brenda to sneak into the living unit kitchen*. Staff #1, RCT, stated Brenda was a part of Staff #2's group assignment. *She stated that after she had Brenda leave the kitchen and go to her room, she was in the back of the living unit folding clothes*. She stated when Brenda came out of her room [choking] "I panicked and screamed for help."

OLTC Complaint Report (Exhibit "F"). The inspectors also found that the facility:

> Failed to ensure all direct care staff were trained and certified as competent with cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions (CPR, airway clearing, Heimlich, and defibrillator) were utilized for choking victims and assure that at least one such staff member works in each home, every shift (24/7);
>
> Failed to ensure supervision was provided during eating to prevent choking and nursing interventions were implemented

during eating to prevent choking and assure that staff trained in the supervision of eating will work in each home, every shift (24/7)

Id. See also Deposition of Charles O'Neal (OLTC Chief Investigator).

It is important to note that AHDC did not appeal these findings, as was its right if there was a disagreement with them. ***Deposition of Margo Green at p. 43-44.***

Law

AHDC is an Intermediate Care Facilities for Individuals with Mental Retardation ("ICF/MR") charged with the care and treatment of developmentally disabled persons. As an ICF/MR it is licensed by the State of Arkansas and governed by the Arkansas Department of Human Services, Division of Developmental Disability Services polices (available at https://ardhs.sharepointsite.net/DHS%20Policies/Forms/AllItems.aspx).

It is also governed by the Conditions of Participation for the United States Center for Medicare and Medicaid Services and its regulations (available at http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Intermediate-Care-Facilities-for-Individuals-with-Intellectual-Disabilities-ICF-IID.html).

As a consequence, the Commission may define AHDC as a "medical care provider" under the ***Ark. Code Ann. § 16-114-201(2).***[1] This would mean

[1] In deposition questioning, counsel for AHDC has challenged whether AHDC is a "healthcare facility" arguing, instead, that it is a "training facility." ***See Deposition of***

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that the Arkansas Medical Malpractice Act and ***Arkansas Model Jury Instruction (Civil) 1504 ("AMI")*** governs the care required in this action. If, however, the Commission does not find that AHDC is "medical care provider," then Brenda's injuries would not meet the definition of a "medical injury" under ***Ark. Code Ann. § 16-114-201(3)***. That would mean that the care required in this case would then likely be governed by ***AMI 1504*** since AHDC would most likely be defined as analogous to a medical care facility that was not providing special medical care such as what a hospital or nursing home type facility would (or, alternatively, the negligence instruction found in ***AMI 302*** for garden-variety negligence).

Under any of these negligence definitions, however, the overriding principle is the care that is required is the care that a reasonably careful caregiver in a licensed ICF/MR would provide under the circumstances similar to those shown by the evidence in this case. ***See AMI 302, 303, 1501, and 1504.*** Accordingly, ***AMI 203*** requires that Claimant establish the following three propositions:

> First, that Brenda Mize sustained damages (as defined in ***AMI 2216***);
>
> Second, that AHDC was negligent (as defined in either ***AMI 302, AMI 1501,*** or ***1504*** depending on whether AHDC is a "medical care provider");

Stephen Schexnayder, M.D. at pp. 106-107. Regardless, Claimant has proceeded with marshaling his evidence under the more stringent Arkansas Medical Malpractice Act. As a consequence, that evidence would certainly meet any lesser evidentiary standards argued by AHDC.

> And third, that such negligence was a proximate cause of Brenda's damages.

Claimant must establish these propositions by a preponderance of the evidence. ***AMI 208*** defines preponderance of the evidence as "the greater weight of evidence." As will be demonstrated below, Claimant's proof in this case meets, and well exceeds, this standard.

Argument

Claimant will discuss each of the three propositions required by ***AMI 203*** in the order that they appear: damages, negligence, and proximate cause.

1. Brenda Mize Sustained Damages Under AMI 2216.

Brett Mize, as administrator of the Estate of Brenda Mize, deceased, represents the Estate of Brenda Mize. He also represents his sister Susan Maddie, his brother Randall Mize, his father Harold Mize, and himself as Brenda Mize's statutory wrongful death beneficiaries under ***Ark. Code Ann § 16-62-102(d)(1).***

Under ***AMI 2216***, statutory wrongful death beneficiaries are entitled to recover for their mental anguish suffered and reasonably probable to be suffered in the future. ***AMI 2216*** defines mental anguish as the mental suffering resulting from emotions, such as grief and despair, associated with the loss of a loved one.

The proof at the hearing will be that Brenda's family was caring, involved, and close to her. Brenda was not just someone the family consigned to AHDC. Brenda was raised with her family who lived day-to-day with her. If Brenda had not developed some of the psychological problems that she did later in life, she would have lived her life with one of them — and that option was given a great effort.

The family took great care in searching for the best place for Brenda when they could no longer take care of her at home. AHDC was the place the family chose for Brenda because they were promised she would receive good care in a safe environment.

Even after she was placed there, the family continued to be involved in her care — attending care plan meetings and visiting on a regular basis. ***MacKay Deposition at p. 45.*** Birthdays, holidays, and special occasions were not missed and still celebrated. She was regularly taken out of the facility to visit in the family's homes or go to town.

The violent nature and suddenness of Brenda's death adds to the emotional trauma and scars suffered by the family. For this, sister Susan Maddie, brothers Randall and Brett Mize, and father Harold Mize are asking the Commission to hold AHDC responsible for this needless tragedy and the emotional trauma they suffered from it.

Moreover, under ***AMI 2216,*** Brett Mize is also suing for the following elements of damage on behalf of the Estate of Brenda Mize:

(a) Brenda's loss of life;

(b) Brenda's conscious pain and suffering prior to her death; an

(c) Brenda's funeral expenses.

The important damage in this case is Brenda's loss of life. ***AMI 2216*** simply identifies as an element of damage that the administrator of the decedent's estate may recover "[t]he decedent's loss of life." The only pertinent comment states:

> As a result of a 2001 amendment to ***Ark. Code Ann. §16-62-101***, damages for the decedent's "loss of life" are now recoverable by the estate as an independent element of damage. These are the damages that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. ***Durham v. Marberry, 356 Ark. 481, 156 S.W.3d 242 (2004)***.

See AMI 2216 cmt.

In ***Durham*** Justice Imber cites the Connecticut case of ***Katsetos v. Nolan, 170 Conn. 637, 368 A.2d 172 (1976)***, in a footnote to support her statement that some states have used the term loss of life damages to "mean the loss of the enjoyment of being alive that is incurred at the point of death forward," noting that the Connecticut Supreme Court held that plaintiffs were entitled to "just damages" which "include compensation for the destruction of her capacity to carry on and enjoy life's activities in a way she would have done had she lived." ***Durham, 356 Ark. at 487 n.2.***

So, the question becomes: what damages should Brenda be awarded as "compensation for the destruction of her capacity to carry on and enjoy life's activities in a way she would have done had she lived?" ***Durham, 356 Ark. at 487 n.2.*** To answer this question, one must understand Brenda's enjoyment of life and the way she lived it. This evidence can be derived from many sources in this case, including her caregivers at AHDC and family.

Specifically, Margo Green, Superintendent of AHDC, stated that Brenda was a unique individual. ***Deposition of Margo Green at p. 10.*** She liked to do her own thing ***Id. at pp. 10-11.*** You could look at Brenda and think about her disabilities, but Brenda was delightful. ***Id. at p. 11.*** She was funny and had a marvelous sense of humor. ***Id.*** She was very astute and could cut to the chase on something when maybe everyone else couldn't. ***Id.*** She could be really outgoing. ***Id. at p. 13.***

Cheryl MacKay, the IPP Coordinator, says Brenda "was just full of life" and "had a plan for every day." ***Deposition of Cheryl MacKay at p. 43.*** Brenda was her own person. ***Id.*** If she woke up and was having a good day, she never met a stranger, knew everybody, and called them by name. ***Id.*** She did what she wanted to do. ***Id.*** She may have three layers of clothes and boots on, or she may have sandals on when it's twenty degrees outside — there wasn't a lot to change her mind. ***Id.*** When she would go to training, she would have a ball. ***Id. at p. 44.*** She would do exactly what she wanted to do. ***Id.*** She was very smart and had a quality of life. ***Id at p. 44-45.***

Angela Burroughs, AHDC Supervisor of Brenda's residence and the Resident Care Techs assigned to her, stated that Brenda "would tell you in a minute 'I'm not a baby' and 'I can do this.'" ***Deposition of Angela Burroughs at p. 54***. She said Brenda would show emotion, laugh, and was happy. ***Id. at p. 59***. Brenda liked talking to staff and had a quality of life." ***Id.*** Ms. Burroughs said the value of Brenda's life was worth every bit of that of a normal person. ***Id.***

Alicia House, the Residential Care Tech who personally took care of Brenda on a daily basis, confirms that Brenda had a quality of life. ***Deposition of Alicia House at p. 9***. Brenda loved to change clothes. ***Id.*** She loved to drink milk. ***Id.*** She liked her nails painted, eye shadow, and makeovers. ***Id.*** She also liked to eat. ***Id.*** Amber Hubbard, another Residential Care Tech who personally took care of Brenda, says loved to change clothes. ***Deposition of Amber Hubbard at p. 42***. She liked to go out to activities and do stuff. ***Id.*** She had a quality of life. ***Id.*** She liked to sit with the girls and watch "The Lion King." ***Id.*** She loved that movie and it was her favorite. ***Id.*** Having worked with people with developmental disabilities, Brenda's life was not worth any less than a normal person's life. ***Id.***

The family will add to this portrait of Brenda being a very unique and outgoing person, who loved her life, and had a quality of life that was worth every bit that of any other human being. They will ask the Commission to

compensate Brenda "for the destruction of her capacity to carry on and enjoy life's activities in a way she would have done had she lived."

As for Brenda's pain and suffering prior to her death, choking to the point of having a cardiac arrest is arguably one of the most unpleasant ways to die imaginable. There is no doubt that Brenda could feel fear and pain. ***Deposition of Margo Green at p. 12.*** It is unclear the exact moment that Brenda could feel no fear and pain, but it is safe to say it was at least from the one minute of time before she came out of her room at 7:24 p.m. to at least the point that AHDC's own medical expert says she losses all muscle tone at 7:26 p.m. ***Deposition of Stephen Schexnayder, M.D. at pp. 37-38.*** It certainly could have been as long as a person can live without oxygen before they suffer an anoxic brain injury—commonly thought to be in the five-minute range. ***See, e.g.,*** http://www.rehabchicago.org/anoxic-brain-injury/. Clearly, she was still alive when she reached the emergency room at 8:02 p.m. where they worked on her extensively until she was transferred at 11:12 p.m. to Baptist Health—Little Rock for a higher level of care. She died there the next day. In any event, the Commission should use its best judgment given the facts of this case and hold AHDC accountable for this harm to Brenda.

For informational purposes, and not as a claim since collateral sources covered most of this, Brenda's medical expenses for two ambulance trips ($4272.40), Baptist Health Medical Center-Arkadelphia ER ($12,003.55), and

Baptist Health Medical Center-Little Rock ($80,049.42) total $96,325.37 and were covered by Arkansas Regional Organ Recovery Agency ("ARORA") and Medicare/Medicaid. Brenda's funeral expenses total $13,997.74 (including $667.25 for her inscription, $1,125 for opening and closing her tomb, $495 for weekend overtime, $95 administrative fee, and a $137.23 florist charge) of which $11,341.03 was Forethought Financial Group, leaving a balance of $2656.71 to be paid by the family.

2. AHDC Was Negligent Under AMI 302, 1501, and 1504 For Three Reasons.

Under ***AMI 1501***, the standard for "medical care providers," AHDC was required to ***possess and apply with reasonable care*** the degree of skill and learning ordinarily possessed and used by other ICF/MR's, engaged in the same type of service in AHDC's locality or in a similar locality. A failure to meet this standard is negligence. Under ***AMI 1504***, the standard for medical care facilities that do not provide special care or attention, AHDC was required to use ***ordinary care*** to determine the mental and physical condition of Brenda and to furnish her the care and attention ***reasonably required*** by her mental and physical condition. ***AMI 303*** defines "ordinary care" as the care that a reasonably careful person would use under the circumstances similar to those shown by the evidence in this case. Under ***AMI 302***, the garden-variety negligence instruction, AHDC was required to

provide the care that a ***reasonably careful person*** would provide under the circumstances of this case.

As discussed below, the proof developed in this case meets any of these standards for three reasons. If the Commission finds that AHDC was negligent for *any* of the three, the only question that then needs to be addressed is whether the negligence was a proximate cause of Brenda's damages.

Claimant retained expert nurse Karen Green McGowan, RN, CDDN to review this matter.[2] Nurse McGowan is a licensed RN in good standing whom has been a nurse for fifty years. She is a clinical nurse consultant primarily providing clinical support services and training to individuals who work with persons with intellectual and developmental disabilities throughout the United States. She is a Certified Developmental Disabilities Nurse with a certification issued by the Developmental Disability Nurses Association and is president-elect of that organization. Nurse McGowan has had a particular interest in swallowing and managing choking risks in the developmentally disabled. She has been certified in numerous federal courts as an expert in the area of swallowing and nutritional management and is "the person who looks at areas around choking and swallowing and other kinds of management of swallowing and eating disorders." Nurse McGowan testified that Brenda Mize is the type of patient that falls under this nursing specialty

[2] AHDC has not retained an expert nurse and, therefore, Nurse McGowan's expert nursing opinions are unchallenged relative to the standard of care required in this case and whether that standard was met by AHDC.

and Nurse McGowan is familiar with assessing and caring for patients like Brenda. Nurse McGowan has been retained by numerous state and federal agencies, including the State of Arkansas and United States Department of Justice, for her expertise in this area and has been qualified as an expert witness in various state and federal courts. She is familiar with the standard of care required at the AHDC and in this case. She has reviewed all of the relevant records in this case including the medical records, IPP, videotapes, investigations, and depositions, among others. ***Deposition of Karen McGowan at pp. 1-19, 38-39.*** She has concluded, within a reasonable degree of nursing certainty, that AHDC violated the standard of care in this case in at least three areas. ***McGowan at pp. 24-25.***

Claimant has also retained Russell Tarr, M.D. Dr. Tarr is licensed physician in the State of Arkansas and is Board-Certified in Emergency Medicine by the American Board of Emergency Medicine. He has practiced at various emergency rooms throughout Arkansas and currently practices at St. Vincent Family Clinic in Little Rock, where he provides urgent care services. He is trained in Advanced Cardiac Life Support, as well as Basic Life Support for healthcare providers (the same training AHDC uses). ***Deposition of Russell Tarr at pp. 1-8.*** He has reviewed all of the relevant records in this case including the medical records, videotapes, investigations, and depositions, among others. ***Tarr at pp. 9-10.*** Dr. Tarr was not asked to opine on the staff supervision or assessment issues — as those areas pertain solely

to nursing. On the areas within his expertise, however, Dr. Tarr concluded, within a reasonable degree of medical certainty, that AHDC violated the standard of care in this case in its resuscitation efforts after Brenda began choking and that the proximate cause of her death was an anoxic brain injury from asphyxiation caused be her choking on the Danish she ate in the kitchen. ***Tarr at p. 15, 29-31.***

a. The First Reason AHDC Was Negligent Was That Brenda Was Not Properly Supervised.

Nurse McGowan has concluded that AHDC's first act of negligence was its failure to properly supervise Brenda while she was eating. ***McGowan at p. 21.***

Nurse McGowan bases this conclusion on the fact that Brenda was in the kitchen unsupervised for over three minutes (from 7:19:55 pm to 7:23:03 pm). ***McGowan at p. 58.*** Even another developmentally disabled resident knew this was improper and "blew the whistle." ***McGowan at p. 27.*** Brenda had an IPP, which is a blueprint to the care she needed, addressed her risks, and told the staff what they need to do to keep her safe from those risks. ***McGowan at p. 28.***

The standard of care and Brenda's IPP had required since 2011 that she have "enhanced supervision procedures when I am in the kitchen." ***McGowan at p. 44.*** Therefore, when she choked in 2013 this risk was nothing new to the staff. ***Id.*** In fact, immediately before the choking on

February 9, 2013, Nurse McGowan found that Brenda had an updated IPP that contained a January 10, 2013, Dysphagia Disorders Survey and Choking Risk Assessment further confirming that Brenda was "at increased risk for choking based on the screening." ***McGowan at p. 45.*** Moreover, the staff had as recently as February 4, 2013, been in-serviced on this new IPP and Brenda's choking risk. ***McGowan at pp. 45-48.***

There are five risks known as the "Fatal Five" that represent the top five things that kill the developmentally disabled. ***McGowan at p. 10.*** Swallowing and choking is at the top of that list. ***McGowan at p. 34.*** The biggest area that Brenda had in terms of her issues with this was her propensity for eating too fast and overstuffing her mouth. ***McGowan at p. 41.*** She was also on medications that compounded this by drying out her mouth as documented on her choking risk assessment. ***Id.***

As Nurse McGowan put it:

> "I can't begin to tell how dangerous [eating too fast and overstuffing the mouth] are for individuals who might have some issue in the back of the throat and having a dry mouth. It really does put them at a higher risk for choking."

McGowan at p. 41-42.

Brenda's IPP appropriately identified these risks. Her IPP states:

> "On 04/01/11, my Team members were contacted to discuss some mealtime concerns. One concern was that I often go into the kitchen and get snacks without a staff member being present. Since I gulp milk, take large bites of snack items, and swallow

without adequate chewing, my Team was concerned I would choke.

***

An increase in supervision was also recommended. On 05/24/11, my team members were contacted again. It was recommended the ***Enhanced Supervision/Monitoring procedures be implemented when I am in the kitchen***.

***

At times, I overfill my mouth and eat too fast. I have a diagnosis of Dysphagia (difficulty swallowing), oral phase. On 01/10/13, a Dysphagia Disorders Survey (DDS), Choking Risk Assessment (CRA), and Pneumonia Risk Assessment (PRA) were completed. The DDS revealed that I have a mild disorder in feeding/swallowing. On the CRA, I received a score of 70%, which indicates that ***I am at increased risk for choking based on the screening***.

McGowan at pp. 43-45 and IPP at p. 13 (The IPP is attached hereto as ***Exhibit "B"***) (emphasis supplied).

Based on these known risks, Brenda's IPP required the following staff supervision to keep her safe:

Direct care staff will use ***Enhanced Supervision/Monitoring procedures when I am in the kitchen. This means a staff member will be right with me at all times when I am in the kitchen.*** Such monitoring should be of such a level that problematic behavior will be much less likely to occur or, should it occur, it will be quickly detected. During Enhanced Monitoring, my group leader/alternate should be designated as having primary responsibility for me.

McGowan at p. 43 and IPP at p. 13 (The IPP is attached hereto as ***Exhibit "B"***) (emphasis supplied).

Nurse McGowan concluded that anytime Brenda had access to food she was supposed to have enhanced supervision. ***McGowan at p. 48.*** She says it defies common sense, as implied in some of counsel for AHDC's questioning, that Brenda would only need enhanced supervision during mealtime but not when she was eating at other times. ***McGowan at pp. 48-49.*** Indeed, Cheryl MacKay, the IPP Coordinator for AHDC, put this illogical contention to rest in her deposition during the following exchanges:

> Q: Okay. So do you agree that when — according to this IPP, when Brenda was in the kitchen, a staff member should be right with her at all times?
>
> A: That's what the team recommended.

Deposition of Cheryl MacKay at p. 30.

***

> Q: Well, there's been implications here that this only applied during meal times and I want to get your comments on—as the coordinator of this plan.
>
> A: It says, "when I am in the kitchen."

Id. at 31.

***

> Q: Now, in this one [on p. 21 of IPP] it says, (as read) "meal time information: enhanced supervision will be provided." Again, when should that enhanced supervision be provided?"

A: As it's spelled out earlier in the IPP. This [on p. 21 of IPP] is just a quick look to be able to see all of the levels of supervision.

Q: So if someone is making an argument that this page 21 modifies page 13 that we went over, that would be incorrect?

A: True.

Id. at 33.

Both of Brenda's caregivers on the day in question, Alicia House and Amber Hubbard, knew Brenda was not supposed to be alone in the kitchen. As stated by Ms. House, "any time a client was in the kitchen, we were supposed to be in there." ***Deposition of Alicia House at p. 11.*** When Ms. House was specifically asked about Brenda's supervision, she stated it was known that Brenda was one of the clients that really had a problem going in and out of the kitchen, that it was known that she would try and sneak in the kitchen and gobble food fast, and that was one of the reasons she was supposed to be supervised while eating. ***Id. at p. 12.*** She said Brenda "was a known choking risk." ***Id. at p. 13.*** Her interpretation of Brenda's IPP was that a staff member was supposed to be "right with Brenda at all times when she was in the kitchen." ***Id. at pp. 16-17.*** It did not mater if she was eating a snack, meal, or drinking "someone needed to be in the kitchen with her." ***Id. at p. 17.***

Amber Hubbard confirmed this. She said if Brenda was in the kitchen, a staff member had to be right there with her. ***Deposition of Amber***

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Hubbard at p. 22. She said it was dangerous to leave a choking hazard resident unsupervised. ***Id. at p. 49.*** She confirms that Brenda was unsupervised at the time she wandered into the kitchen. ***Id. at p. 36.***

Therefore, there should be no doubt that not only the standard of care required Brenda to have enhanced supervision ("someone right with me at all times") while she was in the kitchen, but the facility's own IPP required this. This fact is further confirmed by the facility's termination of Amber Hubbard and the OLTC's investigation. ***Amber Hubbard Notice of Disciplinary Action*** (***Exhibit "C"***) and ***Department of Health and Human Services CMS-2567 (Exhibit "E")*** and ***OLTC Complaint Report (Exhibit "F").***

This required level of supervision was not given to Brenda as evidenced by the three minutes the videotape showing that she was in the kitchen, and shoving food in her mouth, until another resident sounded the alarm. ***McGowan at pp. 21,49-50.*** Indeed, Ms. Hubbard was terminated for her negligence for violating DHS policies related to "maltreatment and neglect." ***Amber Hubbard Notice of Disciplinary Action*** (***Exhibit "C"***). This was AHDC's first act of negligence.

b. The Second Reason AHDC Was Negligent Was That Brenda Was Not Properly Assessed After Being Found in the Kitchen.

AHDC's second act of negligence was its failure to properly assess Brenda after she was exposed to a known danger – again as pointed out by

the only nurse expert to testify in this case and confirmed by videotape. ***Deposition of Karen McGowan at pp. 22-23.***

After Brenda was discovered eating unsupervised in the kitchen, the standard of care and her IPP required that she be properly assessed. ***McGowan at pp. 58-61.*** Nurse McGowan concluded that a proper assessment by the staff member who found her, Amber Hubbard, would have included been to check just to make sure that Brenda did not have any residual food in her mouth, offer her liquids to help her swallow any food she had eaten, sat her down and talked with her to be sure she was alright and to be sure her mouth was empty before she left the room. ***McGowan at pp. 58.*** The video evidences that Ms. Hubbard did not do that. ***Id.***

Instead, Amber Hubbard, according to AHDC's own investigation, did the following:

> At 7:23 p.m. Ms. Hubbard went into the kitchen and rudely said, "Get out of here." The client left the kitchen passing Ms. Hubbard, who never looked at her. Ms. Hubbard threw away the package and the remaining crumbs on the table. She did not ensure that the client had taken small bites. She did not offer any milk or fluids to soften what the client had been eating, as was specified in her treatment plan. Other than to say "Get out of here" Ms. Hubbard did not speak to the person to determine if she was all right or still had food in her mouth. The client was not cued to eat any remaining food. Video surveillance revealed that when the client heard the supervisor call out to Ms. Hubbard, the client took large bites to finish the reminder of her snack, which was believed to be a Danish pastry. She walked unchecked back to her room and within roughly one minute

(7:24 p.m.) she came back out of her room and collapsed and was choking.

Amber Hubbard Notice of Disciplinary Action (Exhibit "C").

The above actions by Amber Hubbard violate the standard of care for this case and Brenda's IPP. ***McGowan at pp. 59-61.*** Indeed, Ms. Hubbard was terminated for her negligence for violating DHS policies related to "maltreatment and neglect." ***Amber Hubbard Notice of Disciplinary Action (Exhibit "C").*** This was AHDC's second act of negligence.

c. The Third Reason AHDC Was Negligent Was That Brenda Was Not Properly Resuscitated.

AHDC's third act of negligence was its failure to properly resuscitate Brenda after she began choking. ***McGowan at p. 23*** and ***Tarr at p. 31.***

The OLTC investigation had severe criticisms of the resuscitation efforts. ***Department of Health and Human Services CMS-2567 (Exhibit "E")*** and ***OLTC Complaint Report (Exhibit "F").*** According to these investigations, the staff did not perform a proper Heimlich maneuver because the only thrusts that were attempted on Brenda to dislodge the Danish she was choking on were not given slightly above the belly button. ***Id.***

Moreover, chest compressions were not given in a ratio of thirty compressions to two breaths (30:2) as directed by the American Heart Association standards of practice. ***Id.*** These investigations also detail deficiencies in the staff's training and certification as competent with

cardiopulmonary resuscitation and emergency life saving measures so correct emergency interventions were utilized after Brenda began choking. ***Id.*** Without a doubt, theses findings demonstrate a facility-wide and systematic laxity in keeping these critical skills up to date to the extent AHDC was cited for an "Immediate Jeopardy" violation requiring immediate correct for the safety of sixty other choking risk residents before the inspectors would leave and allow the facility to continue to operate. ***Id.***

Nurse expert Karen McGowan and physician expert Russell Tarr also found the cardiopulmonary resuscitation and emergency life saving measures deficient.

Nurse McGowan testified about the laxity of the training and certification of the staff in cardiopulmonary resuscitation and emergency life saving measures and how important it is to continually practice these skills ***McGowan at pp. 69-70.*** She also discussed the proper way to resuscitate a person like Brenda who is choking and compared that to what actually happened. ***Id. at pp. 63-70.*** She began describing the proper Heimlich maneuver where a rescuer applies strong thrusts slightly above the belly button to force air into the airway to dislodge food. She compared this to Amber Hubbard's inappropriate and ineffective actions where, as documented in her termination notice, she "took the client by the left arm and pulled up and down, lifting her off the floor several times, [e]ach time she released the client, her head hit the floor [and] continued to shake and pull

the client." ***Id. at pp. 63-65*** and ***Amber Hubbard Notice of Disciplinary Action (Exhibit "C")***.

Nurse McGowan then described the proper way to perform mouth sweeps for food and the correct compression to rescue breath ratio — 30:2. ***Id. at pp. 65-69.*** She concluded the compression and breaths were not done according to standards because they were done at irregular intervals. ***Id. at p. 66-68.*** Moreover, and very sadly, the first chest compressions to circulate the oxygenated blood still in Brenda's body were not even started for almost three minutes after Brenda collapsed — when they are supposed to start immediately. ***Id. at p. 66-67.*** Furthermore, the first two rescue breaths were not even attempted for almost four minutes after Brenda collapsed. ***Id. at p. 68.*** Finally, 911 was not called until almost three minutes after Brenda collapsed and they were able to easily establish an airway once they arrived—further confirming to her the negligent resuscitation by the staff. ***Id. at pp. 67-69.*** Shockingly, at one point during the resuscitation Angel Burroughs, who was doing the chest compressions, stopped compressions, got up, and went to a closet to get a towel for her knees. ***Video at 7:32 p.m.***

When asked how she felt about the overall resuscitation efforts, clearly disgusted, she replied, "You don't want to know how I feel about what I observed on that tape." ***Id. at p. 70.*** She concluded, "In terms of the whole process of CPR and the resuscitation...it was negligence." ***Id. at p. 81.*** "It was gross negligence." ***Id. at p. 85.***

Dr. Tarr also discussed the deficiencies in the cardiopulmonary resuscitation and emergency life saving measures. He first identified the American Heart Association Basic Life Support standards taught to the staff. ***Tarr at pp. 6-8, 13-14.*** He stated the first step in any resuscitation effort is to check for responsiveness and then immediately activate emergency services including calling 911. This was not done for almost three minutes in this case. ***Id. at pp. 12-13.*** This was a violation of the standard of care. ***Id. at p. 17.*** He concluded it was also a violation of the standard of care to not start chest compressions for almost three minutes—since they started within well past the recommended interval of 10-15 seconds. ***Id. at pp. 17-18.***

Finally, Dr. Tarr emphasized the importance of not only the 30:2 ratio of compressions to breaths but also that the rescuers give that at a rate so that 100 compressions per minute are achieved, in cycles of two minutes with only a 10-15 second break between cycles to allow the AED to analyze the heart, per the American Heath Association Basic Life Support Guidelines. ***Id. at pp. 18-21.*** He said this important pattern was never followed. ***Id. at pp. 21-22.*** Dr. Tarr concluded by saying that because the proper resuscitation procedures were not performed in accordance with the American Heart Association standards that the staff was supposed to be trained by, Brenda was harmed and that harm led to her death by anoxic brain injury. ***Id. at pp. 29-30.***

3. AHDC's Negligence Was A Proximate Cause of Brenda's Damages.

Under ***AMI 501*** "proximate cause" means a cause which, in a natural and continuous sequence, produces damage and without which the damage would not have occurred. If two or more causes work together to produce damage, then you may find that each of them was a proximate cause. ***Id.***

Brenda ate a Danish pastry while she was in the kitchen. ***Deposition of Amber Hubbard at p. 31.*** Ms. Hubbard remembers this because she cleaned up the package after Brenda ate it. ***Id.*** Approximately one minute later Brenda came out of her room and was "choking and blue." ***Deposition of Amber Hubbard at p. 25.***

There is no dispute that Brenda was choking on a "cake like" red food substance. ***Depositions of Margo Green at pp. 53,54,55,56,115; Melina Jenkins at pp. 9,10,13; Joe David May at pp. 7,9,10; Tamera Tate at pp. 9,10,11,12,18,19; Terri Key at pp. 14, 27, 43, 50; Alicia House at pp. 32,41,42;*** and ***Angela Burroughs at pp. 34,37,38,85,88.*** As stated by Dr. Tarr when asked about the most likely source of the food that choked Brenda:

> "Based on the deposition of Dr. May, the paramedics, Ms. Tate, the first responder, the most likely source of it was that she had eaten some sort of pastry or Danish, that that was the most likely source and within a good degree of medical certainty more than likely that she got in the kitchen a couple of minutes prior to collapsing."

Tarr at p. 15.

Without a doubt, the preponderance of the evidence points to the Danish that she ate one minute earlier as the culprit—the one that she was negligently allowed to eat, and then not properly assessed and resuscitated. This caused her death by blocking her airway and causing her to have a cardiac arrest and then an anoxic brain injury. ***Deposition of Joe David May at pp. 6-13*** and ***Death Certificate (***The Death Certificate is attached hereto as ***Exhibit "G")*** ("Anoxic Brain Injury Due To Choking"). ***See also Tarr at p. 16-17.***

So which of the three AHDC acts of negligence was the proximate cause of Brenda choking on the food substance? The answer is any of, or all of, the three. This is true because each act of negligence was a cause, which, in a natural and continuous sequence, produced damage. Moreover, all three of the causes worked together to produce the damage and, therefore, could be a proximate cause. ***AMI 501.***

Indeed, it is not disputed that the only expert medical testimony in this case indicates that Brenda begin choking on the Danish that she had eaten unsupervised in the kitchen one minute earlier. ***Tarr at p. 15.*** The only eyewitness — Amber Hubbard — says Brenda was "choking and blue" when she came out of her room. ***Hubbard at p. 25.*** This choking caused Brenda to have a cardiac arrest that led to an anoxic brain injury and her ultimate demise. ***Tarr at pp. 29-31.*** Even AHDC's own expert, Dr. Schexnayder, does not dispute this chain of events. In his deposition he was

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asked:

> Q: Within a reasonable a reasonable degree of medical certainty, do you agree that the cause of Ms. Mize's death was a cardiac arrest caused by a lack of oxygen from choking?
>
> A: Yes, sir. From airway obstruction was the primary event.

Deposition of Stephen Schexnayder at p. 77.

As Dr. Tarr put it when asked about Brenda's cause of death:

> ""[T}here was a certain cause that led to the cardiac arrest... in this case... within a good degree of medical certainty would be from choking that led to hypoxia."

Id. at p. 16. See also pp. 30-31.

As set forth above, the independent treating paramedic and emergency room physician, who responded to this tragedy, confirms this sequence of events.

Brenda would not have had the Danish had she been properly supervised. Therefore, she would never have choked or needed an additional assessment or resuscitation in the first place. This first act of negligence, however, could have been cured had a proper assessment been performed thus alleviating any need for resuscitation. This assessment was not done and that second act of negligence still could have been cured with a proper resuscitation. The resuscitation, however, was also faulty and caused Brenda's death. Even if the Commission finds that the resuscitation was within the standard, which Claimant strongly disputes, the first two acts of

negligence would still be the cause for the choking and ultimate outcome that even a proper resuscitation could not cure.

Conclusion

Brenda Mize was weak and vulnerable, one of the least among us, in that she was unable to independently care for herself. Her family, despite efforts, was unable to care for her. She did, however, have a quality of life — one that her family entrusted to the AHDC. They were promised that Brenda would be in a safe environment.

Brenda's violent death was an unnecessary and completely preventable tragedy. AHDC must be held accountable for its deficient practices in this case, as found by its very own investigators. That is the only way to force AHDC to take its responsibility seriously and prevent this tragedy from reoccurring in the future.

Respectfully submitted,

M. Darren O'Quinn
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ATTORNEYS FOR CLAIMANTS

CERTIFICATE OF SERVICE

I, M. Darren O'Quinn, state that on this 7th day of April 2014, I have served the foregoing pleading via facsimile and electronic mail to the following:

Rich Rosen
Office of Chief Counsel
Arkansas Department of Human Services
P.O. Box 1437, Slot S260
Little Rock, AR 72203

M. Darren O'Quinn

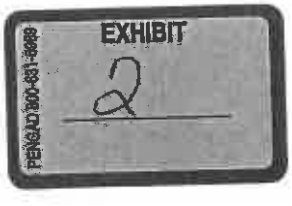
Curriculum Vitae
Stephen M. Schexnayder, M.D.

BACKGROUND, EDUCATION & TRAINING, EMPLOYMENT

DATE OF BIRTH	October 26, 1960
PLACE OF BIRTH	Dumas, Arkansas
HOME ADDRESS & PHONE	#2 Palmetto Court Little Rock, AR 72211 Phone: (501) 225-1714
OFFICE ADDRESS & PHONE	Arkansas Children's Hospital 1 Children's Way Little Rock, AR 72202-3591 Phone (501) 364-1845 FAX: (501) 364-3188
SPOUSE	Rebecca Eldridge Schexnayder, M.D.
CHILDREN	Allison Kate Schexnayder April 20, 1990 Daniel Stephen Schexnayder April 19, 1994 Anne Charlotte Schexnayder April 22, 1996 Amy Grace Schexnayder August 2, 1999

EDUCATION AND TRAINING

1983	B.S.	University of Arkansas, Fayetteville, Arkansas Awarded High Honors
1987	M.D.	University of Arkansas for Medical Sciences, Little Rock, Arkansas
1987-1989	Internship Pediatrics & Internal Medicine	Departments of Pediatrics and Internal Medicine University of Arkansas for Medical Sciences, Little Rock, Arkansas
1989-1991	Residency Pediatrics & Internal Medicine	Departments of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas



1991-1994	Fellowship	Pediatric Critical Medicine, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas
1997-1999		Teaching Scholars Program, University of Arkansas for Medical Sciences, Little Rock, Arkansas

SPECIALTY BOARD CERTIFICATION

1991	Diplomate of the American Board of Pediatrics, No. 47754; recertified, 2005
1991	Diplomate of the American Board of Internal Medicine, No. 136164, recertified, 2001, 2012
1994	Diplomate in Pediatric Critical Care Medicine, American Board of Pediatrics, Subboard Of Pediatric Critical Care Medicine, No. 219653, recertified 2008

ACADEMIC POSITIONS

1991	Chief Resident, Pediatrics and Internal Medicine, Department of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas.
1991	Instructor, Departments of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas
1994-1999	Assistant Professor, Departments of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas
1999	Associate Professor (with tenure), Departments of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas
2005	Professor, Departments of Pediatrics and Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Arkansas
2011	Vice Chair for Education, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas

ADMINISTRATIVE POSITIONS

1994 - 2000	Associate Director, Pediatric Critical Medicine Fellowship, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas.

1997 - 2003	Associate Director, Pediatrics/Internal Medicine Residency, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas.
1999 – 2003	Associate Program Director, Pediatrics Residency, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas
2002 – 2007	Physician Advisor, Arkansas Children's Hospital Information Technology Group, Arkansas Children's Hospital, Little Rock, Arkansas.
2003–Present	Chief, Section of Critical Care Medicine, University of Arkansas for Medical Sciences Department of Pediatrics
2003 – 2007	Fellowship Director, Pediatric Critical Care Medicine, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas.
2007 – 2012	Associate Fellowship Director, Pediatric Critical Care Medicine, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas.
2009 – 2011	Secretary, Medical Staff, Arkansas Children's Hospital, Little Rock, Arkansas.
2011–Present	Vice Chief, Medical Staff, Arkansas Children's Hospital, Little Rock, Arkansas.

LICENSURE

1987	Arkansas, No. C-7327

CERTIFICATION

1991	Provider, Instructor, and Medical Director, Pediatric Advanced Life Support, American Heart Association
1992	Provider, Instructor, and Medical Director, Advanced Cardiac Life Support, American Heart Association
1993	Provider, Instructor, and Medical Director, Pediatric Advanced Life Support, American Academy of Pediatrics and American College of Emergency Physicians
1993	Provider and Instructor, Advanced Trauma Life Support, American College of Surgeons

HONORS AND AWARDS

1981	Alpha Epsilon Delta
1982	Omicron Delta Kappa

1982	Phi Beta Kappa
1982	Mortar Board
1986	Alpha Omega Alpha
1987	Faculty Key, College of Medicine, University of Arkansas for Medical Sciences
1996	Golden Apple Award, presented by Emergency Medicine housestaff for outstanding teaching
1997	Teacher of the Year, presented by Pediatric Housestaff
1997	Excellence in Medical Education Award, Department of Pediatrics
1998	Red Sash Award, College of Medicine, for Outstanding Medical Student Teaching
1998	Educator of the Year, Department of Pediatrics
1999	Nominated for Golden Apple Award from Emergency Medicine Housestaff
2000	President's Citation for Distinguished Service to Society of Critical Care Medicine
	Patient satisfaction awards, Arkansas Children's Hospital 1997, 1998, 1999
2000	Educator of the Year, Department of Pediatrics
2001	Red Sash Award, College of Medicine, for Outstanding Medical Student Teaching
2002	Educator of the Year, Department of Pediatrics
2002	Educator Emeritus, Dep. Of Pediatrics (awarded to three time winners of Educator of the Year)
2003	Golden Apple Award, presented by Emergency Medicine housestaff for outstanding teaching
2003	Betty Ann Lowe Distinguished Chair in Pediatric Education (three year term)
2003	Best Doctors in America
2004	Red Sash Award, College of Medicine, for Outstanding Medical Student Teaching
2005	Fellow, American College of Critical Care Medicine

2005	Best Doctors in America
2006	Best Doctors in America
2006	Re-award of Betty Ann Lowe Distinguished Chair in Pediatric Education
2007	Best Doctors in America
2008	Red Sash Award, College of Medicine, for Outstanding Medical Student Teaching
2008	Best Doctors in America
2009	Arkansas Times' Best Doctors
2009	Best Doctors in America
2010	Mr. and Mrs. Morris Oakley Endowed Chair in Critical Care Medicine
2010	Red Sash Award, College of Medicine, for Outstanding Medical Student Teaching
2010	Nominee for 2010 Society of Critical Care Medicine Shubin Weil Master Clinician/Teacher: Excellence in Bedside Teaching Award
2010	Best Doctors in America
2011	Educational Innovation Award, University of Arkansas for Medical Sciences College of Medicine
2011	Best Doctors in America
2011	Chancellor's Faculty Teaching Award, University of Arkansas for Medical Sciences

Professional Service Experience

DIRECT PATIENT CARE RESPONSIBILITIES

1991 - Present	Attending Physician, Emergency Department, Arkansas Children's Hospital
1991 - Present	Attending Physician, Internal Medicine Clinic, University of Arkansas for Medical Sciences

1994 - Present	Attending Physician, Pediatric Critical Care Medicine Service, Arkansas Children's Hospital
2005- Present	Attending Physician, Sedation Team, Arkansas Children's Hospital

PROFESSIONAL APPOINTMENTS

1991 - Present	Active Medical Staff, Arkansas Children's Hospital, Little Rock, Arkansas
1991- Present	Courtesy Staff, University Hospital Little Rock, Arkansas
1999 - 2000	Associate Medical Director, Pediatric Intensive Care Unit, Arkansas Children's Hospital
2000 - 2011	Medical Director, Pediatric Intensive Care Unit, Arkansas Children's Hospital
2011 – Present	Medical Director, Pediatric Understanding and Learning through Simulation Education (PULSE) Center
2011 – Present	Medical Team Leader, Pediatric Intensive Care Unit Arkansas Children's Hospital

EDITORIAL POSITIONS

1994 - 1998	Reviewer for *Chest*
1994 - 2000	Reviewer for *Annals of Emergency Medicine*
1995 - 2001	Editorial Board, Pediatric Multidisciplinary Critical Care Knowledge Assessment Program, Society of Critical Care Medicine (in service training exam for pediatric critical care fellows) Associate Editor, 1998 Editor, 1999
1996	Editorial Board, Critical Care Self Assessment Program, Society of Critical Care Medicine
1996 - 1999	Reviewer for *Pediatric Pulmonology*
1996 - 2005	Editorial Board, Pediatric Critical Care Website, Electronic repository for pediatric critical care resources

1999 - Present	Reviewer for *Pediatrics*
1999 - 2005	Reviewer for *Journal of the American Medical Association (JAMA)*
1999 - Present	Medical Consultant/Editorial Advisor, *Pediatric Commentary*, physician publication of Arkansas Children's Hospital
2002	Reviewer, Advanced Cardiac Life Support for the Experienced Provider, American Heart Association. 2003
2003	Reviewer for *Principles and Practices, Advanced Cardiac Life Support,* American Heart Association.
2004 - Present	Reviewer for *Critical Care Medicine*
2004 - Present	Reviewer for *Pediatric Critical Care Medicine*
2009 - Present	Associate Senior Science Editor, American Heart Association Emergency Cardiovascular Care Program
2010 - Present	Peer Reviewer for *Scientific Statements*, American Heart Association

PROFESSIONAL SOCIETIES

National

1987 - Present	American Academy of Pediatrics Junior Fellow 1991 - 1994 Fellow 1994 - Present Critical Care Medicine Section, Member Emergency Medicine Section, Member, 1991-2000 Abstract Reviewer 1998 Annual Meeting Subcommittee on Pediatric Head Injury, 1998-2002
1988 - Present	American College of Physicians Associate Member 1988-1991 Member 1991 - Present
1992 - 96	American College of Chest Physicians
1991 - Present	Society of Critical Care Medicine Associate Member, 1991-1994 Member, 1994 - Present Member, Task Force on Clinical Practice Guidelines, 1994 -1997 Member, Resident Education Committee

	1996 - 2004 Member, Pediatric Internet Working Group 1996 - 2000
1991 - Present	American Heart Association, Arkansas Affiliate Pediatric Advanced Life Support Committee - 1994 - 2003 Chairman, 2000 - 2001 National Faculty, Advanced Cardiac Life Support - 1996-1997 National Faculty, Pediatric Advanced Life Support – 1999-2001 Special Consultant to the National Pediatric Resuscitation Subcommittee, 2000 Member, National Pediatric Resuscitation Subcommittee, 2001-Present Chair, National Pediatric Resuscitation Subcommittee, 2003-2005 Immediate Past Chair, National Pediatric Resuscitation Subcommittee, 2005-2007 Member, National Emergency Cardiac Care Committee, 2003-2007 Member, Pediatric Scientific Advisory Board, National Registry of Cardiopulmonary Resuscitation International Working Group, 2006 – Present Get With The Guidelines Resuscitation Pediatric Research Task Force (National), 2011-2015
1992 - 2005	Southern Society for Pediatric Research
1995 - Present	Pediatric Critical Care Colloquium 1994, Scientific Session Moderator Co-Director for 1997 National Course 1999, Scientific Session Moderator 2000, Plenary Session Moderator 2000, Steering Committee Member 2012-2015, Chair, Steering Committee

COMMITTEES

State and Local

1994 - 2002	Arkansas Safe Kids Coalition Advisory Committee, Arkansas Department of Health Coalition Spokesman, 1998 - 2002

University of Arkansas for Medical Sciences

1997 - 2008	Graduate Medical Education Committee, University of Arkansas for Medical Sciences. Internal Review Subcommittee 1998-2000 Chairman, Outcomes and Evaluation Committee, 2000 - 2001 Chairman, Performance Improvement Committee, 2001 - 2002 Vice-Chairman of GME committee, 2000 - 2003 Executive Committee, 2000 - 2008 Chair, Work Hours Task Force, 2002-2003 Chair, 2003 – 2006 Chair, Finance Committee, 2006-2008
1998 - 2003	Continuing Medical Education Advisory Committee
2000	UAMS College of Medicine representative, Promotion and Tenure Committee, UAMS Office of Educational Development Chairman, 2001-2002
2003	Member, Search Committee, Associate Dean for Continuing Medical Education and Faculty Affairs
2006-2007	Member, Search Committee, Urology Chair Search Committee
2008	Promotion and Tenure Guideline Revision Task Force
2009 - Present	Children's Faculty Group Practice Executive Committee

Department of Pediatrics

1994 - 1997	Pediatric Housestaff Curriculum Committee
1992 - Present	Pediatric Advanced Life Support Teaching Faculty Medical Director, 1993 - Present
1993 - Present	Advanced Pediatric Life Support Teaching Faculty Course Director, 1994 - Present
1993	Resident Grand Rounds Evaluation Committee
1994 - Present	Housestaff Interview Committee
1994 - 1995	Problem Based Learning Task Force
1994- 2005	Education Coordinator, Pediatric Critical Care Medicine
1995 - 2000	Education Committee

	Chairman, Subcommittee for Outstanding Educator Award, 1995
1995 - Present	Housestaff Advisors Committee
1995 - 1999	Fellows Day Committee Chairman, 1996 - 1998
1997 - 2004	Continuing Medical Education Director, Department of Pediatrics
1999 - Present	Department of Pediatrics Promotion and Tenure Committee
2000 - 2007	Education Advisory Committee
2000	Chairman, Strategic Planning Committee for Pediatric Education

Arkansas Children's Hospital

1993 - 2001	PICU Quality Improvement Committee Chairman, 2000 – 2001
1994 - 1997	Bioethics Committee
1994 - 2001	Transfusion Committee Member, 1994 Chairman, 1995 - 2000
1995 - 1996	Family-Focused Care Committee
1994 - 1995	Emergency Department Sedation Task Force
1994 - 1996	Emergency Department Admissions Re-engineering Committee
1997 - 2002	Trauma Steering Committee
1997 - 1999	Surgical Affairs Committee, Ex-Officio member
1997 - 2010	Cardiopulmonary Resuscitation Task Force Chairman 1997-2005
1997 – 2002	Continuing Education Committee
1999 – 2002	Medical Staff Executive Committee
2000 – Present	Intensive Care Committee

2000 - Present	Pharmacy and Therapeutics Committee
2001 - 2011	Intensive Care Committee Chair, 2005 - 2011
2001 - 2003	Hospital Board of Directors Finance Committee
2002 – 2003	Education Council
2002 – Present	Information Management Committee
2005 – 2011	Respiratory Care Services Council
2005 – 2010	Allocation Committee
2008 – 2011	Centennial Campaign Medical Staff Leadership Committee
2009 – 2011	Secretary, Medical Staff
2009 – Present	Medical Staff Executive Committee
2011 – Present	Building & Grounds Committee
2011 - Present	Vice Chief, Medical Staff

RESEARCH EXPERIENCE

GRANTS (RESEARCH AND EDUCATIONAL)

1992	Siemens Corp. for "Comparison of work of breathing in pediatric patients during continuous positive airway pressure, pressure support, and volume support ventilation utilizing the Servo 300 ventilator", $10,000 (Co-investigator with M. Heulitt, M.D., P.I.), Funded.
1993	Southern Medical Association for "A Randomized, Double-blinded trial of oral ketamine, glycopyrollate, and lorazepam with merperidine, promethazine, and chlorpromazine for sedation in the pediatric emergency department", $2,300 (Principal investigator), Arkansas Children's Hospital Research Institute, Funded.
1994	Clifton R. Brooks Memorial Medical Research Fund for "Does glutamine reduce bacterial translocation in vivo?", $12,000 (principal Investigator), Funded.

1994 Bristol Myers Squibb, Inc. for printing of "Pediatric Emergency Medicine Syllabus", $850 (Principal), Funded.

1995 Smith Kline Beecham Laboratories, Inc. for printing of "Pediatric Critical Care Medicine Syllabus", $300 (Principal), Funded.

1994 Arkansas Lung Association for "A Comparison of intramuscular methylprednisolone with oral prednisolone in children with exacerbations of asthma", $1,000 (Co-investigator with H. Farrar), Funded.

1995 Smith Kline Beecham Laboratories, Inc. for printing of "Pediatric Critical Care Medicine Syllabus", $300 (Principal), Funded.

1996 SmithKline Beecham Pharmaceuticals, Inc. For Support of Fellows' Day, $250 (Principal), Funded.

1996 Bristol-Myers Squibb, Inc. For Fellows' Day, $500 (Principal), Funded.

1996 Glaxo, Inc. For Fellows Day', $300 (Principal), Funded.

1996 Bromide levels during prolonged use of vecuronium bromide and pancuronium bromide. Avant MG (principal investigator), Co-investigators: Farrar H, James L, Schexnayder SM. Funded by Children's University Medical Group. $2,100.

1997 Computer resource development grant, Medical Education Foundation for Arkansas. $10,000 (funded).

1997 Bristol-Myers Squibb, Inc. For Fellows' Day, $500 (Principal), Funded.

1997 Glaxo, Inc. For Fellows Day', $300 (Principal), Funded.

1997 Educational Grants for Pediatric Critical Care Colloquium. Funded by Arkansas Children's Hospital Foundation, Arrow International, Bristol Myers Squibb, Inc., Cook Critical Care, Diametrix Medical, Inc. Glaxo Wellcome, KCI, Nicolet Biomedical, Ohmeda, Inc., Pediatric Medical Group, Sensormedics Critical Care, Siemens Medical Corporation, Wyeth Ayerst Laboratories,. Total $21,250, Funded.

1997 Educational Grant for Pediatric Critical Care Colloquium. Merck Human Health Division, $5,000 in donated rental equipment.

1998 Bristol-Myers Squibb, Inc. For Fellows' Day, $500 (Principal), Funded.

1998 Innovations in Education Award, UAMS Dept. Of Pediatrics, $10,000.

1998	Glaxo, Inc. For Fellows Day', $300 (Principal), Funded.
1998	Educational Grants for Primary Care Pediatrics 1998, Department of Pediatrics CME Course, $3,000 (Principal), Funded by Merck Human Health, Pfizer Laboratories, Roche Laboratories, Ross Laboratories, W.B. Saunders, Inc., Wyeth Ayerst Laboratories, Total $3,000, Funded.
1999	Educational Grants for Emergency Cardiac Care 1999, $2500 (Principal), funded by Laerdal Medical Corporation, Survivalink Inc., and Roche Laboratories
2000	Educational Grants for 2000 Pediatric Critical Care Colloquium, $4000 (Principal), funded, Cook Critical Care and Roche Laboratories
2000	"A Multicenter, Single Blind, Pharmacokinetic and Pharmcodynamic Study to Evaluate Single and Multiple Doses of Omeprazole in a Pediatric Population Ages 0-24 Months Inclusive". AstraZeneca, Principal investigator, funded, Total Direct Costs: $37,249.
2001	"An Initial Study of the Pharmacokinetics, Pharmacodynamics, Safety and Tolerability of Intravenous Doses of Pantoprazole in Hospitalized Pediatric Patients", Wyeth-Ayerst Laboratories, Principal investigator, funded, Total Direct Costs $30,850.
2002	Educational Grants for 2002 Pediatric Teaching Skills Course, $1200 (Principal), funded, Roche Laboratories
2003	Investigation of the Efficacy and Safety of Drotrecogin Alfa (Activated) in Pediatric Severe Sepsis; Eli Lilly and Company. Co-investigator, funded. Total direct costs are $36,851.50
2004	A Multicenter, Randomized, Observer Blinded Clinical Trial to Determine the Overall Safety of Lorazepam Administered as a Continuous Infusion or Intermittent Boluses, and Midazolam Administered as a Continuous Infusion for Sedation of Critically Ill, Mechanically Ventilated Pediatric Patients, NIH-NICHD-2003-11, Principal Investigator for this site, Total Direct Costs $311,384.00
2007	A Phase I, Randomized, Open-Label, Multi-National Study to Evaluate the Pharmacokinetics of Repeated Once-Daily Intravenous Doses of Esomeprazole in Pediatric Patients 0 to 17 Years Old, Inclusive, , Principal Investigator for this site, Total Direct Costs $27,100.00
2008	Development and applicability of a new stable isotope method to determine protein requirements in critically ill children, C0-investigator, Children's University Medical Group, Total Direct Costs $39,000

2011	Medical Education Foundation for Arkansas, Distinguished Lecturer Grant, $1000
2012	Medical Education Foundation for Arkansas, Distinguished Lecturer Grant, $1000
2012	Medical Education Foundation for Arkansas, Pediatric Resuscitation Training for Medical Students, $6500

PUBLICATIONS

MANUSCRIPTS

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Schexnayder SM, Allen RM, Doyle LL. Training the masses: Teaching resident teaching skills during housestaff orientation. *Acad Med* 2002; 77:464-5.

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administrators, and community leaders. Simultaneous publication in: *Ann Emerg Med* 2004; 43:83-99.; *Circulation* 2004; 109:278-91; *Pediatrics* 2004 113:155-68.

Heard JH, O'Sullivan P, Smith CE, Harper RA, Schexnayder SM. An institutional system to monitor and improve the quality of residency education. *Acad Medicine* 2004: 79: 858-864.

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Kearns GL, Blumer J, Schexnayder SM, James, LP, Adcock KG, Reed MD, Daniel JF, Gaedigk A, Paul J. Single-Dose Pharmacokinetics of Oral and Intravenous Pantoprazole in Children and Adolescents. *J Clin Pharmacol* 2008;48:1356-1365.

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Kleinman ME, Chameides L, Schexnayder SM, Samson RA, Hazinski MF, Atkins DL, Berg MD, de Caen AR, Fink EL, Freid EB, Hickey RW, Marino BS, Nadkarni VM, Proctor LT, Qureshi FA, Sartorelli K, Topjian A, van der Jagt EW, Zaritsky AL. 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care: Part 14 Pediatric Advanced Life Support, *Circulation* 2010 Nov 2;122(18 Suppl 3):S876-908.

Kleinman ME, de Caen AR, Chameides L, Atkins DL, Berg RA, Berg MD, Bhanji F, Biarent D, Bingham R, Coovadia AH, Hazinski MF, Hickey RW, Nadkarni VM, Reis AG, Rodriguez-Nunez A, Tibballs J, Zaritsky AL, Zideman D; Pediatric Basic and Advanced Life Support Chapter

Collaborators. Part 10: pediatric basic and advanced life support: 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2010 Oct 19;122(16 Suppl 2):S466-515.

Kleinman ME, Chameides L, Schexnayder SM, Samson RA, Hazinski MF, Atkins DL, Berg MD, de Caen AR, Fink EL, Freid EB, Hickey RW, Marino BS, Nadkarni VM, Proctor LT, Qureshi FA, Sartorelli K, Topjian A, van der Jagt EW, Zaritsky AL. Pediatric advanced life support: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Pediatrics*. 2010 Nov;126(5):e1361-99.

Kleinman ME, de Caen AR, Chameides L, Atkins DL, Berg RA, Berg MD, Bhanji F, Biarent D, Bingham R, Coovadia AH, Hazinski MF, Hickey RW, Nadkarni VM, Reis AG, Rodriguez-Nunez A, Tibballs J, Zaritsky AL, Zideman D; Pediatric Basic and Advanced Life Support Chapter Collaborators. Pediatric basic and advanced life support: 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Pediatrics*. 2010 Nov;126(5):e1261-318.

Berg MD, Schexnayder SM, Chameides L, Terry M, Donoghue A, Hickey RW, Berg RA, Sutton RM, Hazinski MF. Pediatric basic life support: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Pediatrics*. 2010 Nov;126(5):e1345-60.

Stroud MH, Prodhan P, Moss M, Fiser R, Schexnayder S, Anand K. Enhanced monitoring improves pediatric transport outcomes: a randomized controlled trial. *Pediatrics*. 2011 Jan;127(1):42-8

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IMAGES AND SUMMARIES

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REVIEWS

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Schexnayder, SM. "Antibiotic and antiseptic coated central venous catheters". Review of paper for Evidence Based Journal Club of Pediatric Critical Care (electronic publication of Pediatric Critical Care Web Site [peer reviewed]), 1998, http://PedsCCM.wustl.edu/EBJ/THERAPY/Raad-CVCs.html

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Schexnayder SM. Vasopressin in pediatric cardiac arrest, International Liaison Committee on Resuscitation, Evidence evaluation worksheet for International Consensus on Resuscitation Science Conference, Dallas, Texas, http://circ.ahajournals.org/cgi/content/full/CIRCULATIONAHA.105.170522/DC27

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BOOKS

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BOOK CHAPTERS

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EDITORIALS

Efferen LS, Schexnayder SM. Results of the Multidisciplinary Critical Care Knowledge Self-Assessment Program, 2000 Exam. *Crit Care Med* 28(10):3561, 2000.

Schexnayder SM, Hestir DM. A new perspective on community consultation in pediatric resuscitation research. *Crit Care Med* 34(10):2684-5, 2006.

CASE REPORTS

Bhutta AT, Savell VH, Schexnayder SM, Reye's syndrome: Down but not out. *South Med J.* 96(1):43-5, 2003.

Stroud MH, McCarthy RL, Schexnayder SM. Fatal pulmonary fat embolism following spinal fusion surgery. *Ped Crit Care Med*, 7(3):263-6, 2006.

Ortmann LA, Jaeger MW, James LP, Schexnayder SM. Coma in a 20-month old child from an ingestion of a toy containing 1,4-butanediol, a precursor of γ-hydroxybutyrate. *Ped Emerg Care* 2009 Nov;20(11):758-60.

MULTIMEDIA TEACHING TOOLS

Student/resident evaluation scenarios, set of three patient encounters for UAMS Housestaff Teaching Skills Course, Producer: Schexnayder SM, ACH Instructional Media Center, 2000.

Advanced airway procedures, for American Heart Association Pediatric Advanced Life Support. Outpost Media Productions, Lakeland, Florida. Content experts for production: Schexnayder SM, Nadkarni VM, Zaritsky AL. July, 2001.

Coping with the Death of a Child: A Continuing Education Module, American Heart Association, 2003

Braner DA, Schexnayder SM. Pediatric Status epilepticus. American Heart Association, 2004.

Tegtmeyer K, deCaen A, Zaritsky AL, Schexnayder SM. Pediatric Intraosseous Infusion, American Heart Association, 2005.

ABSTRACTS

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Heulitt MJ, Schexnayder SM, Binns M, Anders M, Torres A, High frequency ventilation as a bridge off ECMO for refractory hypercapnia in pediatric respiratory failure. Presented at the Extracorporeal Life Support Organization Annual Meeting, Dearborn, Michigan, October, 1993.

Schexnayder SM, Stine KC, Webster PA, Heulitt MJ, Becton DL. A technique for automated exchange transfusion in children and young adults. Clin Res 41(4):783A, 1994Presented at the Southern Society for Pediatric Research, New Orleans, Louisiana, February 1994 and the Pediatric Critical Care Colloquium, Seattle, Washington, October, 1994.

Schexnayder SM, Wiggins PA, Heulitt MJ, Torres A, Moss MM. Enteral feeding in infants and children during extracorporeal membrane oxygenation (poster).. Extracorporeal Life Support Organization Annual Meeting, Dearborn, Michigan, September, 1994.

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Schexnayder SM, Allen RM. Teaching Young Teachers: A Primer in Teaching Skills for Residents. Presented at the Generalists in Medical Education 20th Annual Meeting, October, 1999, Washington, DC.

Farst, KJ, Schexnayder SM. Acute eosinophilic pneumonia, Presented at Southern Society for Pediatric Research Annual Meeting, February, 2000, New Orleans, Louisiana.

Schexnayder SM, Schutze GE, Farst KJ, Ochoa ER, and Peel JP. Teaching Skills Training for Residents, Presented at Southern Society for Pediatric Research Annual Meeting, February, 2000, New Orleans, LA

Schexnayder SM, Allen RM, Peel JL. Charting Your Own Course; Designing a Teaching Skills Course for Residents. Workshop presented American Association of Medical Colleges Southern Group on Education Affairs Annual Meeting, March, 2000. Richmond, VA.

Bhutta AT, Gilliam CH, Shaw JL, Parker JG, Simpson DD, Schexnayder SM. Effect of maximum barrier precautions and antibiotic coated catheters on blood stream infections. Presented at the Society of Southern Society for Pediatric Research, February, 2001. New Orleans, Louisiana.

P Bledsoe GH, Schexnayder SM, Carey MJ, Dobbins WN, Gibson DR, Hindman JW, Collins T, Wallace BH, Cone JB,, Ferrer,TJ. The Negative Effect of the Repeal of the Arkansas Motorcycle Helmet Law, Presented at the Eastern Association for the Surgery of Trauma (oral presentation), January 2002.

Pafford MB Schexnayder SM. Pancreatitis associated with hyperosmolar nonketotic coma. J Invest Med 50(1):112A Presented at the Southern Society for Pediatric Research, February, 2002. New Orleans, Louisiana.

Schexnayder SM, Fiser RT, Farrar H. Essentials of Pediatric Resuscitation: A primer for third year medical students during a pediatric clerkship. Presented at the American Academy of Pediatrics, Washington, DC, October, 2005.

Cenac S, Fiser RT, Dyamenhalli U, Bhutta AT, Moss MM, Schexnayder SM, Fontenot E, Seib P, Cabrera G, Baker L, Chipman C, Weygandt L, Jaquiss RDB, Imamura M, Prodhan P. Intra-hospital transports and interventions on extracorporeal life support (ECLS)-is it safe? Presented at Extracorporeal Life Support Organization Annual Meeting, Atlanta, Georgia. September, 2006.

Stroud MH, Garcia X, Johnson S, Fluger M, Aitken ME, Shutta AT, Schexnayder SM, Prodhan P. Presence of Peripheral Nucleated Red Blood Cells is Associated with Adverse Outcomes in Severe Pediatric Trauma. Presented at American Pediatric Society & Society for Pediatric Research, Honolulu, Hawaii, May 2008.

Kennedy JL, Schexnayder SM, Moss MM, Tailounie M, Ortmann L, Byrnes J and Stovall SH. Primary Amebic Meningoencephalitis- A Single Case Report in the South. Presented at the Southern Society for Pediatric Research (Poster), February, 2009, New Orleans, Louisiana.

Reeves D, Garcia X, Schexnayder SM, Jones S. Bilateral chylothoraces in a newborn: a consequence of enteroviral infection? (Poster) Presented at the Southern Society for Pediatric Research (Poster), February, 2009, New Orleans, Louisiana.

Jaeger MW, Ortmann L, James L, Schexnayder SM. Coma in a 20-month old child from an ingestion of a toy containing 1,4-butanediol, a precursor of hydroxybutyrate. Presented at the Southern Society for Pediatric Research (Poster), February, 2009, New Orleans, Louisiana.

Ortmann L, Tuzcu V, Ugur A, Schexnayder SM, Bhutta A. Predicting outcome in Pediatric Cardia Arrest: the role of cerebral oxygenation monitoring. Presented at the Society of Critical Care Medicine 39th Critical Care Congress, January, 2010, Miami Beach, Florida.

Gardner AH, Stovall SH, Stern JE, Wilson CD, Gossett JM, Prodhan P, Schexnayder SM, Jaquiss RDB, Fiser RT. Effectiveness of Anti-fungal Prophylaxis in Pediatric ECMO Patients. Presented at the 26th Annual Children's National Medical Center Symposium on ECMO & Advanced Therapies for Respiratory Failure, February 2010, Keystone, Colorado.

Smoot M, Prodhan P, Shelnutt M, McCrakon A, Nick T, Schexnayder SM. Fatigue during infant CPR: Are guideline changes needed? Presented at the Southern Society for Pediatric Research (Poster), February, 2010, New Orleans, Louisiana.

Woodruff R, Shelnutt MD, Schexnayder SM. Biphasic defibrillation in pediatric cardiac arrest. Presented at the Southern Society for Pediatric research (Poster), February, 2010, New Orleans, Louisiana.

Thompson T, Pasala S, Gephardt G, Boateng B, Schexnayder S. Pediatric Critical Care and Emergency Medicine Regional Boot Camp improves Fellow confidence in essential skills and communication. Presented at the Society of Critical Care Medicine 41st Critical Care Congress, February, 2012, Houston, Texas. *Critical Care Medicine*, December 2011, 39(12), p18.

James CA, Moore Mary B, Schexnayder S, Braswell LE. Life support scenarios in Pediatric IR practice. Presented at the 5th Pediatric Interventional Radiology Symposium (E-poster), October 2012, Hospital for Sick Children, Toronto, Canada.

James CA, Moore MB, Schexnayder S, James LP, Braswell LE. Advance Life Support in Pediatric IR: (Scientific Poster). Mid-America Interventional Radiological Society October 20-21, 2012.

James CA, Moore MB, Schexnayder S, James LP, Braswell LE. Advance Life Support in Pediatric IR. (Scientific Poster). 5th Pediatric Interventional Radiology Symposium. Toronto, Ontario October 26-28, 2012.

James CA, Moore M, Schexnayder S, James LP, Johnston J, Green J, Hill T, Braswell L. Advance Life Support in Pediatric IR (oral presentation). Annual Meeting, Society for Pediatric Radiology, San Antonio, TX, May 17, 2013.

Teaching Experience

DEPARTMENT OF PEDIATRICS TEACHING RESPONSIBILITIES

1994 - Present	Faculty, Pediatric Critical Care Medicine rotation for residents
1994 - Present	Lecturer, Pediatric Intern Orientation Lectures
1994 - Present	Lecturer, Pediatric Resident Core Curriculum Lecture Series
1994- Present	Director and Lecturer, Pediatric Critical Care Medicine Lecture Series for residents
1994 - Present	Grand Rounds, Department of Pediatrics
1995 - 1998	Pediatric Sophomore Physical Diagnosis Preceptor
1995 - 2003	Pediatric Medicine Third Year Medical Student Preceptor
1997 - 1999	Objective Structure Clinical Examination Preceptor, University of Arkansas for Medical Sciences
1998 – 2004	Continuing Medical Education Director, Department of Pediatrics

EDUCATIONAL PROGRAMS AND COURSES

October, 1991	Faculty, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
January, 1992	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
May, 1992	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
June, 1992	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
June, 1992	Faculty, Pediatric Advanced Life Support Instructor Course, Little Rock, Arkansas
July, 1992	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
September, 1992	Faculty, Advanced Pediatric Life Support Course, Little Rock, Arkansas.
December, 1992	Faculty, Pediatric Advanced Life Support Instructor Course, Little Rock, Arkansas.
March, 1994	"Dealing with families in crisis", Pediatric Resident Core Curriculum Lecture Series.
June, 1994	"Cardiopulmonary resuscitation update", Pediatric Resident Core Curriculum Lecture Series.
July, 1994	"Airway management", Pediatric Intern Orientation Lecture Series
August, 1994	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
November, 1994	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
December, 1994	"Pediatric Shock", Pediatric Resident Core Curriculum Lecture Series.
January, 1995	Medical Director, Pediatric Advanced Life Support Instructor's Course, Little Rock, Arkansas.
February, 1995	"Increased Intracranial Pressure", Pediatric Resident Core Curriculum Lecture Series.
March, 1995	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
April , 1995	Faculty, Pediatric Advanced Life Support Course, Little Rock, Arkansas.

June, 1995	"Doing the bop with kids: High frequency oscillatory ventilation in Pediatric Respiratory Failure, Pediatric Grand Rounds.
June, 1995	Faculty and Course Director, Pediatric Advanced Life Support Course for incoming housestaff.
July, 1995	"Airway management", Pediatric Intern Orientation Lecture Series.
August, 1995	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
November, 1995	Medical Director, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
October, 1995	"Turning the PAGE in Critical Care: Perfluorocarbon-Assisted Gas Exchange," Pediatric Seminar.
January, 1996	Medical Director, Pediatric Advanced Life Support Instructor's Course, Little Rock, Arkansas.
February, 1996	Medical Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
March, 1996	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
June, 1996	Faculty and Course Director, Pediatric Advanced Life Support Course for incoming housestaff.
July, 1996	Medical Director, Pediatric Advanced Life Support Instructor's Course, Little Rock, Arkansas.
August, 1996	"Airway management", Pediatric Intern Orientation Lecture Series.
August, 1996	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
September, 1996	Medical Director, Advanced Pediatric Life Support Course for Pediatric and Emergency Medicine Housestaff, Little Rock, Arkansas.
November, 1996	Medical Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas. Special course for pediatric dentists.
November, 1996	Medical Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.

December, 1996	Electrolyte Emergencies in Critically Ill Children", Pediatric Resident Core Curriculum Lecture Series.
March, 1997	Medical Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
April, 1997	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
May, 1997	"The Medical Internet", Pediatric Seminar.
June, 1997	Faculty and Course Director, Pediatric Advanced Life Support Course for incoming housestaff.
August, 1997	"Medical Informatics", Dept. of Pediatrics Summer Science Program.
August, 1997	"Airway management", Pediatric Intern Orientation Lecture Series.
August, 1997	Medical Director, Advanced Cardiac Life Support Course, Little Rock, Arkansas.
September, 1997	Medical Director, Advanced Pediatric Life Support Course for Pediatric and Emergency Medicine Housestaff, Little Rock, Arkansas.
October, 1997	Medical Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
November, 1997	"Shaken Baby Syndrome", Arkansas Children's Hospital Trauma Conference.
December, 1997	"Shaken Baby Syndrome", Emergency Medicine Residents Lecture Series, University of Arkansas for Medical Sciences.
December, 1997	Medical Director, Pediatric Advanced Life Support Course, UAMS, Little Rock, Arkansas.
March, 1998	Course Director, Pediatric Advanced Life Support Course, Little Rock, Arkansas.
May, 1998	Course Director, Primary Care Pediatrics 1998, statewide continuing medical education course , Little Rock, Arkansas.
May, 1998	"Is Your Office Ready for An Emergency", Primary Care Pediatrics 1998, Little Rock, Arkansas.

June, 1998	Faculty and Course Director, Pediatric Advanced Life Support Course for incoming housestaff.
July-August, 1998	Course Director, "Craving the Golden Apple", Medical Teaching Skills Course for senior pediatric residents (six sessions). Little Rock, Arkansas.
August, 1998	"Medical Informatics", Dept. of Pediatrics Summer Science Program.
September, 1998	"Fluid and Electrolyte Emergencies in the PICU:, Pediatric Residents Core Curriculum Conference Series
September, 1998	Course Director, Advanced Pediatric Life Support Course for Pediatric and Emergency Medicine Housestaff, Little Rock, Arkansas.
September, 1998	"Airway management", Pediatric Intern Orientation Lecture Series.
October, 1998	"Improving Your Teaching Skills", Faculty Development Course for Department of Pediatrics Faculty. Little Rock, Arkansas.
October, 1998	Course Director, Pediatric Advanced Life Support Instructor Course, Little Rock, Arkansas.
November, 1998	Course Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
January, 1999	Course Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
March, 1999	Course Director, Pediatric Advanced Life Support Provider Course, Little Rock, Arkansas.
April, 1999	Course Director, Emergency Cardiac Care, ten hour CME course for professionals in emergency cardiac care, Hot Springs, Arkansas
May, 1999	Course Director, Primary Care Pediatrics 1999, statewide continuing medical education course, Heber Springs, Arkansas.
May, 1999	"The critically ill child: The first 30 minutes", Primary Care Pediatrics 1999, Heber Springs, Arkansas
May, 1999	Course Director, Advanced Cardiac Life Support Provider Course, Little Rock, Arkansas.
June, 1999	"Pediatric respiratory emergencies", Family Medicine Intensive Review Course, Little Rock, Arkansas

June, 1999	"Teaching Skills for Housestaff", UAMS New Housestaff Orientation
June, 1999	Course Director, Pediatric Advanced Life Support Instructor Course, Little Rock, Arkansas.
June, 1999	Faculty and Course Director, Pediatric Advanced Life Support Course for incoming housestaff.
August, 1999	Course Director, Advanced Pediatric Life Support Course for Pediatric and Emergency Medicine Housestaff, Little Rock, Arkansas.
August, 1999	"Airway management", Pediatric Intern Orientation Lecture Series.
September, 1999	"Introduction to Teaching Skills", three hour seminar for first year pediatric and medicine-pediatric residents
November, 1999	Course Director, "Craving the Golden Apple", Medical Teaching Skills Course for senior pediatric residents (five sessions). Little Rock, Arkansas.
December, 1999	"Bringing Teaching to A New Level: Developing Residents as Teachers", Pediatric Grand Rounds, University of Arkansas for Medical Sciences and Arkansas Children's Hospital
March, 2000	Faculty and Course Director, Pediatric Advanced Life Support Course, Arkansas Children's Hospital
April, 2000	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
May, 2000	Faculty and Course Director, Pediatric Advanced Life Support Course, special course for pediatric dentists, Arkansas Children's Hospital
June, 2000	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
June, 2001	Workshop Faculty, Teaching Skills Workshop for all incoming UAMS housestaff
August, 2000	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
November, 2000	Course Director, Primary Care Pediatrics 2001 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Branson, Missouri

September, 2000	CPR 2000: New Resuscitation Guidelines, Primary Care Pediatrics 2000 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Branson, Missouri.
September, 2000	"Introduction to Teaching Skills", three hour seminar for first year pediatric and medicine-pediatric residents
October, 2000	"History of Present Illness", Introduction to Clinical Medicine I course, UAMS Freshman College of Medicine.
November, 2000	"New Guidelines for Pediatric Resuscitation", Pediatric Trauma Conference, Arkansas Children's Hospital .
January, 2001	"Instructor Update for 2000 Guidelines on Cardiopulmonary Resuscitation", Arkansas Children's Hospital
February, 2001	"Instructor Update for 2000 Guidelines on Cardiopulmonary Resuscitation", Arkansas Children's Hospital
April, 2001	Course Director, Advanced Cardiac Life Support Provider Course, Arkansas Children's Hospital
May, 2001	Faculty, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
June, 2001	Faculty and Course Director, Pediatric Advanced Life Support Course, Arkansas Children's Hospital
June, 2001	Workshop Director, Teaching Skills Workshop for all incoming UAMS housestaff
July, 2001	Course Director, "Craving the Golden Apple", Medical Teaching Skills Course for senior pediatric residents (five sessions). Little Rock, Arkansas.
August, 2001	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
August, 2001	"Airway management", Pediatric Intern Orientation Lecture Series.
September, 2001	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
November, 2001	"New Guidelines for Pediatric Resuscitation", Pediatric Grand Rounds, Arkansas Children's Hospital

October, 2001	Instructor, Advanced Cardiac Life Support Provider Course, Arkansas Children's Hospital
October, 2001	"History of Present Illness", Introduction to Clinical Medicine I course, UAMS Freshman College of Medicine.
November, 2001	Course Director, Primary Care Pediatrics 2000 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Branson, Missouri.
November, 2001	Making a Child's Visit Less Painful: New Tricks, Primary Care Pediatrics 2000 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Branson, Missouri.
January, 2002	Instructor, Advanced Cardiac Life Support Provider Course, Arkansas Children's Hospital
April, 2002	Instructor, Advanced Cardiac Life Support Provider Course, Arkansas Children's Hospital
April, 2002	"Catastrophic Illnesses that Present with Common Complaints", Emergency Medicine Resident Conference, University of Arkansas for Medical Sciences
May, 2002	Faculty and Course Director, Pediatric Advanced Life Support Course, Special Course for Pediatric Dentists, Arkansas Children's Hospital
June, 2002	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2002	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
August, 2002	"Why Being a Physician is Still a Great Career", Summer Science Student Lecture Series, Arkansas Children's Hospital
August, 2002	Course Director, "Craving the Golden Apple", Medical Teaching Skills Course for senior pediatric residents (four sessions). Little Rock, Arkansas.
August, 2002	"Extubation in the Pediatric Patient", Pediatric Respiratory Therapy Core Curriculum
August, 2002	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
August, 2002	"Airway management", Pediatric Intern Orientation Lecture Series.

November, 2002	Course Director, Primary Care Pediatrics 2002 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Hot Springs, Arkansas.
November, 2002	Office Emergencies: New Gear for Stressful Times, Primary Care Pediatrics 2002 in conjunction with the Arkansas Academy of Pediatrics Annual Meeting, Hot Springs, Arkansas.
March, 2003	"Resuscitation in the 21st Century", The Cutting Edge of Pediatric Critical Care Symposium, University of Arkansas for Medical Sciences.
April, 2003	Instructor, Advanced Cardiac Life Support Provider Course, Arkansas Children's Hospital
June, 2003	Faculty and Course Director, Pediatric Advanced Life Support Course, Arkansas Children's Hospital
June, 2003	Workshop Director, Teaching Skills Workshop for all incoming UAMS housestaff
July, 2003	"Why Being a Physician is Still a Great Career", Summer Science Student Lecture Series, Arkansas Children's Hospital
July, 2003	"Teaching Skills for Senior Residents". Workshop for Emergency Medicine Residents (two hours), University of Arkansas for Medical Sciences
July, 2003	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2003	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
August, 2003	Course Director, "Craving the Golden Apple", Medical Teaching Skills Course for senior pediatric residents (four sessions). Little Rock, Arkansas.
September, 2003	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
September, 2003	"Airway management", Pediatric Housestaff Lecture Series.
November, 2003	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
January, 2004	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students

March, 2003	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
March, 2004	"Pediatric shock", Block 10 course for senior medical students.
April, 2004	"Extracorporeal life support for respiratory failure", Pediatric ECMO (extracorporeal membrane oxygenation) course for physicians and technicians, Arkansas Children's Hospital
June, 2004	Workshop Director, Teaching Skills Workshop for all incoming UAMS housestaff
June, 2004	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2004	"Why Being a Physician is Still a Great Career", Summer Science Student Lecture Series, Arkansas Children's Hospital
July, 2004	"Teaching Skills for Senior Residents". Workshop for Emergency Medicine Residents (two hours), University of Arkansas for Medical Sciences
July, 2004	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2004	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
September, 2004	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
September, 2004	"Airway management", Pediatric Housestaff Lecture Series.
October, 2004	"Presentation Skills", three hour workshop for pediatric residents
November, 2004	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
January, 2005	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
March, 2005	CPR: State of the Art, Pediatric Critical Care Fellows Conference Series
March, 2005	"Emergency Toys: New Devices for Stressful Times", Pediatric Housestaff Alumni Reunion
April, 2005	"CPR, State of the Art", Cardiology/Cardiovascular Surgery Conference

April, 2005	"Pediatric Defibrillation", Angel One Transport Continuing Education Conference
May, 2005	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2005	Workshop Director, Teaching Skills Workshop for all incoming UAMS housestaff
June, 2005	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2005	"Why Being a Physician is Still a Great Career", Summer Science Student Lecture Series, Arkansas Children's Hospital
July, 2005	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2005	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
September, 2005	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
October, 2005	"Adult Learning", seminar for pediatric fellows core curriculum
November, 2005	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
January, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
February, 2006	"New Guidelines in Cardiopulmonary Resuscitation", Pediatric Grand Rounds, UAMS/ Arkansas Children's Hospital
March, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
April, 2006	"Presentation Skills for Academics", seminar for pediatric fellows core curriculum
June, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students

June, 2006	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
August, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2005	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
October, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
November, 2006	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
November, 2006	"Rapid sequence intubation", Pediatric Emergency Medicine fellows conference
January, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
February, 2007	Venous thrombosis and thrombolembolism", Pediatric Critical Care State of the Art curriculum
April, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
May, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
July, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2007	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
September, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
November, 2007	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
January, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students

March, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
May, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2008	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
August, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2008	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
October, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
November, 2008	"Effective Presentations", Teaching Scholars, University of Arkansas for Medical Sciences, Invited Presentation for Faculty
November, 2008	Presentation Skills Seminar, University of Arkansas for Medical Sciences, Two hour workshop for Faculty
November, 2008	"Acute Neurologic Problems in Pediatrics", University of Arkansas for Medical Sciences and Arkansas Children's Hospital, Presentation for APN students
November, 2008	"Pharmacokinetics", Pediatric Critical Care Medicine Fellows Board Review
December, 2008	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
January, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
February, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
April, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students

June, 2009	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
September, 2009	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
October, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
December, 2009	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
February, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
April, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2010	Faculty and Course Director, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
August, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
August, 2010	Faculty and Course Director, Advanced Pediatric Life Support Course, Arkansas Children's Hospital
September, 2010	"FTEs and RVWs: What does it all mean?". Office of Faculty Development Presentation for UAMS Faculty. Arkansas Children's Hospital and University of Arkansas for Medical Sciences
October, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
November, 2010	"New Pediatric Resuscitation Guidelines". Pediatric Grand Rounds. Arkansas Children's Hospital and University of Arkansas for Medical Sciences
December, 2010	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students

April, 2011	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2011	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
July, 2011	Faculty and Course Director, Southeast Regional Pediatric Critical Care and Emergency Medicine Fellows Boot Camp
September, 2011	Faculty and Course Director, Advanced Pediatric Life Support Skills Lab, Arkansas Children's Hospital
March, 2012	"Surviving the manuscript peer review process without self-inflicted injury: Voices of experience. Fellows Education Conference
May, 2012	"Essentials of Pediatric Resuscitation". Three hour workshop on resuscitation skills for third year medical students
June, 2012	Faculty, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2012	Faculty, Southeast Regional Pediatric Critical Care and Emergency Medicine Fellows Boot Camp
October, 2012	Faculty and Course Director, Advanced Pediatric Life Support Skills Lab, Arkansas Children's Hospital
June, 2013	Faculty, Pediatric Advanced Life Support Instructor's Course, Arkansas Children's Hospital
July, 2013	Faculty, Southeast Regional Pediatric Critical Care and Emergency Medicine Fellows Boot Camp

EXTRAMURAL INVITED PRESENTATIONS

October, 1991	"Acute Renal Failure and the Hemolytic Uremic Syndrome" Critical Care Nursing Symposium, Little Rock, Arkansas.
October, 1992	Extracorporeal membrane oxygenation in adults: The Arkansas Experience, Arkansas Chapter, American College of Physicians, Hot Springs, Arkansas.
October, 1992	"All terrain vehicle accidents in children" Symposium on Critical Care and Emergency Medicine, University of Arkansas for Medical Sciences and University of Tennessee College of Medicine, Hot Springs, Arkansas.

April, 1993	Faculty, Pediatric Advanced Life Support Instructor Course, St. Mary's Hospital, Rogers, Arkansas.
June, 1993	Faculty, Pediatric Advanced Life Support Instructor Course, Baxter Regional Medical Center, Mountain Home, Arkansas.
March, 1994	"Management of the pediatric organ donor", Arkansas Regional Organ Recovery Agency Coordinators Conference.
March, 1994	Course Director, Pediatric Advanced Life Support Instructor Course, Texarkana College of Further Education, Texarkana, Arkansas
April, 1994	Course Director, Pediatric Advanced Life Support Course, St. Vincent's Infirmary Medical Center, Little Rock, Arkansas.
June, 1994	Course Director, Pediatric Advanced Life Support Course, St. Bernard's Regional Medical Center, Jonesboro, Arkansas.
August, 1994	Course Director, Pediatric Advanced Life Support Course, Area Health Education Center-Southeast, Pine Bluff, Arkansas.
September,1994	Course Director, Pediatric Advanced Life Support Instructor Course, Texarkana Community College, Texarkana, Arkansas.
February, 1995	"Pediatric Shock", Area Health Education Center-Southeast, Pine Bluff, Arkansas.
May, 1995	Course Director, Pediatric Advanced Life Support Course, St. Bernard's Regional Medical Center, Jonesboro, Arkansas.
May, 1995	Course Director, Pediatric Advanced Life Support Instructor Course, St. Bernard's Regional Medical Center, Jonesboro, Arkansas.
July, 1995	Course Director, Pediatric Advanced Life Support, Dequeen Medical Center, Dequeen, Arkansas.
April, 1996	"Nutritional Support of the Critically Ill Child", Southeast Regional Symposium, Society of Critical Care Medicine, Columbus, Georgia.
July, 1996	Course Director, Pediatric Advanced Life Support, Siloam Springs Medical Center, Siloam Springs, Arkansas.
December, 1996	"Injury Prevention in Children", UAMS Interactive Video Conference.

May, 1997	"Enteral Formula Composition and Bacterial Translocation, American Thoracic Society Annual Meeting, San Francisco, California.
July, 1997	"Injury Prevention", Little Rock Air Force Base Medical Staff.
February, 1998	"Pediatric Respiratory Emergencies", Area Health Education Center-Southeast, Pine Bluff, Arkansas.
April, 1998	"Initial Management of the Critically Ill Child", Symposium on Critical Care and Emergency Medicine, sponsored by University of Arkansas for Medical Sciences and University of Tennessee College of Medicine, Hot Springs, Arkansas
April, 1999	"Improving Your Teaching Skills", Emergency Cardiac Care, Hot Springs, Arkansas.
October, 1999	"Shaken baby syndrome", Pediatric Critical Care/ Trauma Symposium, Arkansas Children's Hospital
November, 1999	"The Critically Ill Child: The First 30 Minutes", Annual Meeting, Arkansas Chapter, American Academy of Pediatrics, Branson, Missouri.
November, 1999	Course Director, APLS: The Pediatric Emergency Medicine Course, 12 hour pre-course before the Annual Meeting, Arkansas Chapter, American Academy of Pediatrics, Branson, Missouri.
March, 2000	"The Critically Ill Child", Symposium on Critical Care and Emergency Medicine, sponsored by University of Arkansas for Medical Sciences and University of Tennessee College of Medicine, Hot Springs, Arkansas
March, 2000	"Shaken baby syndrome", Arkansas Society of Pediatric Nurses, Little Rock, Arkansas
May, 2000	"Shaken baby syndrome", Nursing Care of the Hospital Patient, New Orleans, LA.
June, 2000	"The Future of Fellowship Training in Pediatric Critical Care", Pediatric Critical Care Colloquium, Montreal, Canada.
July, 2000	"Pediatric Emergencies", Arkansas Academy of Family Physicians Annual Scientific Symposium, Little Rock, Arkansas
May, 2000	Faculty, Advanced Cardiac Life Support Provider Course, North Little Rock Veteran's Administration Hospital, North Little Rock, Arkansas.

June, 2001	Faculty and Course Director, Pediatric Advanced Life Support Course, Arkansas Heart Hospital
November, 2001	Faculty, Advanced Cardiac Life Support Provider Course, North Little Rock Veteran's Administration Hospital, North Little Rock, Arkansas.
June, 2002	"Case Studies in Critically Ill Children", Hawaii and Pacific Island Emergency cardiovascular Care Conference Honolulu, Hawaii
June, 2002	"Pediatric Respiratory Emergencies" Hawaii and Pacific Island Emergency Cardiovascular Care Conference Honolulu, Hawaii
November, 2002	Faculty, Advanced Cardiac Life Support Provider Course, North Little Rock Veteran's Administration Hospital, North Little Rock, Arkansas.
May, 2003	"Head Injuries across the Age Spectrum", Nursing Care of the Hospitalized Child, Atlanta, Georgia.
May, 2003	"Case Studies in Respiratory Assessment", Nursing Care of the Hospitalized Child, Atlanta, Georgia.
October, 2003	Course Director for "Preparing for Life in Academics", one and a half day seminar at American Academy of Pediatrics National Conference and Exhibition, New Orleans, Louisiana
October, 2003	"Teaching Skills: A Primer", American Academy of Pediatrics National Conference and Exhibition, New Orleans, Louisiana
October, 2003	"Effective Feedback", American Academy of Pediatrics National Conference and Exhibition, New Orleans, Louisiana
October, 2003	"Effective Presentations", American Academy of Pediatrics National Conference and Exhibition, New Orleans, Louisiana
November, 2003	"Advanced Airway Management" American Academy of Pediatrics National Conference and Exhibition, New Orleans, Louisiana
November, 2003	Faculty, Pediatric Advanced Life Support Course, Cardinal Glennon Children's Hospital, St. Louis, Missouri
January, 2004	"Controversies in Pediatric CPR", Grand Rounds, Department of Emergency Medicine, Johns Hopkins Medical Institute, Baltimore, Maryland.

January, 2004	"The Risks and Rewards of a Career in Medicine", Alpha Epsilon Delta Induction banquet (premedical honor society), University of Arkansas, Fayetteville, Arkansas.
April, 2004	"Abusive head trauma", Mid South Conference on Child Abuse and Neglect, Hot Springs, Arkansas.
September, 2004	"Vasopressin in pediatric cardiopulmonary arrest", International Liaison Committee on Resuscitation, Budapest, Hungary
January, 2005	"Vasopressin in pediatric cardiopulmonary arrest", International Liaison Committee on Resuscitation International Consensus Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care, Dallas, Texas
March, 2005	"Future Guidelines for Pediatric Resuscitation", American Heart Association Stakeholders Conference, Dallas, Texas
May, 2005	"Update in Pediatric Resuscitation", Northeast Arkansas EMS Update, Paragould, Arkansas
May, 2005	"Drowning", Northeast Arkansas EMS Update, Paragould, Arkansas
September, 2005	"Challenging Cases", Primary Care Pediatrics, Branson, Missouri
October, 2005	"Teaching Skills Overview", American Academy of Pediatrics Annual Meeting, Washington, DC,.
September, 2005	"Challenging Cases", Primary Care Pediatrics, Branson, Missouri
January, 2006	"New Guidelines in Pediatric Resuscitation", Society of Critical Care Meeting 4th Annual Critical Car
October, 2006	"Educational Enhancements in Pediatric Advanced Life Support (PALS) Training", American Academy of Pediatrics National Conference and Exhibition, Atlanta, Georgia
October, 2006	"New Guidelines in Pediatric Resuscitation, Grand Rounds, Dept. of Emergency Medicine, Johns Hospital Medical University, Baltimore, Maryland
June, 2007	"Reducing Catheter-Related Bloodstream Infections in the PICU", Fifth World Congress on Pediatric Critical Care, Geneva Switzerland
October, 2005	"Effective Presentations", American Academy of Pediatrics Annual Meeting, San Francisco, California

April, 2008	"Atypical Resuscitation Scenarios", Nursing Care of the Hospitalized Child, Las Vegas, Nevada
April, 2008	"Friends, Fruit and CPR: Picking the Right Alphabet from the Soup of Resuscitation (PALS, PEARS & BLS)", Nursing Care of the Hospitalized Child, Las Vegas, Nevada
November, 2008	"Status Epilepticus", Area Health Education Center-Southeast, Pine Bluff, Arkansas.
January, 2009	"Reducing In-hospital Pediatric Cardiac Arrest through Early Recognition: Pediatric Emergency Assessment, Recognition, and Stabilization", National Registry of CPR Users Group (webinar)
March, 2009	"Etomidate in for intubation in pediatric septic shock", Pediatric Task Force, International Liaison Committee on Resuscitation, Osaka, Japan (webinar).
May, 2009	Panelist, "Current Practice: In-Hospital ECMO", International Emergency Cardiopulmonary Bypass Network Conference, University of Pennsylvania, Philadelphia
September, 2009	"In pediatric patients with cardiac arrest, does the use of NaHCO3 compared with no NaHCO3, improve outcome?", International Liaison Committee on Resuscitation, Pediatric Task Force (webinar).
February, 2010	"Etomidate in Pediatric Septic Shock", International Liaison Committee on Resuscitation Consensus Confernce, Dallas TX.
November, 2010	"New Science in Pediatric Resuscitation", American Heart Association National Faculty Update, Chicago, IL.
November, 2010	"New Pediatric Resuscitations Guidelines", American Heart Association National Faculty Update, Chicago, IL.

MEDIA APPEARANCES

July, 1994	"Playground safety for children", KARK Television, Channel 4.
September, 1994	"Lightning Injuries in children". KARK Television, Channel 4.
September, 1994	"Lightning Injuries in children". KATV Television, Channel 7.
September, 1994	"Lightning Injuries in children". KTHV Television, Channel 11.
June, 1995	"Heat-Related Injuries", KARK Television, Channel 4.
July, 1995	"Fireworks Injuries", KARK Television, Channel 4.

July, 1995	"Prevention of Heat Related Injuries ", KARK Television, Channel 4.
December, 1995	Dads and Docs: Injury Prevention and Emergency Medical 1997 Conditions, Series of 12 radio infomercials for KARN Radio.
July, 1996	"Heat-Related Injuries", KARK Television, Channel 4.
December, 1996	"Carbon Monoxide Poisoning", KARK Television, Channel 4.
January, 1997	"Hypothermia and cold-related illnesses", KARK Television, Channel 4.
March, 1997	Sudden Infant Death Syndrome in Arkansas, KARN Radio,
July, 1997	"Fireworks -related injuries" KARN Radio.
September, 1997	"Dealing with Stressed Families", KARK Television, Channel 4.
October, 1997	"Carbon monoxide poisoning", KARN Radio.
February, 1998	"Balloon Safety", Kidsense, syndicated news program for KATV Television, Channel 7, and eight other affiliates across U.S.
March, 1998	"Childhood Poisoning", KARK Television, Channel 4
May, 1998	"Heat-Related Illness", KTHV Television, Channel 11.
May, 1998	"Safe Kids Day", KTHV Television, Channel 11.
May, 1998	"Household Injury Prevention" KTHV Television, Channel 11
June, 1998	"Preventing heat related illness", CBS This Morning, broadcast nationally to 265 CBS affiliate stations.
July, 1998	"Preventing fireworks injuries", KARK TV, Channel 4
July, 1998	"Fireworks-related injuries", KTHV TV, Channel 11
August, 1998	"Playground safety", KATV TV, Channel 7
November, 1998	"Injury Prevention", KARN radio
February, 1999	"Working with dying children and their families", KARK, Channel 4
April, 1999	"Preventing infant suffocation", KHTV Channel 11
June, 1999	"Gunshot injuries in children", CBS Evening News broadcast nationally to 265 CBS affiliate stations.
June, 1999	"Fireworks injuries", KKYK TV, Channel 22
July, 1999	"Preventing infant suffocation", KARK TV, Channel 4
February, 2001	"Bronchiolitis", KTHV TV, Channel 11
May, 2001	"Firearm-related injuries", KTHV TV, Channel 11
March, 2003	"Family Focused Care", KTHV TV, Channel 11
April, 2003	"When Prevention Fails: Intensive Caring", KATV Channel 7
May, 2003	"Snakebites", KTHV TV, Channel 11
November, 2003	"Life-threatening complications of influenza in children", Associated Press
May, 2004	"Medical Miracles", KTHV Channel 11
January, 2007	"Reducing Infections" in the ICU.

RESIDENT GRAND ROUNDS MENTOR

1995	Anne Klasner, M.D. , "Environmental Emergencies"
1996	Victoria Moffatt, M. D., "Lightning Injuries"
1997	Cindy Bimle, M.D., "Ten Things You Need to Know When Your Nurse Doesn't Show Up"
1997	Deborah Quade, M.D. ,"Altered Mental Status"
1998	Jenny Tock, M. D. "Increased Intracranial Pressure"
1999	Melinda Houston, M.D. "Cardiopulmonary Resuscitation"

2007	Pete Stellman, MD "Making sense of the morass of the medical internet"
2003	Michael Pafford, MD, "Family Presence During Resuscitation"

RESEARCH PROJECTS MENTORED

1996 –1997	Bromide levels during prolonged use of vecuronium bromide and pancuronium bromide. Avant MG (principal investigator), Co-investigators: Farrar H, James L, Schexnayder SM. Funded by Children's University Medical Group.
1997	Effect of a medical screening program on emergency department use in pediatric Medicaid patients. Principal investigator: Prince J, (emergency medicine resident), co-investigator: Schexnayder SM.
2001	Financial ramifications of the repeal of the motorcycle helmet law in Arkansas. Principal investigator: Gregory Bledsoe, MD (emergency medicine resident), co-investigators: Schexnayder SM, Ferrer T, Carey MJ. Received best manuscript award from UAMS Dept. of Emergency Medicine.
2004	Vasopressin in pediatric cardiac arrest; a review of the National Registry of Cardiopulmonary Resuscitation; Principal investigator: Jay Duncan, MD, co-investigators Schexnayder SM, Berg RA.
2006	Effect of rescuer fatigue in infant CPR. Principal investigator: Michele Smoot, MD, (pediatric emergency medicine fellow), co-investigator: Schexnayder SM.

FELLOWS TRAINED

1994	James D. Marshall, M.D.
1994	Patricia Webster, M.D.
1994 -1996	Janet Carmack, M.D.
1994 - 1997	Michael Avant, M.D.
1994 - 1997	Richard T. Fiser,M.D.
1995 - 1998	Venu Devabhaktuni, MBBS
1997 - 2000	Ronald Sanders, M.D.
1998 - 2001	Umesh Narsinghani, MBBS
1999 - 2002	Adnan Bhutta, MBBS
2000 - 2003	Patricia Wankum, MD
2001 - 2004	Adriana Lopez, MD
2001 - 2002	Brian Eble, MD
2003 - 2005	Basam Alsaati, MD

2003 – 2006	Jay Duncan, MD
2004 – 2007	Tom Bannister, MD
2004 – 2007	Michael Stroud, MD
2006 – 2009	Muayyad Tailounie, MD
2007 – 2010	Laura Ortmann, MD
2007 – 2010	Katherine Clement, MD
2008 – Present	Johnny Byrnes, MD
2008 – 2011	David Smith, MD
2009 – 2011	Melena Chan, MD
2009 - 2012	Sanjiv Pasala, MD
2010 – Present	Courtney Ranallo, MD
2011 – Present	Jeremy Garlick, MD
2011 – Present	Kate Miller, MD
2011 – Present	Mahsun Yeurik, MD
2012 – Present	Katherine Irby, MD
2012 – Present	Mubbasheer Ahmed, MD

RESIDENT ADVISEES (MEDICINE-PEDIATRICS PROGRAM)

1995 - 1996	Tracy Angelocci, M.D.
1995 - 1996	Don Steely, M.D.
1995 - 1998	Debbie Quade, M.D.
1995 - 1998	Todd Callahan, M.D.
1995 - 1999	Clay Brashears, M.D.
1996 - 2000	Larry Markham, M.D.
1996 - 2000	David Slay, M.D.
1997 - 2001	Robert Beard, M.D.
1997 - 2001	Laura Johnson, M.D.
1998 - 2002	Eve Boger, M.D.
1998 - 2002	Phillip Rhoads, M.D.
1999 - 2003	Keith Coward, MD
1999 - 2003	Chris Morgan, MD
2000 - 2004	Lance Faddis, MD
2000 - 2004	Jim Brewer, MD
2000 – 2004	Teresa Nimmo, MD
2001 - 2005	Misty Leigh Williams, MD
2001 - 2005	Steve Shrum, MD
2001 - 2004	Josephine Ta, MD
2002 - 2006	Karen Gray, MD
2003 – 2006	Brandon Treece, MD
2003 - 2005	Matt Self, MD
2005 – 2009	Kathy Liverett, MD
2008 – 2011	Branson Bolden, MD
2009 – 2012	Michael Atkins, MD

Civic And Community Service

1990 - 1996	Camp Physician, Summer Spree Youth Camp, Siloam Springs, Arkansas
1994	Learning Center Teacher, Fellowship Bible Church
1994 - 1997	Medical Consultant, Dorcas House , a shelter for women and children who are victims of domestic violence and substance abuse
1995 - Present	Medical Missionary, World Gospel Outreach, Tegucigalpa, Honduras
1995 - 1997	Co-Medical Director, Dorcas House Family/Internal Medicine Clinic
1995 - 1997	Medical Director, Dorcas House Medical Clinic
1995 - 1997	Medical Director, Community Services Pediatric Clinic
1995 - Present	Small Group Leader, Fellowship Bible Church
1995 - 1996	Volunteer Teaching Assistant, Christ Lutheran School
May, 1999	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
November, 1999	Project Team Leader, Sharefest 1999, City-wide Community Service Project involving over 100 central Arkansas churches
May, 2000	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
June, 2001	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
June, 2002	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
June, 2003	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
2002 – 2005	Volunteer physician, Clinica El Samaritano
April, 2004	CPR Instructor, Christ Lutheran School
June, 2004	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
September, 2004	Elder, Fellowship Bible Church, Little Rock, Arkansas
May, 2005	CPR Instructor, Christ Lutheran School
June, 2005	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
October, 2005	Debate Judge, Little Rock Central High School Forensics Tournament
May, 2006	CPR Instructor, Christ Lutheran School
June, 2006	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
May, 2007	CPR Instructor, Christ Lutheran School
June, 2007	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
February, 2008	Debate Judge, North Little Rock High School Forensics Tournament
May, 2008	CPR Instructor, Christ Lutheran School
May, 2008	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
July, 2008	Board of Directors, Fellowship Bible Church
October, 2008	Board of Directors, World Gospel Outreach, Tegucigalpa, Honduras
October, 2008	Debate Judge, Central High School Forensics Tournament

January, 2009	Debate Judge, North Little Rock High School Forensics Tournament
April, 2009	Debate Judge, Arkansas Tournament of Champions State Forensic Tournament
May, 2009	CPR Instructor, Christ Lutheran School
May, 2009	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
May, 2010	CPR Instructor, Christ Lutheran School
May, 2010	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
2010 – 2011	Kitchen Volunteer, Little Rock Compassion Center
May, 2011	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras
September, 2011	Debate Judge, Central High School Forensics Tournament
January, 2012	Debate Judge, JW Patterson Invitational Debate Tournament, Heritage Hall, Oklahoma City, OK
April, 2012	Debate Judge, Arkansas Tournament of Champions State Forensic Tournament
2012 – Present	Chairman, Board of Directors, World Gospel Outreach, Tegucigalpa, Honduras
June, 2012	Medical Mission Team Leader, World Gospel Outreach, Tegucigalpa, Honduras

DEVELOPMENTAL DISABILITIES SERVICES

ARKADELPHIA HUMAN DEVELOPMENT CENTER

INDIVIDUAL PROGRAM PLAN
ANNUAL REVIEW

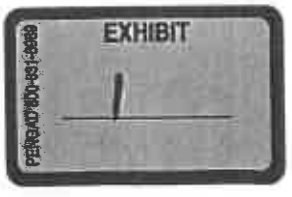
MEETING DATE: 01/16/13

IDENTIFYING INFORMATION:

NAME: Brenda Kimberly Mize
MASTER NUMBER: 79462
SEX: Female
RACE: White
DOB: 05/09/65
AGE: 47
ADMISSION DATE: 09/11/06
RESIDENCE: 290 Pine
RESPONSIBLE PARTY: Brett Mize
RELATIONSHIP: Brother/Curator
CITY/COUNTY: Bentonville/Benton
INTELLECTUAL FUNCTIONING LEVEL: Severe
ADAPTIVE BEHAVIOR FUNCTIONING LEVEL: Profound
PRIMARY DISABILITY: Mental Retardation

DIAGNOSES:

AXIS I:	Bipolar I Disorder most recent episode manic
AXIS II:	Severe mental retardation
AXIS III:	Elevated blood pressure without hypertension
	Bilateral cataracts
	Dysmenorrhea
	Minimal anemia
	Hypothyroidism
	Dysphagia (difficulty in swallowing), oral phase
	Constipation
	Allergic rhinitis
	Foot xerosis (excessive dryness), bilateral
	Severe hyperkeratosis (thickening of the skin) bilateral plantar feet



THE FOLLOWING PEOPLE ATTENDED MY MEETING:

SIGNATURE/TITLE	PRINTED NAME
Cheryl S. MacKay, PCL @ DDP	Cheryl S. MacKay
Brenda Hamilton, RN	BRENDA HAMILTON
Althea Elaine Mitchell, RCS	Althea Elaine Mitchell
Stephanie Thomas RIS	Stephanie Thomas
H.L. Mize	H. L. Mize
Brett Mize	Brett Mize
Reshuna Johnson RCT	Reshuna Johnson
Brenda Mize by csm	Brenda Mize

THE FOLLOWING PEOPLE WERE IDENTIFIED AS MEMBERS OF MY INTERDISCIPLINARY TEAM:

NAME	ROLE
Brenda Kimberly Mize	Person Receiving Services
Brett Mize	Brother/Curator
Susan Maddie	Sister
Harold Mize	Father
Randy Mize	Brother
Brandy Davis	Direct Care, First Shift
Reshina Johnson	Direct Care, Second Shift
Stephanie Thomas	Rehabilitation Instructor, Adult Enrichment I (AE I)
Brenda Hamilton	Registered Nurse
Cheryl S. MacKay	Program Coordinator/Qualified Developmental Disability Professional

THE FOLLOWING PEOPLE PARTICIPATED THROUGH WRITTEN INPUT ONLY:

NAME	ROLE
Sharon Adams	Psychological Examiner
Christine Anderson	Licensed Social Worker
Sharon Boone	Licensed Practical Nurse
Kevin Boyles	Occupational Therapist
Alice L. Cleves	Speech/Language Pathologist
Brandy Davis	Direct Care, First Shift
Robert Dorman	Physician
Stacy Freeman	Consulting Dietitian
Gary Gehrki	Physician
Billy Haygood	Physical Therapist
Glynis Jones	Direct Care, Third Shift
Terrie Kay	Licensed Practical Nurse
Christy Moder	Licensed Practical Nurse
Gary Newman	Pharmacy Consultant
Vickey Sims	Licensed Practical Nurse
Ron Spann	Dentist

SIGNATURE(S) BELOW INDICATE REVIEW:

SIGNATURE	ROLE	DATE
Judy L May Judy L. May	Quality Assurance Analyst	01-30-13

MY PROGRESS SINCE MY LAST STAFFING:

BEHAVIORAL OBJECTIVES/TRAINING LOCATION

*A) In the course of my daily schedule, I will have 0 incidents of physical aggression toward others for 12 months by 02/03/13.

RP: ADAMS/PSYCHOLOGY

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	-	0	0	-	+	-	+	+	+	+
0	0	1	1	1	3	1	2	0	0	0	0

*B) In the course of my daily schedule, I will have no more than 5 incidents of tantrum behavior (including profanity/name calling, threats, screaming/crying) per month for 12 months by 02/03/13.

RP: ADAMS/PSYCHOLOGY

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	+	+	-	-	+	-	+	+	+	-
1	1	0	2	6	19	3	7	2	1	0	10

*C) In the course of my daily schedule, I will have no more than 6 incidents of noncompliance/refusal per month for 12 months by 02/03/13.

RP: ADAMS/PSYCHOLOGY

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	+	+	-	-	+	-	+	+	+	+
3	2	0	5	10	22	6	16	3	2	1	6

*D) In the course of my daily schedule, I will have no more than 2 incidents of being up at night per month for 12 months by 02/03/13.

RP: ADAMS/PSYCHOLOGY

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	+	+	+	-	+	+	+	+	+	+
0	0	0	0	0	2	0	0	1	0	0	1

*E) In the course of my daily schedule, I will have 0 incidents of self-injurious behavior per month for 12 months by 02/03/13.

RP: ADAMS/PSYCHOLOGY

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	+	+	+	-	+	-	+	+	+	+
0	0	0	0	0	3	0	2	0	0	0	0

*F) When given a choice of tasks, I will help clean my room 50% of the time for 6 consecutive months by 07/31/12.

SP: DAVIS/290 PINE 1st SHIFT

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	-/POA	+	-/POA	+	-/POA	+	+	+	+	+	+
34%	48%	68%	32%	36%	33%	47%	50%	76%	59%	64%	68%

COMMENTS/POA:

03/12	adjusting to moving back to the home	07/12	increase social praise
05/12	increase verbal praise		

BEHAVIORAL OBJECTIVES/TRAINING LOCATION

*G) When given a choice of tasks, I will help clean my room 80% of the time for 6 consecutive months by 02/03/13.

SP1: DAVIS/290 PINE 1st SHIFT (non-priority)

SP2: JOHNSON/290 PINE 2nd SHIFT

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
#1											
#2 +	-/POA	-/POA	-/POA	+	+	+	-/POA	+	-/POA	+	0/POA
100%	58%	33%	22%	30%	86%	87%	32%	33%	27%	45%	45%

COMMENTS/POA:	
03/12	SP2 - adjusting to moving back to the home - will increase verbal praise
04/12	SP2 - increase edible reinforcers and verbal praise (new group leader)
05/12	SP2 - increase verbal praise
09/12	SP2 - increase verbal praise
11/12	SP2 - increase session time
01/13	SP2 - increase verbal praise

*H) When I exercise more, I will maintain a healthy weight by 02/03/13.

SP: JOHNSON/290 PINE 2nd SHIFT

RP: HAMILTON/REGISTERED NURSE

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
SP - Record # of sessions I exercised for 20 minutes per month											
11 sess	13 sess	10 sess	11 sess	12 sess	11 sess	6 sess	9 sess	10 sess	9 sess	8 sess	10 sess
RP - Record monthly weight (recommended weight range ~~140-150 lbs.~~) (115 - 150 lbs.) (revised April 2012)											
+4	+2.2	+2.2	+2.6	+2.6	+4.8	-6.4	+5.2		+2.0	-2.8	+5.4
145	147.2	149.4	152	154.6	159.4	153.0	158.2	refused	160.2	157.4	162.8

COMMENTS:	
03/14/12	Dr. Gehrki - Problems reported: 'clarification order - may use ketchup, mustard, or syrup to moisten food instead of gravy' Doctor's orders: 'current diet doesn't restrict above items as long as this is the case; may use anything that client finds palatable; keep in mind that mustard is a very hi sodium source and the other two items are hi in simple carbs (i.e. sugar, high fructose corn syrup)'
04/04/12	Dr. Dorman - Doctor's orders: 'discontinue the mechanical soft fruit snack order and offer midafternoon and bedtime snacks according to her diet'

*I) When requested, I will put lotion on my feet 50% of the time for 12 months by 02/03/13.

SP1: DAVIS/290 PINE 1st SHIFT

SP2: JOHNSON/290 PINE 2nd SHIFT

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
#1 +	+	+	+	-/POA	+	+	+	+	+	+	+
100%	87%	83%	60%	40%	41%	45%	50%	62%	73%	78%	57%
#2 +	+	-/POA	+	+	+	+	+	+	+	+	-/POA
100%	50%	25%	60%	75%	92%	87%	86%	60%	67%	78%	29%

COMMENTS/POA:	
04/12	SP2 - increase edible reinforcers and verbal praise - new group leader
06/07/12	Brenda had a pedicure.
06/12	SP1 - new staff working with Brenda; will have the same staff working with her to help keep a positive working relationship with her
01/13	SP2 - increase verbal praise

BEHAVIORAL OBJECTIVES/TRAINING LOCATION

*J) When requested, I will repeat the purpose of my Lithium ER 50% of the time for 3 months by 06/30/12.
RP: HAMILTON/REGISTERED NURSE

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	-/POA	+	-/POA	-/POA	-/POA	+	+	-/POA	+	-/POA	-/POA
30%	18%	23%	22%	15%	11%	24%	31%	9%	16%	14%	8%

COMMENTS/POA:

03/12	moved back to old home; no changes in training methods will be made at this time
05/12	RN talked with LPNs regarding lack of progress; LPNs report Brenda refuses to participate in training at times; RN will inservice LPNs regarding training procedures on the program description to ensure everyone is training using the same methods (inservice completed 06/05/12)
06/12	Nurses will continue to encourage participation in SAM program.
07/12	Brenda has refused to participate in training, at times, this month. Staff will continue to encourage participation and reward positively.
10/12	Brenda refuses to participate in the SAM program and the majority of the time she will not come to the medication room to take her medications. The nurses must go to her room to administer her meds.
12/12	No progress; the Team will review this objective on 01/16/13.
01/13	During Brenda's annual review meeting, which was held on 01/16/13, the Team discussed her lack of progress on this objective and recommended that training be discontinued.

K) When requested, I will repeat the purpose of my Klonopin 50% of the time for 3 months by 11/30/12.
RP: HAMILTON/REGISTERED NURSE

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13

L) When requested, I will repeat the purpose of my Synthroid 50% of the time for 3 months by 05/31/13.
RP: HAMILTON/REGISTERED NURSE

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13

*M) When I finish an activity, I will put away my materials, with no more than 4 reminders, 50% of the time for 9 months by 02/03/13.
SP: THOMAS/AE I **BL: 0%**
RP: MITCHELL/290 PINE SUPERVISOR **BL: 0%**

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
SP +	+	+	-/POA	+	-/POA	+	-/POA	+	+	-/POA	+
16%	44%	54% (1/9)	33%	40%	28%	33%	22%	28%	44%	36%	42%
[redacted]		RP +	+	+	0/POA	+	-/POA	+	+	+	+
		25%	35%	40%	40%	45%	30%	35%	38%	42%	43%

COMMENTS/POA:

05/12	SP - At times, Brenda refuses to stay in training; will encourage her with preferred activities. When Brenda refuses to stay in training, she is receiving training in her home.
07/12	SP/RP - Increase in behavior problems; no changes in training methods will be made at this time
09/12	SP - doesn't want to stay in training; jumps up and leaves room; reinforce with preferred activities
09/12	RP - There has been an increase in her inappropriate behaviors; increase verbal praise.
12/12	SP - refusing to stay in area and not going to training consistently; will reinforce with preferred activities

BEHAVIORAL OBJECTIVES/TRAINING LOCATION

*N) When provided verbal prompts, I will finish a leisure activity 50% of the time for 6 months by 02/03/13.
SP: THOMAS/AE I **BL: 0%**
RP: MITCHELL/290 PINE SUPERVISOR **BL: 0%**

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
SP +	+	+	+	+	+	+	COMPETENT **********				
16%	33%	66%	66%	60%	71%	66%	66%				
		RP +	+	See Comments	-/POA	+	-/POA	+	+	+	-/POA
		25%	30%		20%	30%	20%	25%	29%	36%	0%

COMMENTS/POA:

06/12	RP - On days Brenda refused to attend training in AE I, she also refused to participate in training in her home. Staff will continue to encourage Brenda to participate in training.
07/12	RP - increase in behavior problems; no changes in training methods will be made at this time
09/12	RP - There has been an increase in her inappropriate behaviors; increase verbal praise.
01/13	RP - increase session time

O) When provided verbal prompts, I will finish a leisure activity 80% of the time for 6 months by 02/03/13.
RP: THOMAS/AE I **BL: 66%**

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
								BL	-/POA	+	-/POA
								66%	58%	64%	63%

COMMENTS/POA:

11/12	reinforce with edibles
01/13	has been refusing to stay in training; will provide her with preferred activities

*P) When I choose to leave training early and return home, I will help set up my place setting for lunch, with assistance, 80% of the time for 6 consecutive months by 02/03/13.
P: MITCHELL/290 PINE SUPERVISOR

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
+	+	+	-/POA	+	-/POA	+	+	+	+	+	+
42%	50%	66%	60%	62%	20%	30%	35%	40%	42%	50%	56%

COMMENTS/POA:

05/12	increase verbal praise
07/12	increase in behavior problems; no changes in training methods will be made at this time

SERVICE OBJECTIVES

S1) To ensure that I am receiving the lowest effective dosage of medication, staff will ensure a psychiatric consult is scheduled quarterly and the physician considers the need for a medication reduction when I have had zero incidents of physical aggression, tantrum behavior, noncompliance, being up at night, and self-injurious behavior for 6 consecutive months.

RP1: ADAMS/PSYCHOLOGY REVIEW DATES: 02/29/12 and monthly until 01/31/13

RP2: HAMILTON/REGISTERED NURSE REVIEW DATES: 02/29/12, 05/31/12, 08/31/12, 11/30/12

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13
#1 - Record # of incidents of target behaviors per month											
-	-	-	-	-	-	-	-	-	-	-	-
3	2	1	6	11	27	9	22	5	2	1	12

#2 - Record date I was seen by the psychiatrist and any medication changes	
03/01/12	Dr. Alexander - 'no med change; return to clinic in 3 months'
06/2012	Several appointments have been scheduled for Brenda to see Dr. Alexander. However, Brenda has refused to come to the Clinic. Efforts will be continued.
07/13/12	Brenda refused to come to clinic. Dr. Alexander changed the time Brenda receives her Seroquel: 300mg every morning and 800mg every night at bedtime; return to clinic in 1 month.
07/16/12	Received call from RCS stating Brenda has had inappropriate behavior x3 days; contacted Dr. Alexander and informed her. Received orders to change Seroquel to 300mg every morning, 300mg at noon daily, and 500mg at bedtime. [Brett Mize, brother/curator, notified 07/17/12]
08/02/12	Dr. Alexander - Impression: 'cycling - manic behavior' Recommendations: 'start Haldol 2mg by mouth two times a day; return to clinic in 1 week'
08/02/12	Brett Mize contacted. He said he was fine with Brenda taking Haldol but he requested information regarding possible side effects.
08/06/12	Brett Mize called. He said he received the information about Haldol and has some concerns about the possible side effects. He said he would like to talk with Dr. Alexander about a different medication for Brenda.
08/09/12	Dr. Alexander - Remarks: 'behaviors have improved - spoke with her brother - he states she had negative side effects from Haldol or something like it; says had tremors and lip smacking; agreed to watch for now' Recommendations: 'possibly try Geodon if behaviors continue'
09/13/12	Dr. Alexander - Remarks: 'behaviors have improved; watch for now;' no med changes; return to clinic in 1 month' [Brenda refused to attend the meeting.]
11/01/12	Dr. Alexander - 'no med changes; return to clinic in 2 months'
01/11/13	Dr. Alexander - 'no med changes; return to clinic in 1 month'

S2) When staff continues the current effective oral hygiene practices and provides intensified toothbrushing for me at least once daily, my oral hygiene should improve from poor for fair.

RP: SPANN/DENTIST REVIEW DATES: 06/30/12, 12/31/12

02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	01/13

cord the date of my visit and my oral hygiene rating	
04/03/12	hygiene exam; fair to poor oral hygiene; somewhat cooperative to brushing; needs help
08/20/12	no show for hygiene appointment; behavior
08/28/12	refused to come to Dental clinic
09/04/12	refused to come to Dental clinic; we will consult Elaine and PC
09/19/12	partial hygiene exam; fair oral hygiene; uncooperative to treatment; desensitization
01/02/13	Brenda refused to come to the Dental Clinic for her staffing exam today and also last week.
01/03/13	partial hygiene exam for staffing; poor; declining oral health; refused treatment

SERVICE OBJECTIVES			
S3) To keep me from hurting myself if I choose not to sleep on my mattress, staff will make sure my safety mat is in good condition.			
RP: NASH/OT/PT	REVIEW DATES: 04/30/12, 07/31/12, 10/31/12, 01/31/13		
02/12 03/12 04/12 05/12 06/12 07/12 08/12 09/12 10/12 11/12 12/12 01/13			
Record monitoring date and condition of my safety mat			
04/02/12	no problem	10/01/12	no problem
07/25/12	no problem	01/02/13	no problem
COMMENTS:			
04/04/12	Verbal orders/Dr. Dorman - 'provide mat for person to lay on when she chooses not to sleep on her mattress'		

TRANSITION SECTION:

Background: Brenda used to live with her mother in Louisiana. Then, she moved to a group home in Jefferson Parrish. When Hurricane Katrina hit in 2005, the group home was damaged and Brenda had to move. Her brother told the Team there were several months after the hurricane when he was unaware of where his mother and Brenda were living. When he was finally able to contact Brenda, he brought her home to live with him. After the hurricane, their mother passed away. This, added to the trauma of Katrina, made things tougher for Brenda. He requested placement for Brenda because he was unable to provide the amount of supervision she required in his home. Brenda was admitted to the Arkadelphia Human Development Center (HDC) on August 14, 2006, for respite care until she could be admitted as a regular admission. She became a regular admission on September 11, 2006.

Brenda has an Axis I diagnosis of Bipolar I Disorder most recent episode manic. For Brenda, this disorder is demonstrated by periods of agitated behavior during which she may stay up at night, change her clothing many times, and go through other people's belongings while becoming quite agitated when attempts are made to get her to stop. She will also refuse to take her medications, during these periods, which only exacerbates the manic activity. The manic activity has resulted in physical altercations with other persons served in her home. During the past year, a Behavior Support Plan (BSP) has been in place for Brenda to address physical aggression toward others, self-injurious behavior, tantrum behavior (including profanity/name calling, threats toward others, and screaming/crying), noncompliance/refusal, and being up at night. It addresses environmental structuring (clear and consistent expectations, varied activities), reinforcement, and specific interventions to interrupt problematic behavior. Her medication regimen includes Seroquel, Lithium ER, and Klonopin.

Professional Judgment: When polled prior to this Interdisciplinary Team (IDT) meeting, Brenda's IDT members were in agreement that she should continue living in an HDC. It was agreed that Brenda needs to learn to do more things for herself. However, improving her behavior seems to be her most significant barrier to living successfully in the community.

Guardian Opinion: Brett Mize, Brenda's brother/curator, indicated on the Service Location Survey for Guardians that he chooses for Brenda to remain in an HDC and receive ICF/IID services. He noted the following statements. "Brenda is well cared for and efforts are made to train Brenda to function in society." "Brenda was given care at Magnolia housing/home on their facility. She would not stay inside or behave. Brenda was not able to stay as they could not keep her safe or manage her." "Brenda is bipolar with schizophrenia and severe/moderate retardation. She cannot be kept safe outside of a HDC environment. The care she requires is too extensive for a community service provider." On the Service Choice Form, Mr. Mize indicated that he is opposed to community placement at this time.

IDT Transition Plan: It is the consensus recommendation of the IDT that Brenda remain in the HDC with a transition plan designed to assist her with developing skills for a lesser restrictive lifestyle in her current environment. She is happy living where she lives and receiving the services provided by the Center. It is the responsibility of her Team to monitor her response to provided services and address needed changes.

TEAM DISCUSSION:

My Interdisciplinary Team met on January 16, 2013, to review and update my Individual Program Plan (IPP). My Social Worker invited me to the meeting. I attended and participated in the Team's discussion by stating things I want to do next year. My brother, Brett Mize, is my curator. He has given permission for my father, Harold Mize; my sister, Susan Maddie; and my brother, Randy Mize, to participate as members of my Interdisciplinary Team. They were all invited to attend my meeting. Brett and my father attended and actively participated in the Team's discussion to update my IPP. A copy of my IPP will be sent to my brother/curator and other family members for their review. If they have questions, they can call my Program Coordinator or Social Worker. Cheryl S. MacKay is my Program Coordinator/QDDP. She will be responsible for monitoring my services and contacting my Team regarding significant changes recommended in my services. When Ms. MacKay is not available, a message can be left for the Nursing Home Administrator in charge and follow-up procedures will be initiated.

Services for me are determined through an evaluation process. Based on the results and my interests, decisions for services are made by my Team, which includes me and my family members listed above. I am currently receiving the following services: health, dental, behavior support, adult enrichment, and financial. I have a physical exam completed yearly with other health services being provided, as needed. Specialized consultations are scheduled as recommended by my doctor, Dr. Dorman. At such time, an appointment would be made for me to receive services in the community.

There are no limitations placed on my residence and there is no threat of disruption to my life. There are also no limitations on how long I may remain at the Center. Since my admission, the Center has remained an appropriate living situation for me. If my brother and I should indicate a desire for me to move, my Social Worker would help us find a place that could meet my needs. Every effort would be made to arrange a trial placement, in case it is not what I need or I am not successful and want to return.

My Team discussed the evaluations and assessments completed for this meeting. To help decide what is needed next year, they also talked about the objectives I have been working on and my progress. A copy of the monthly data is included as part of this IPP.

OUTCOME 1: I have a transition plan to help me achieve my goals.

GOAL #1: I want to stay healthy.	
BARRIERS	**SERVICES/SUPPORTS**
• At times, I display physical aggression toward others, self-injurious behavior, tantrum behavior (including profanity/name calling, threats toward others, and screaming/crying), noncompliance/refusal, and being up at night. My previous annual review meeting was held on 02/03/12. From 02/01/12 through 12/31/12, I received 108 reports of inappropriate behavior documenting the following number of incidents: physical aggression - 9; self-injury - 5, tantrum behavior - 42; noncompliance/refusal - 71; and being up at night - 3. This can be compared with 67 reports filed during the previous reporting period (02/01/11 through 01/31/12) documenting the following number of incidents: physical aggression - 8; self-injury - 5, tantrum behavior - 37; noncompliance/refusal - 40; and up at night - 3. Since I have not had very many incidents of being up at night, my Team recommended that my Behavior Support Plan (BSP) be modified to remove being up at night from my list of target behaviors.	• Staff members who work with me daily will ensure the procedures in my BSP are followed, as written.

GOAL #1: I want to stay healthy.	
BARRIERS	**SERVICES/SUPPORTS**
• When my Team met four years ago, I had been taking grooming items out of my grooming kit and, at times, emptying the bottles/containers on the floor. My Team had recommended that I have two grooming kits: one with non-dispensable items such as my brush, comb, toothbrush, etc. and one with dispensable items such as my shampoo, toothpaste, lotion, etc. It was also recommended that my grooming kit with dispensable items be kept in a secure location so I do not pour out the items and possibly slip and fall.	• During this meeting, my Team agreed that my grooming kit with dispensable items still needs to be kept in a secure location. The need to continue keeping my grooming kit with dispensable items in a secure location will be reconsidered when I have had zero incidents of physical aggression, tantrum behavior, and noncompliance for six consecutive months. • Updated consent from my brother/curator and Human Rights Committee approval will be obtained.
• During my bouts of agitation, I may change my clothes/shoes many times. I may also take my clothes/shoes out of my drawers and closet, pile them up on the floor, and urinate on them. I have also been known to tear up my clothes/shoes.	• As recommended by my Team, my clothing choices, including selection of shoes, should be restricted to those that are adequate to meet my needs for the current season. As needed, staff members will provide me with assistance to facilitate good coordination of clothing items. The need to continue restricting my clothing choices will be reconsidered when I have had zero incidents of physical aggression, tantrum behavior, and noncompliance for six consecutive months. • Updated consent from my brother/curator and Human Rights Committee approval will be obtained.
• I have several DVDs and CDs. However, I do not take good care of them. My brother requested that my DVDs/CDs be kept in a secure location during those times I do not request access to them.	• My Team agreed that my DVDs and CDs still need to be kept in a secure location during those times I do not request access to them. • Updated consent from my brother/curator and Human Rights Committee approval will be obtained.
• During a previous meeting, my brother told my Team I may get excited around the holidays, especially with parties going on and people going home. He said I may or may not want to go home during that time.	• If I should express a desire to go home around the holidays, my family will be contacted.
• I take medication (Seroquel, Lithium ER, Klonopin) to help with my behavior. I could possibly have side effects associated with my medication. My brother wants to be called before any medication changes are made. This is because my family is concerned that changing my medications or taking me off medications could cause my behavior to become out of control to the point of requiring hospitalization.	• My nurses will ensure I take medication for my behavior, as ordered. Quarterly psychiatric consults will be scheduled for me so my psychiatrist can monitor the effectiveness of my medication and monitor for possible side effects. If medication changes are recommended, my brother will be called before any changes are made. • My Team will monitor to ensure the risk of allowing my inappropriate behaviors to escalate to the point of injuring myself or anyone else exceeds the possible risk of side effects of my medication.

GOAL #1: I want to stay healthy.	
BARRIERS	**SERVICES/SUPPORTS**
• Even though I know how, there are times when I refuse to clean my bedroom or allow a staff member to help me clean it. • I do not like to leave my bedroom furniture (couch, wardrobes, tables) in one place. At times, I will push the furniture around the room or try to tip it over. • I do not like to leave my mattress on my bed.	• Direct training will be provided for me to learn to clean my room, when given a choice of tasks. • My bedroom furniture (couch, wardrobes, tables) will be secured so I do not hurt myself. • Direct care staff will encourage me to leave my mattress on my bed. A safety mat will be kept in my room to keep me from hurting myself if I choose not to sleep on my mattress.
• I have a diagnosis of Minimal anemia.	• My nurses will ensure I take medication, as ordered. Lab work will be completed, as ordered.
• I weigh more than I should. My December 2012 weight was 157.4 pounds. Over the past year, my weight has ranged from a low of 141 pounds (January 2012) to a high of 160.2 pounds (November 2012). My current weight is 7.4 pounds above my new recommended weight range (115 - 150 lbs.).	• Direct care staff will ensure I receive a supplemented diet (midafternoon and bedtime snacks with supplement), as recommended by my family. • Direct care staff will encourage me to exercise to help me to achieve a weight within my recommended weight range.
• I have a diagnosis of Constipation. No problems have been reported during the past year.	• Direct care staff will ensure I drink eight glasses of water daily. • My nurses will ensure I take medication to prevent constipation, as ordered. If I still have problems, the nurse will give me additional medication. If needed, I will see my doctor to determine the need for changes in my treatment plan. My Program Coordinator will receive a copy of the doctor's report.
• I have a diagnosis of elevated blood pressure without hypertension.	• At this time, I am not taking any medication. My blood pressure will be monitored as often as my doctor thinks is needed. He will review the readings on a routine basis. If I should have any problems with my blood pressure, my nurse will inform my Program Coordinator.
• I have cataracts on both eyes. My last vision exam was completed by Dr. Teed on 05/28/09. He reported my vision as 20/40 in both eyes. He noted that my mild cataracts just need to be watched for now. No glasses were prescribed. Another exam was attempted on 07/25/11, but I refused to get out of the car at the doctor's office.	• Another vision exam will be scheduled for me.

GOAL #1: I want to stay healthy.	
BARRIERS	**SERVICES/SUPPORTS**
• On 04/01/11, my Team members were contacted to discuss some mealtime concerns. One concern was that I often go into the kitchen and get snacks without a staff member being present. Since I gulp milk, take large bites of snack items, and swallow without adequate chewing, my Team was concerned I would choke. A recommendation was made for my doctor to address whether I can have any kind of milk since this seems to be one of the things I really like. [As recommended, Dr. Gehrki ordered that I may have regular milk on 04/03/11.] It was also recommended that small portions of snack items be made available to me, such as individual servings of pudding, small donuts, small cookies, etc. An increase in supervision was also recommended. On 05/24/11, my Team members were contacted again. It was recommended that Enhanced Supervision/Monitoring procedures be implemented when I am in the kitchen. • At times, I eat or drink from other people's plates or glasses and use my fingers to eat when utensils are more appropriate. • At times, I overfill my mouth and eat too fast. I have a diagnosis of Dysphagia (difficulty swallowing), oral phase. On 01/10/13, a Dysphagia Disorders Survey (DDS), Choking Risk Assessment (CRA), and Pneumonia Risk Assessment (PRA) were completed. The DDS revealed that I have a mild disorder in feeding/swallowing. On the CRA, I received a score of 70%, which indicates that I am at increased risk for choking based on this screening. On the PRA, I received a score of 20%, which indicates that I am at normal risk for pneumonia based on this screening.	• Direct care staff will use Enhanced Supervision/Monitoring procedures when I am in the kitchen. This means a staff member will be right with me at all times when I am in the kitchen. Such monitoring should be of such a level that problematic behavior will be much less likely to occur or, should it occur, it will be quickly detected. During Enhanced Monitoring, my group leader/alternate should be designated as having primary responsibility for me. • Direct care staff will ensure I receive a modified texture diet (mechanical soft with gravy or sauce to make food moist; may use ketchup, mustard, or syrup to make food moist instead of gravy) to prevent choking. They will also ensure that small portions of snack items are made available to me. If I should have problems with choking, my nurse will inform my Program Coordinator. • Based on the results, it is recommended that I should continue with my present diet with no additional evaluations warranted at this time. Should I have changes in my nutritional or respiratory status then further evaluation and treatment may be warranted. It was also recommended that staff should continue to cue me to chew food well and drink at a slower pace.
• I have a diagnosis of Allergic Rhinitis. However, I am not taking any medication at this time.	• If I should have problems, an appointment will be scheduled for me to see my doctor.
• I have a diagnosis of Dysmenorrhea (severe pain or cramps in the lower abdomen during menstruation).	• My nurses will ensure I receive medication, as ordered.
• I was seen in the Dental Clinic on 01/03/13. My oral hygiene was rated as poor and it was noted that I have gingivitis. • My Dentist noted bruxism on my most recent Dental Assessment. This means I grind my teeth. • I am usually uncooperative in the Dental Clinic.	• Direct care staff will provide brushing for me three times daily, flossing once daily. They will also monitor toothbrushing, checking for plaque and/or inflamed gums. • Appointments for me to have my teeth cleaned will be scheduled every four months. Direct care staff will be present during dental procedures. • To help me become more cooperative when I go to the Dental Clinic, desensitization appointments will be scheduled for me to just have my teeth brushed.

GOAL #1: I want to stay healthy.	
BARRIERS	**SERVICES/SUPPORTS**
• I have a diagnosis of Hypothyroidism. This means I have a deficiency in the production of thyroid hormones by the thyroid gland, resulting in a slowing of the metabolic rate.	• My nurses will ensure I receive medication to treat this condition. Lab work will be completed, as ordered.
• I have a diagnosis of Foot xerosis (excessive dryness), bilateral. I also have a diagnosis of Severe hyperkeratosis (thickening of the skin) bilateral plantar feet. • I do not know how to put lotion on my feet.	• My nurses will ensure I receive treatment for my feet, as ordered. Appointments with the podiatrist will be scheduled, as ordered. • Direct training will be provided for me to learn to put lotion on my feet.
• I do not know how to take my medication without help from the nurse. I have been working on an objective to learn the purpose of one of my medications. However, my progress has been limited. My Team recommended that training on this objective be discontinued. • After reviewing my Self-administration Assessment, my Team is in agreement that I am completing the steps of the Self-administration of Medication program to the best of my ability so no further training was recommended. • At times, I refuse to come to the medication room to take my medication.	• My nurses will encourage me to complete the skills I have demonstrated the capability of completing (wait my turn to come to the medication room, remain in the medication room until all my medication is dispensed, drink liquids without spillage, throw away my trash). • When I refuse to go to the medication room, this will be documented on a Behavior Report. Then, my nurse will take my medication to me in my private room and give it to me there.
• At times, I have problems with urinary tract infections (UTI). However, no problems were reported during the past year. I will say that my back is hurting when I have a UTI.	• Appointments will be scheduled for me to see my doctor, as needed.
• At times, I am uncooperative for medical/lab procedures. • Three appointments have been scheduled for me to go for a bone density test but I refused to go each time.	• To help me become more cooperative, the following Calming/Desensitization Techniques will be used. Before a procedure, a familiar staff member should clearly and simply explain the procedure to me. During the actual course of the procedure, I will be comforted, kept informed of the ongoing events, and assured of the reasonably expected outcome. The staff member will speak in a soft and soothing manner and use physical contact to comfort me, if appropriate. The staff member will keep me informed as to what is happening and offer assurance periodically about the progress of the procedure. After or on the way back from the procedure, the staff member should comfort me and praise my behavior during the visit. • Another appointment will be scheduled for me to go for a bone density test.
• I am uncooperative for mammograms. I refused my annual mammogram on 10/09/12. I received a breast exam by the clinic physician on 08/01/12, and the result was normal.	• My nurses will complete a breast exam for me monthly. My doctor will complete a breast exam for me every six months. A mammogram will be scheduled for me annually.

GOAL #1: I want to stay healthy.

BEHAVIORAL OBJECTIVES/TRAINING LOCATION AND SCHEDULE/DOCUMENTATION FREQUENCY

*A) In the course of my daily schedule, I will have 0 incidents of physical aggression toward others for 12 months by 01/16/14.
RP: ADAMS/PSYCHOLOGY
Daily
BR per incident

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/PLAN OF ACTION (POA):

*B) In the course of my daily schedule, I will have no more than 5 incidents of tantrum behavior (including profanity/name calling, threats, screaming/crying) per month for 12 months by 01/16/14.
RP: ADAMS/PSYCHOLOGY
Daily
BR per incident

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

*C) In the course of my daily schedule, I will have no more than 6 incidents of noncompliance/refusal per month for 12 months by 01/16/14.
RP: ADAMS/PSYCHOLOGY
Daily
BR per incident

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

D) In the course of my daily schedule, I will have 0 incidents of self-injurious behavior per month for 12 months by 01/16/14.
RP: ADAMS/PSYCHOLOGY
Daily
BR per incident

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

*E) When given a choice of tasks, I will help clean my room 50% of the time for 2 consecutive months by 03/31/13.
SP: DAVIS/290 PINE 1st SHIFT
7 - 5 min sess per week
5 times per week

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

*F) When given a choice of tasks, I will help clean my room 80% of the time for 6 consecutive months by 01/16/14.
SP1: DAVIS/290 PINE 1st SHIFT (non-priority)
SP2: JOHNSON/290 PINE 2nd SHIFT
7 - 5 min sess per week
5 times per week

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
#1											
#2											

COMMENTS/POA:

GOAL #1: I want to stay healthy.

BEHAVIORAL OBJECTIVES/TRAINING LOCATION AND SCHEDULE/DOCUMENTATION FREQUENCY

*G) When I exercise more, I will lose 10 lbs by 01/16/14.

SP: JOHNSON/290 PINE 2nd SHIFT

RP: HAMILTON/REGISTERED NURSE

SP:
3 - 20 min sess per week
3 times per week

RP: weigh monthly

	02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
SP - Record # of sessions I exercised for 20 minutes per month												
RP - Record my monthly weight (recommended weight range 115-150 lbs.)												
COMMENTS												

*H) When requested, I will put lotion on my feet 50% of the time for 12 months by 01/16/14.

SP1: DAVIS/290 PINE 1st SHIFT

SP2: JOHNSON/290 PINE 2nd SHIFT

Daily - 2 min sess
3 times per week

	02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
#1												
#2												
COMMENTS/POA:												

I) When requested, I will put lotion on my feet 80% of the time for 12 months by 01/16/14.

SP1: DAVIS/290 PINE 1st SHIFT

SP2: JOHNSON/290 PINE 2nd SHIFT

Daily - 2 min sess
3 times per week

	02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
#1												
#2												
COMMENTS/POA:												

SERVICE OBJECTIVES

S1) To ensure that I am receiving the lowest effective dosage of medication, staff will ensure a psychiatric consult is scheduled quarterly and the physician considers the need for a medication reduction when I have had zero incidents of physical aggression, tantrum behavior, noncompliance, and self-injurious behavior for 6 consecutive months.

RP1: ADAMS/PSYCHOLOGY REVIEW DATES: By 02/28/13 and monthly until 01/31/14

RP2: HAMILTON/REGISTERED NURSE REVIEW DATES: By 02/28/13, 05/31/13, 08/31/13, 11/30/13

	02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
#1 - Record # of incidents of target behaviors per month												
#2 - Record date I was seen by the psychiatrist and any medication changes												

GOAL #1: I want to stay healthy.												
SERVICE OBJECTIVES												
S2) When staff provides brushing for me three times daily, flossing once daily and monitors toothbrushing, checking for plaque and/or inflamed gums, my oral hygiene should improve from poor to fair. **RP: SPANN/DENTIST** REVIEW DATES: By 05/31/13, 09/30/13, 01/13/14												
02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14	
Record the date of my visit and my oral hygiene rating												

S3) To keep me from hurting myself if I choose not to sleep on my mattress, staff will make sure my safety mat is in good condition. **RP: NASH/OT/PT** REVIEW DATES: By 04/30/13, 07/31/13, 10/31/13, 01/31/14											
02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
Record monitoring date and condition of my safety mat											

GOAL #2: I want to participate in more leisure activities.	
BARRIERS	SERVICES/SUPPORTS
• During the past year, I attended training in the Adult Enrichment I (AE I) training area. I have been listening to music, watching television, completing art activities, cutting out pictures, working Word Find puzzles, looking at magazines, and assembling puzzles. These are my favorite activities. • My leisure and interaction skills are limited. I do not always finish the leisure activity I start. When I do finish an activity, I do not put away my materials. I do not respect property belonging to other people or share materials. I do not always want to stay in training the entire time. • Depending on my mood, there are some days when I am very particular as to which staff members work with me in AE I.	• Direct training will be provided for me to finish a leisure activity. Direct training will also be provided for me to put away my materials when I finish an activity. • Encouragement will be provided for me to stay in training the entire time. When I choose to leave training early and return home, direct training will be provided for me to finish a leisure activity, put away my materials, and help set up my place setting for lunch, with assistance. If I return home before 2:45 p.m., I will help clean my room. An objective is already in place for this skill. • My choices regarding staff members will be respected, as much as possible.
• I do not always choose age appropriate leisure items. This was discussed by my Team during a Team Meeting held on 02/04/10. My family stated that it is difficult to find age appropriate leisure items that I enjoy. It was recommended that staff members who work with me daily contact my QDDP regarding changes in my preference of leisure activities so this information can be passed along to my family.	• Staff members who work with me daily will contact my QDDP regarding changes in my preference of leisure activities so this information can be passed along to my family.

GOAL #2: I want to participate in more leisure activities.

BEHAVIORAL OBJECTIVES/TRAINING LOCATION AND SCHEDULE	DOCUMENTATION FREQUENCY
*J) When I finish an activity, I will put away my materials, with no more than 4 reminders, 50% of the time for 9 months by 01/16/14. **SP: THOMAS/AE I** **RP: MITCHELL/290 PINE SUPERVISOR**	SP: 9:00 - 11:00 a.m. 1:00 - 2:45 p.m. RP: (when I refuse to stay in training) 3 times per week

	02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14
SP												
RP												

COMMENTS/POA:

K) When provided verbal prompts, I will finish a leisure activity 50% of the time for 6 months by 01/16/14. **RP: MITCHELL/290 PINE SUPERVISOR**	9:00 - 11:00 a.m. 1:00 - 2:45 p.m. (when I refuse to stay in training) 3 times per week

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

*L) When provided verbal prompts, I will finish a leisure activity 80% of the time for 6 months by 01/16/14. **RP: THOMAS/AE I**	9:00 - 11:00 a.m. 1:00 - 2:45 p.m. 3 times per week

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

*M) When I choose to leave training early and return home, I will help set up my place setting for lunch, with assistance, 80% of the time for 6 consecutive months by 01/16/14. **RP: MITCHELL/290 PINE SUPERVISOR**	All sessions All sessions

02/13	03/13	04/13	05/13	06/13	07/13	08/13	09/13	10/13	11/13	12/13	01/14

COMMENTS/POA:

There are many people at the Center who will work with me to help me achieve my goals. They have found I progress faster if I am reinforced for doing things I need to do. Some of my most effective reinforcers include beverages and foods, especially milk, soft drinks, and soft cookies; social praise; staff attention; extra free-time; listening to music; watching television, especially "The Price Is Right," Shirley Temple movies, Court TV, and music videos; working Word Find puzzles; using colored pencils; going to see preferred staff members; wearing sunglasses/safety goggles; and shopping at the Dollar Store. I can do some things for myself that will help me achieve my goals. Some of them are:

- I communicate my wants and needs verbally. I start a conversation with staff and let them know what I like and dislike.
- I dress and undress with no prompting from staff members. I arise and dress when verbally prompted.
- I toilet with no prompting from staff members, except for closing the door before using the toilet. However, this is considered a strength for me.
- I wash my hands when requested. I dry my hands, wash my face, and brush my teeth with no prompting from staff members.
- I eat using a spoon, fork, and knife. I drink from a cup/glass, drinking fountain, soft drink can/bottle, and straw. I open a soft drink can and milk/juice carton and pour the contents into a glass without spillage. However, I prefer to drink out of a soft drink can or milk/juice carton rather than pouring the contents into a glass. I use salt/pepper shakers, pour from a pitcher without spillage, and put sugar/sweetener on foods and in beverages.
- I operate a radio, television, cassette tape player, VCR, DVD player, and CD player. I operate light switches and a lamp. I plug and unplug an electrical cord safely.
- I take clothes from my drawers and hangers. I hang clothes on hangers. I put dirty clothes in the hamper. I put clean clothes in the correct drawers. I strip my bed of dirty linens. I open and close doors.
- I get in and out of a car, lock and unlock a car door, and fasten and unfasten my seatbelt. I avoid holes/obstacles when walking. I walk to routine and non-routine places on campus.
- I point to named coins, insert coins/bills into a vending machine, point to a desired item to purchase, verbally indicate a desired item to purchase, pick up a selected item to purchase, place a selected item in a cart/basket, push the correct buttons for a vending purchase, remove the vending item after my purchase is completed, and remove the change from a vending machine. When provided assistance, I make a purchase.
- I wait my turn to come to the medication room, remain in the medication room until all medications are dispensed, drink liquids without spillage, and throw away my trash.
- I sit on furniture appropriately, communicate greetings, look at the speaker's face, maintain an appropriate social distance, shake hands, and assist with passing out snacks to others. I paste/glue objects; use scissors; watch television, movies, and videos; dance; play simple games; look at a newspaper, catalogs, and magazines; listen to music; paint multi-colored pictures; and assemble puzzles. I respond to the source of touch, sound, light, and temperatures. I discriminate sounds. I identify colors, temperatures, textures, shapes, and tastes. When given a choice, I select an activity. I write my first and last names.

OUTCOME 2: I choose my daily routine and how to use my free time.

When I was first admitted, I lived in 287 Pine. I moved to 289 Pine on March 5, 2007, so I could live with ladies who had abilities and interests similar to mine. During a previous annual review meeting, my Team discussed the fact that I would have the opportunity to move to 290 Pine, after some renovations were completed, which would allow me to live with fewer ladies and have more personal space. My Team was in agreement with my moving to this new home. I moved to 290 Pine on October 24, 2007. At times, I have trouble getting along with my housemates but my Team agreed that 290 Pine continues to be appropriate for me. I have my own bedroom in this home. During a previous annual review meeting, my brother requested that my room be decorated to be more home-like. He was told that pictures have been hung on my walls but I remove them soon after they are hung because I do not want pictures on my walls. Different decorations have been discussed with me but I told staff that I do not want anything on my walls.

I am able to choose my daily routine when provided assistance from staff members. During my free time, I am able to choose what I want to do. My preferred activities include spending time alone; talking with preferred staff and persons served; listening to music; watching television, especially "The Price Is Right," Shirley Temple movies, Court TV, and music videos; completing art work/drawing; listening to CDs; working Word Find puzzles; cutting pictures out of magazines; assembling puzzles; going for walks; attending dances; shopping; going to the movies; dining in restaurants; riding a three-wheel cycle; spending time with my family; talking with my family on the telephone; and participating in off-campus activities.

When I want to be alone, I can go to my bedroom. A staff member in my home has been assigned to help me with my personal hygiene, if I should need it. I am satisfied with this arrangement.

Since my previous staffing, my community involvement included going to get my hair cut, shopping, going out to eat in restaurants, participating in a picnic at the Lower Dam, and going to get a pedicure. Staff members who accompanied me during these activities reported that my behavior was appropriate. During the next year, staff members will continue to ensure I have the opportunity to participate in a variety of community activities.

When I am prevented from participating in my regular schedule of activities, with the exception of illness or planned vacation days, I will be provided alternate activities in my residence. These may include recreational activities or activities that reinforce my program in other areas. The doctors at the Center have requested that I stay inside and all outdoor activities be cancelled when the heat index reaches 95 degrees or the wind chill factor is below 20 degrees. The Weather Channel has a website that shows what the heat index or wind chill factor could reach, as well as what it is at any given time. The Program Supervisors will check that website regularly and let other staff know when I need to stay inside.

OUTCOME 3: I exercise my rights and am afforded due process when my rights are limited.

My Social Worker has met with me and explained my rights to me. However, I have some problems understanding them. Staff members talk with me often about what I am able to do and how I should respect the rights of others. Having privacy and personal possessions are the most important rights I exercise. Staff members keep me informed about my medical needs and my rights regarding my services. Some of my rights are restricted due to the fact that I am unable to understand or exercise my civil and legal rights. That is why my brother, Brett Mize, has been named my curator. He makes sure none of my rights are violated and assists me with making decisions in all areas of my life. My Team did not feel that any changes were needed.

My brother must authorize the release of any personal information to outside agencies. This information, as well as reports of outside consultations, is maintained in my master file. Only DDS personnel, who have a need-to-know, have access to my information. Personal Health Information (PHI) is kept confidential in accordance with federal HIPAA and state regulations.

OUTCOME 4: I am respected.

Observation and interviews with staff indicate that I am treated respectfully in all situations. At times, depending on my mood, I prefer being called by a different name (Annie, Shirley Temple). Staff members stated they typically ask me what my name is each day because, at times, I get upset if someone calls me a different name than the one I want to be called. I am related to with dignity and respect in keeping with what is deserving of a human being, an adult, and an American citizen. The Center provides me with the same cultural heritage practiced by my family. My IPP is consistent with the overall treatment philosophy that I am a unique and important person. My Interdisciplinary Team attempts to meet my needs and desires in a manner that is both therapeutic and satisfactory. My right to the pursuit of happiness and a better quality of life is aided by giving me the best treatment and training the Center has to offer. In the event services other than the Center can provide are indicated, such are secured.

OUTCOME 5: I am safe.

The following levels of supervision have been established to ensure I am safe and receive necessary monitoring during my daily routine:

Sleeping	**Indirect supervision should be provided.** A staff member checks on me periodically to make sure I am all right. A safety mat will be kept in my room to keep me from hurting myself if I choose not to sleep on my mattress.
Dressing	**Independent** - I dress and undress with no prompting from staff members. I arise and dress when verbally prompted.
Toileting	**Independent** - I toilet with no prompting from staff members, except for closing the door before using the toilet. However, this is considered a strength for me.
Grooming	**Indirect supervision should be provided.** I wash my hands when requested. I dry my hands, wash my face, and brush my teeth with no prompting from staff members.
Bathing	**Indirect supervision should be provided.** Indirect supervision means that a staff member is in the area with me but she does not have to be within arm's length and she may be supervising more than one person at a time.
Toothbrushing	**Indirect supervision should be provided.** Direct care staff will provide brushing for me three times daily, flossing once daily. They will also monitor toothbrushing, checking for plaque and/or inflamed gums.
Mealtime Information	**Enhanced Supervision/Monitoring will be provided.** **Diet order:** Mechanical soft with gravy or sauce to make food moist; midafternoon and bedtime snacks with supplement; may have regular milk; 8 glasses of water daily; may use ketchup, mustard, or syrup to make food moist instead of gravy **Adaptive Equipment:** none **Special Needs:** Staff should continue to cue me to chew food well and drink at a slower pace
Campus Mobility	**Independent**
On-campus activities	1:8 ratio
Off-campus activities	1:2 ratio
Sunscreen Protocol	The AHDC sunscreen protocol will be followed when I need to be outside more than 30 minutes. Staff will make sure sunscreen is applied to my skin at least 30 minutes before going out and reapplied every 1 - 2 hours. Any signs of sunburn will be documented on a Marks Report and reported to the nurse. Frequent breaks and hydration will also be provided.
Self-administration of medication	My nurses will encourage me to complete the skills I have demonstrated the capability of completing (wait my turn to come to the medication room, remain in the medication room until all my medication is dispensed, drink liquids without spillage, throw away my trash).
Emergency Procedures	During fire or tornado drills, I comply with requests regarding following proper procedures. However, supervision and guidance should be provided to ensure I remain safe.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

BRETT RENOUDET MIZE,
as SPECIAL ADMINISTRATOR
of the ESTATE of BRENDA MIZE, DECEASED

CLAIMANT

VS.

CLAIM #13-0865-CC

STATE OF ARKANSAS,
DEPARTMENT OF HUMAN SERVICES,
DIVISION OF DEVELPOMENTAL
DISABILITIES SERVICES

RESPONDENT

RESPONDENT'S PRE-TRIAL BRIEF

Comes now Respondent, the State of Arkansas, Department of Human Services, Division of Developmental Disabilities Services ("DDS"), submits the following points and authorities:

Introduction

The Claimant herein seeks damages in the amount of $1,000,000 from the Arkansas Department of Human Services, Division of Developmental Disabilities Services (hereinafter "DDS"), for a claimed wrongful death of Brenda Mize. Brenda Mize died on February 10, 2013, at the age of 47 years. At the time of her death, Brenda Mize was a resident of the Arkadelphia Human Development Center ("HDC") and had been institutionalized there for approximately 8 years. Prior to her admission to the HDC, Brenda Mize was institutionalized elsewhere for a number of years, as well. The HDC is an intermediate care facility for the mentally retarded. It is a training facility and not a nursing home. Brenda Mize was a person with severe intellectual disabilities and suffered from mental illness. She was mentally retarded.

Claimant, Brett Mize, administrator of the Estate of Brenda Mize, asserts a wrongful death claim on behalf of himself, his father and the siblings of Brenda Mize. Claimant assets that HDC staff were negligent because Brenda Mize ate food without staff supervision in the kitchen of her home, which he asserts was in violation of Brenda's Individual Program Plan (hereinafter "IPP" or "care plan"). Brenda Mize later choked in her bedroom and collapsed in the hallway of her home. Claimant further asserts that the HDC staff resuscitation efforts to unblock Brenda's airway and to save her life were also negligent.

For the reasons more fully explained below, the claim should be denied because evidence, presented through the depositions and the video recording of the events complained, show no wrongful act, default or neglect by HDC staff. Though the event was tragic and unfortunate, it was not negligent or wrongful. Page 21 of the Brenda's care plan (IPP), established that Brenda was independent in her home and was not under direct, enhanced supervision as argued by Claimant. Instead, page 21 of the IPP, the portion titled as the IPP "outcome," established the that Brenda Mize was only under "enhanced" supervision at scheduled "mealtimes." Enhanced supervision is direct, close supervision or monitoring of a resident. These events did not occur during any mealtime nor are they alleged to have happened at any mealtime. Significantly, as will be explained below, even Claimant's own "expert" witness, Karen McGowan, agreed that the levels of supervision for Brenda were identified on page 21 of the IPP and *only* required "enhanced" supervision at "mealtime." Thus, Claimant's arguments to the contrary are unsupported by the evidence, including his *own* evidence.

Dr. Stephen Schexnayder, an Arkansas Children's Hospital emergency room physician, who is a full professor of medicine and a leading national expert in resuscitation/CPR, reviewed the video recording of the event, and found the CPR performed by HDC staff to be reasonable

and adequate under the circumstances. Dr. Schexnayder explained that because Brenda's airway was blocked, she could not be saved unless her airway was cleared (Schexnayder 40/17-20). He further opined that chest compressions, not rescue breaths, were designed to clear a blocked airway on an unresponsive choking victim like Brenda (Schexnayder 30/15-24). Dr. Schexnayder's testimony alone negates any actionable claim of negligence against staff in their CPR efforts to save Brenda.

Significantly, even Claimant's expert medical witness, Dr. Tarr, agreed that performing rescue breaths on a person who, like Brenda, was totally blocked would be "futile" (Tarr 48/16-20). Dr. Tarr also testified that one function of chest compressions was to dislodge such a blockage (Tarr 49/11-19; 50-11-15). Thus, Claimant's argument that the CPR was negligent because HDC staff failed to provide rescue breathing to Brenda in the standard recommended cycle of 30 chest compressions to two rescue breaths is unsupported by the medical testimony and, again, contrary to his *own* evidence.

Consequently, the acts complained of by Claimant about the level of staff supervision for Brenda and the CPR performed to save her life, were neither wrongful nor neglectful as required in order for Claimant to prevail on his wrongful death claim.[1]

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[1] It is anticipated that Claimant will also introduce a "survey" conducted by the Office of Long-Term Care (hereinafter "OLTC") and the deposition of Les O'Neal, the OLTC surveyor. As explained more fully in the last section below, the OLTC survey was materially flawed. As conceded by the surveyor in his deposition, the survey was based on inaccurate facts, incorrect interpretations, and misapplied regulations. The surveyor admitted that the survey based on his own "interpretation" of the IPP supervision requirements for Brenda and not on what the IPP actually required (O'Neal depo 55/24; 76/13-25). He also acknowledged that he misapplied of the federal standard on CPR certification requirements for staff (O'Neal depo 58/20-59/2), and agreed that, despite his own survey findings, one way to dislodge a blocked airway on an

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Argument

Claimant sued DDS for wrongful death under Ark. Code Ann. §16-62-102, the Wrongful Death Statute, which provides:

> (a)(1) Whenever the death of a person or an unborn child as defined in § 5-1-102 is *caused by a wrongful act, neglect, or default* and the act, neglect, or default would have entitled the party injured to maintain an action and recover damages in respect thereof if death had not ensued, then and in every such case, the person or company or corporation that would have been liable if death had not ensued shall be liable to an action for damages, notwithstanding the death of the person or the unborn child as defined in §5-1-102 injured, and although the death may have been caused under such circumstances as amount in law to a felony.

(italics added).

In order to prevail on a wrongful death claim for either (1) the asserted failure to supervise Brenda or (2) for the claim that the CPR was improperly administered to Brenda under the circumstances, then Claimant must first establish the acts or defaults complained of were either wrongful or neglectful. Thus, Claimant must establish that staff had a *duty* under the IPP/care plan to provide "enhanced" supervision to Brenda at the time she was entered the kitchen of her home, that staff *breached that duty of care* and that the breach was the *proximate cause of Brenda's death* or Claimant must establish the CPR performed by staff was so deficient under the circumstances that it *breach the duty of care* owed to Brenda *and proximately caused her death*. The law of negligence requires the plaintiff in a lawsuit to establish that a duty was

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unresponsive choking victim was through chest compressions done to Brenda and then, if and when dislodged, start rescue breaths (O'Neal depo 47/4-15). The surveyor admitted that his survey completely failed to account for the AED (automatic defibrillator) directed pauses in the CPR (O'Neal depo 55/1-6) even though he knew that an AED was used during the rescue (O'Neal depo 50/19-22).

owed by the defendant. *Kowalski v. Rose Drugs,* __ Ark. __, 376 S.W.3d 109 (2011). The law of negligence also requires that the breach be the proximate cause of the injury. Before an act can be said to be the proximate cause of an injury, the injury must be the probable and natural consequence of that act. *Gathright v. Lincoln Ins. Co.*, 286 Ark. 16, 688 S.W.2d 931(1985). It must be a cause which, in a natural and continuous sequence, produces damage and without which the damage would not have occurred. *Schubert v. Target Stores, Inc.,* 2010 WL 4910126 (Dec. 2, 2010).

Based upon the evidence and testimony of the witnesses, including the deposition testimony of the both parties' expert witnesses, Claimant failed to prove the staff conduct was either wrongful or neglectful on both claims.

Brenda Was Only Under "Enhanced" Supervision At Mealtime

Despite the clear language of page 21 of Brenda's IPP, Claimant argues that Brenda was to be supervised whenever she was in the kitchen and cites page 13 of the IPP as the basis for his claim. He asserts that because Brenda was not supervised when she was in the kitchen, that staff breached the IPP. However, Claimant's argument is out of context and is contrary to the evidence. The IPP clearly directed that Brenda only be on enhanced supervision at mealtime. *See* IPP, page 21 – Exhibit 1 attached hereto.

Page 21 of Brenda's IPP listed the levels of supervision for Brenda. Margo Green, the HDC Superintendent with twenty years of experience running an HDC, testified that Brenda's levels of supervision were stated on page 21 of the IPP (Green 79/14-20). Cheryl McKay, the IPP coordinator, also testified that Brenda's levels of supervision on were listed on page 21 of the IPP (McKay 33/8-10). Even Karen McGowan, Claimant's *own* expert witness agreed that page 21 of the IPP identified the levels of supervision established for Brenda (McGowan 136/7-

18). Thus, Claimant's claim that the supervision requirement is listed on page 13, instead of page 21, is incorrect and contrary to the witness testimony, including the testimony of his *own* expert witness.

Page 21 of the IPP states "[t]he following levels of supervision have been established to ensure I am safe and receive necessary monitoring during my daily routine." It then lists the levels of supervision for Brenda. All levels listed for Brenda are either "indirect supervision" or "independent" except for "mealtime," which is listed as "enhanced supervision/monitoring." See IPP, p. 21 – Exhibit 1.

Significantly, this was also agreed upon by Ms. Green, Ms. McKay and Karen McGowan, Claimant's expert witness. Ms Green testified that, per page 21, Brenda was to have direct enhanced supervision during meals and snack time only (Green 16/13; 80/6-12; 82/22-25; 110/18-20; 114/14-18; 116/5-7). Ms. McKay also testified that enhanced supervision was listed for Brenda under "Mealtime Information" only (McKay 58/17-21). She explained that there were only three meals per day and snacks were scheduled (McKay 58/23-59/7). Finally, Ms. McGowan stated that page 21 of the IPP required "enhanced supervision" only at "mealtime" (McGowan 136/19-25).

Thus, there was no dispute in the evidence that Brenda was only to be on enhanced supervision at mealtime under her IPP. There was also no dispute that when Brenda entered the kitchen on February 9, 2013 and ate, it was not one of the scheduled mealtimes.

Despite this evidence, Claimant argues that it is page 13, not page 21 of the IPP that controls the supervision level Brenda. It is anticipated that Claimant will rely on statements made by several witnesses after Claimant directed each of them to page 13, without directing

them to page 21 as well. Thus, the witnesses were question by Claimant without the benefit of reviewing the remainder of the IPP, particularly page 21.

As a result of Claimant's tactic, several of the witnesses *initially* agreed with Claimant because it *appeared* that page 13 discussed supervision when Brenda was in the kitchen. **Every one of these witnesses later corrected their testimony when asked about page 21 of the IPP during questioning by Respondent, DDS.**

Moreover, Claimant's argument about page 13 simply ignores the context expressed at the beginning of page 13, itself ("On 04/01/11, my Team members were contacted to discuss some mealtime concerns."). *See* IPP, page 13 – Exhibit 1. Hence, we know that the discussion the followed was about the Team's "mealtime concerns." Thus, Claimant's arguments are negated by the very expressed context upon which the discussion on page 13 was based. In context, it is clear that the discussion on page 13 was not simply requiring supervision whenever Brenda walked into the kitchen as argued by Claimant but, instead, it was when she was in the kitchen at "mealtime." Placed in proper context, page 13 is consistent with page 21, which required enhanced supervision only at mealtime.

This is also consistent with the testimony of Ms. Green, the HDC Superintendent, who testified Brenda was independent in the home at all times other than mealtime (Green 116/8-9; 80/13-16). She explained that this meant that Brenda could walk anywhere in her cottage on her own, be alone in her room, and be alone in the bathroom (Green 80/17-22). Ms. Green confirmed that it was <u>not</u> a violation of Brenda's IPP simply because Brenda was in the kitchen eating without supervision because Brenda was free to move around the home without supervision (Green 17/25-18/1; 47/14-15). However, if staff knew that Brenda went into the kitchen for a snack or to look through the refrigerator, they were to supervise her at that time

(Green 18/9-12). The staff here did not know Brenda was in the kitchen (Green 121/7-8). At the point staff found out Brenda was in the kitchen, they went to check on her (Green 47/16-17) and reacted (Green 115/12-13; 121/12-14). She further explained that Brenda was even allowed to walk without supervision between building on campus (Green 81/5-9; 81/18; 82/15-21).

Likewise, Ms. McKay and Ms. McGowan (Claimant's expert witness) both testified that that Brenda was independent and could go anywhere in her home (McKay 61/ 9-15) (McGowan 148/25-149/5). Ms. McKay stated there was no guard at the kitchen door and the door may not legally be locked (McKay 61/16-19) without the approval of the human rights committee because locking the door was a restriction (McKay 60/1-2). Even Ms. McGowan, Claimant's expert witness, testified that the HDC cannot just lock the kitchen door to keep residents out of the kitchen because that is a restriction that must be approved by a "Human Rights Committee" (McGowan 147/20-21). Ms. McGowan acknowledged that even if the restriction to lock the kitchen door was requested, it was a request that could not be honored because locking the door to the kitchen also restricted the rights of the other residents of the home (McGowan 148/17-20). Ms. McGowan confirmed the care plan did not state that staff was to provide one on one supervision to make sure Brenda does not go into the kitchen (McGowan 149/19). She also confirmed that when staff learned Brenda was in the kitchen, they got her out (McGowan 150/2-4).

Based upon the evidence, particularly, Brenda's IPP, it is clear that Brenda was independent and not supposed to be under enhanced supervision when she entered the kitchen on February 9, 2013 and ate. Moreover, Brenda was not on "one to one" supervision or enhanced supervision in her home (or on campus) throughout the day. Thus, staff was not required to be

with her at all times, as Claimant argues. When staff learned that Brenda was in the kitchen staff responded and got her out.

Consequently, the supervision claim should be denied because HDC staff had no duty to supervise Brenda every time she walked into the kitchen, particularly when staff was unaware she even walked into the kitchen. Moreover, there was no breach of any duty to supervise Brenda because the HDC staff complied with Brenda's IPP. For staff to be with Brenda every time she walked into the kitchen or to otherwise keep her out of the kitchen her as Claimant argues, staff would have needed to supervise (or guard) Brenda "one on one" at all times throughout the day or lock the kitchen door, neither of which the IPP required or envisioned.

Because the staff fully complied with Brenda's IPP, the staff supervision here was neither wrongful or neglectful, as required in order for Claimant to prevail under the wrongful death statute. Therefore, this claim should be denied.

HDC Staff Efforts to Save Brenda Were Proper

In addition to the supervision claim, Claimant also asserts that the rescue efforts of HDC staff in administering CPR were negligent. In particular, Claimant takes issue with what he believes is the failure of HDC to administer CPR strictly in accordance with the recommended 30 chest compressions to 2 rescue breaths ratio and because of several pauses in the administration of CPR. However, Claimant's arguments were specifically rejected by Dr. Stephen Schexnayder, a leading expert in the field of adult and pediatric resuscitation and CPR. Moreover, even Claimant's *own* medical expert, Dr. Tarr, agreed that chest compressions are a way to dislodge a choking victim's blocked airway and trying to administer rescue breaths to a

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person with a blocked airway is futile.[2] Even Claimant's other expert, Karen McGowan testified that administering the two rescue breaths would do nothing since Brenda's airway was blocked (McGowan 111/3-8).

Oddly, Claimant complains there were too many chest compressions and not enough rescue breaths despite the expert testimony that the chest compressions, and not the rescue breaths, were Brenda's *only* chance at survival until her airway cleared. However, all agree that rescue breaths were given, just not in the strict 30-2 ratio as one would give a primary cardiac arrest patient who was not choking with a blocked airway.

Despite all this medical testimony to the contrary, including that of Claimant's *own* experts, Claimant asserts that the failure to provide rescue breaths in strict accordance with the CPR guidelines 30 to 2 ratio was negligent. It clearly was not.

Respondent, DDS, called Dr. Stephen Schexnayder as its expert witness and Dr. Schexnayder testified by deposition. Dr. Schexnayder is a "critical care physician" at Arkansas Children's Hospital (Schexnayder 5/25-6/6). He practices in the hospital's intensive care unit (ICU), emergency room and is on the hospital sedation team (Schexnayder 6/6-8; 8/7-11). Dr. Schexnayder also teaches UAMS medical residents and fellows (6/10-12). Including his residency and fellowship, Dr. Schexnayder has practiced medicine at Arkansas Children's

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[2] Dr. Tarr testified that Brenda appeared to be "totally blocked" (Tarr 48/10). He admitted that it is probably futile to perform rescue breaths on a person who is totally blocked (Tarr 48/16-20). He stated that it is a "reasonable assumption" that Brenda could not get any air in until her airway blockage was cleared (Tarr 54/22-3) and that one function of chest compressions is to dislodge a blockage (Tarr 49/11-19; 50/11-15). Dr. Tarr stated that the chest compressions were the most important thing to do (53/19-24).

Hospital for 27 years (Schexnayder 6/19-25). He is a physician licensed in the State of Arkansas (Schexnayder 7/6).

Dr. Schexnayder is board certified by the American Board of Pediatrics in both general pediatrics and critical care medicine (Schexnayder 7/9-10). He is also board certified in adult internal medicine by the American Board of Internal Medicine (Schexnayder 7/11-14). In addition to his board certifications, Dr. Schexnayder is certified in pediatric advanced life support and is involved in national training and development programs in advanced life support (8/17-21). He is certified in both pediatric and adult advanced life support by the American Heart Association ("AHA") (Schexnayder 8/25-9/3).

Dr. Schexnayder served at the national level with the American Heart Association and was one of the authors of their CPR guidelines (Schexnayder 9/7-10). He was the national chair of the AHA's Pediatric Resuscitation Committee and served on the Emergency Cardiac Care Committee which oversaw the writing of the American Heart Associations' CPR guidelines (9/15-19). Dr Schexnayder was a named author on the AHA's 2010 CPR guidelines Executive Summary, which was the overall view of the CPR guidelines (Schexnayder 10/3-5; 12/9-11). He also was a named author of two chapters within the guidelines (Schexnayder 10/5-6).

Dr. Schexnayder's extensive *Curriculum Vitae* (CV) is attached to as Exhibit 2.

Dr. Schexnayder reviewed several witness depositions, the video, and Brenda Mize's medical records from the Arkadelphia hospital emergency room (Schexnayder 18/10-16). He was also provided with information about the make and model of the AED used by the Arkadelphia Human Development Center. [3] (Schexnayder 18/22-25).

[3] An AED is an automatic external defibrillator (Schexnayder 19/3). The AED prompts and walks the operator through the entire process (Schexnayder 21/12). Once the pads are placed on

Dr. Schexnayder recounted that several years ago, the AHA CPR guidelines were called "standards" (Schexnayder 25/18-119). They are now referred to as "guidelines" (Schexnayder 25/20). This is because the guidelines need to be applied to the *individual* circumstances and that every cardiac arrest is different (Schexnayder 25/22-24).

They are not standards. He testified that the guidelines are *"not one size fits all"* (Schexnayder 26/19-22). He further explained that the guidelines themselves account for the fact that they need to be *adapted to the individual situation* (Schexnayder 27/18-22). Dr. Schexnayder read a portion from the Executive Summary of the American Heart Association's 2010 CPR Guidelines, as follows:

> "The recommendations in the 2010 *Guidelines confirm the safety and effectiveness of many approaches*, acknowledge an effectiveness of others, and introduces new treatments based upon intensive evidence, evaluation, and consensus of experts. The new recommendations do not imply that using past Guidelines is unsafe or ineffective. In addition, *it's important to note they will not apply to all rescuers and all victims and all situations. The leader of the resuscitation attempt may need to adapt application of these recommendations."*

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the person, the cords are plugged into the AED and the AED orally instructs the operator that it is analyzing and not to touch the patient (Schexnayder 22/12-13). This process takes approximately 30 seconds (Schexnayder 23/10-13). The AED will then orally instruct the operator to either shock or start CPR (Schexnayder 23/10-13). It then recycles through the same process every two minutes, instructing the operator to not touch the person while it reassesses (Schexnayder 24/4-9).

Dr. Schexnayder testified that the pauses in CPR observed on the video were generally consistent with the cycling of the particular AED used by HDC staff (Schexnayder 47/22-48/4). There were a few pauses in the 20-30 second range and one for approximately 35 seconds (Schexnayder 48/1-2). He testified the use of the AED was appropriate here (48/14-16).

Dr. Schexnayder explained that in some situations there is a primary cardiac arrest and in others, such as with a choking victim, the cardiac arrest is secondary (Schexnayder 28/3-15). He explained it is secondary because the heart stops due to a low oxygen level, which in choking instances, is due to the blocked airway (Schexnayder 28/14-19).

Dr. Schexnayder testified that with a choking victim, you first need to establish an airway for the patient to get air (Schexnayder 29/3-4). The obstruction needs to be relieved (Schexnayder 29/4-5). **"If the patient is unconscious, the current recommendation is for chest compressions."** (Schexnayder 29/5-6). The purpose of the chest compressions is to generate pressure in the chest in order to dislodge the blocked airway (Schexnayder 30/15-24).

He explained that in past guideline versions, the use of "back blows" to try to dislodge the blockage and "abdominal thrusts" was included for unconscious choking victims (Schexnayder 29/9-15). He testified that there is no data to suggest that any one method is more effective than the others (29/19-21). Though "back blows" and "abdominal thrusts" are not part of the current recommendations, Dr. Schexnayder testified that they are not incorrect and, scientifically, are equally effective (Schexnayder 31/2-5).

Dr. Schexnayder testified that Brenda collapsed within a minute of her complete airway obstruction (Schexnayder 35-2-4; 35/8). However, he explained that Brenda was not in cardiac arrest when she first collapsed (Schexnayder 35/13-16). Dr. Schexnayder opined that Brenda likely went into cardiac arrest at 7:26:15, approximately two minutes *after* she first collapsed (Schexnayder 37/22-38/2; 38/3-12). He explained that the cardiac arrest occurred when Brenda lost all muscle tone (Schexnayder 37/25-38/2). He found that HDC staff administered chest compressions began within *a minute* of the time that Brenda went into cardiac arrest (Schexnayder 39/39/1). **Dr. Schexnayder opined "[t]hat's very reasonable care for someone**

who has a cardiac arrest." (Schexnayder 39/4-5). **He further opined "in a residential setting like this, I think that's really quite good."** (Schexnayder 39/9-10). Dr. Schexnayder testified staff was also observed actually removing food from Brenda's mouth (Schexnayder 37/19) and was still removing food from her mouth after she was placed flat onto the floor (Schexnayder 38/17-18).

Significant to Claimant's assertions here, Dr. Schexnayder explained that **if the airway is blocked, there is no value in giving breaths to the victim** (Schexnayder 40/1-5). **Cardiac function cannot be restored if the airway is completely blocked** (Schexnayder 44/2-5). If the complete airway obstruction is not relieved, the patient has no chance of survival (Schexnayder 45/16-18). He stated that **"if the airway is completely blocked, you can't get air in, and you never will resuscitate a patient from asphyxia arrest."**[4] (Schexnayder 40/17-20). Dr. Schexnayder testified that though the rescue breath cycle is 30 chest compressions to two breaths (64/15-17) the rescue breaths would not be helpful until the airway was cleared (67/8-14). **Dr. Schexnayder testified that if he were the person there, he would focus "all" his efforts up to the 7:26 period [when Brenda went into cardiac arrest] to clearing the airway** (79/4-8). Then, once Brenda went into cardiac arrest, the airway clearance maneuver [chest compressions] is the same as the CPR (79/8-11). **Dr. Schexnayder testified that he had no criticisms of staff from 7:24 to 7:26 "[b]ecause they were doing things that seemed to clear the airway."** (80/1-4; 80/18).

Based upon his review of the video here and upon the CPR guidelines, Dr. Schexnayder opined, to a reasonable degree of medical certainty, that:

1. that Brenda Mize suffered a complete airway obstruction (Schexnayder 42/41/24-42/5)

[4] Asphyxial cardiac arrest is cardiac arrest caused by a blocked airway (40/4-7).

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2. **the chest compressions performed by HDC staff were "the appropriate way to relieve her [Brenda's]obstructed airway"** (Schexnayder 44/23-24); and

3. **the chest compressions and rescue efforts by HDC staff, which he observed on the video, were reasonable.** (Schexnayder 49/9; 49/14; 51/).

Dr. Schexnayder explained that for patients who experience out-of hospital cardiac arrest, the national survival rate to hospital discharge is just six percent (Schexnayder 49/10-12). He stated though the rescue efforts here were reasonable, he believed the outcome was not unexpected (Schexnayder 49/13). He testified that approximately 400 people die each year from an airway obstruction that cannot be cleared (Schexnayder 45/23).

Dr. Schexnayder also addressed the use of a suction machine. He testified that a suction machine would not be helpful with a complete airway obstruction (Schexnayder 51/9-13) because, when used in adults, the suction tubing inserted into the mouth is much smaller that the object that caused the complete obstruction (Schexnayder 51/13-17). Suction machines are designed to remove *thin* secretions such as saliva, blood or particulate matter (Schexnayder 51/17-22).

Dr. Schexnayder opined that the rate of the chest compressions by staff looked appropriate (95/6) and, if he were present, would not have made corrections to it (95/9-12). **Dr. Schexnayder testified "I believe it was a reasonable resuscitation attempt."** (110/15-16; 110/23-24). Dr. Schexnayder noted that that biggest pause in the resuscitation was actually when the EMS took over (111/22-23).

Consequently, Claimants arguments that the CPR here was somehow deficient, improper or otherwise negligent in any way was specifically rejected by Dr. Schexnayder, a leading expert

in the field, who actually works in the emergency room of Arkansas Children's Hospital and the claim should be denied.

Though Dr. Schexnayder's experience and national expertise are clear and extensive, Claimant's expert witnesses are not as experienced.

Though trained in emergency medicine several years ago, Dr. Tarr testified he actually works at the St. Vincent's Clinic West (Tarr 32/22-24), which is a medical clinic, not a hospital (Tarr 32/25-33/4). He stated it is a clinic where you would go when you have a cold (Tarr 33/5-7). **Unlike Dr. Schexnayder, Dr. Tarr does not actually work in any emergency room** (Tarr 33/8-10). Dr. Tarr also is not published in the fields of emergency medicine, resuscitation, or CPR (Tarr 33/12-21) and he conceded that, unlike Dr. Schexnayder, he had nothing to do with the development of the American Heart Association guidelines on resuscitation, CPR and choking (Tarr 35/1-7).

Claimant's other expert, Karen McGowan, an RN, testified for Claimant about nursing standards in HDCs and about CPR. However, on cross-examination by Respondent, DDS, it was discovered that Ms. McGowan is not certified in CPR or the Heimlich maneuver and has not actually practiced "hands on" nursing since the 1970s, more than 35 years ago. (McGowan 89/1-25; 90/18-23; 129/4). Ms. McGowan testified that she rendered opinions of about other individuals' CPR despite her own lack of certification in CPR (McGowan 90/8-17). Ms. McGowan also testified that she "doubts" the "CDDN" designation which she uses after her name is a title or designation even recognized by the Arkansas State Board of Nursing (McGowan 88/13).

Significantly, much of Claimant's own expert testimony, as point out above, is consistent with the opinions of Dr. Schexnayder and negates Claimant's arguments about the quality of the

CPR. Moreover, as Dr. Schexnayder discussed, because CPR is not 100 % effective for those having an out of hospital cardiac arrest, even assuming *arguendo* that the CPR efforts to save Brenda were somehow negligent, which they were not, the claim should still be denied because failure to perform CPR in a the strict 30-2 ratio (as Claimant asserts) is still no guarantee of survival. Thus, there is no causal connection between the any perceived or claimed improper administration of CPR and Brenda's death. As Ms. McGowan testified, choking can happen to anyone and "it would be stupid to assume" that the Heimlich maneuver works 100 percent of the time (132/11-18). She conceded it does not (132/19-21).

Claimant's Reliance On The Flawed OLTC Survey Is Misguided

After Brenda died, the Office of Long-Term Care ("OLTC") conducted a survey of the facility and found several noncompliance issues. Claimant now relies upon the survey as the basis of his claim. The survey was even attached it to the complaint. However, now that the parties have deposed and questioned the OLTC surveyor and learned the actual basis and grounds of the purported non-compliance by the HDC, it was clear that Claimant's reliance on its findings were misplaced. The OLTC survey of the HDC was flawed and incorrect.

Mr. O'Neal testified that a survey is an inspection (O'Neal 5/3-4). He stated that the HDC is not a nursing home, not a skilled nursing facility but, instead, is a training facility (O'Neal 26/8-13). He stated that anytime a resident of the facility goes to an emergency room, the facility must report it to OLTC, which the HDC did (O'Neal 8/19-21). As a result, there was a survey on February 12, 2013 (O'Neal 9/6).

Significantly, the survey was based upon the finding by Mr. O'Neal that Brenda Mize required supervision when eating, went into the kitchen, ate a Danish, choked, came out of her

room and fell over unconscious (O'Neal 10/8-17). Per Mr. O'Neal, the complaint report says the "[c]lient is seen [in the video] getting up and taking a food item with her to her room" (O'Neal 30/9-11). This is finding is factually incorrect and Mr. O'Neal conceded he only "thought" she had food when she left the kitchen (O'Neal 31/7-8). He testified at his deposition that he actually "didn't pay that close attention to it" (O'Neal 33/6). He stated it is "very possible" that OLTC just assumed that Brenda had something in her hand (O'Neal 32/9-15). Significantly, even Claimant's own expert witnesses, Karen McGowan, testified that there was nothing in Brenda's hands when she left the kitchen.[5] (McGowan 120/8-9; 123/14-18).

Mr. O'Neal conceded that if the video showed there was nothing in Brenda's hand when she left the kitchen, then the OLTC complaint report is incorrect (O'Neal 31/18-21). The evidence shows it was incorrect.

Mr. O'Neal next stated that the complaint report was also premised on the IPP requirement that Brenda Mize was to be supervised while "eating." (O'Neal 32/19-24). He stated that Brenda was found eating alone in the kitchen in violation of the individual care plan (O'Neal 17/9-14). He testified the violation cited was based upon his own "interpretation" that the IPP required enhanced supervision when "eating" (O'Neal 55/24). He stated that his interpretation was based on the language of page 13 of the IPP (O'Neal 71/20-25). He agreed, however, that if his interpretation is wrong, then the OLTC survey findings were incorrect (O'Neal 57/18-23).

After further examination, Mr. O'Neal testified that if the care plan stated that Brenda is only to be supervised at a one to one level during "mealtime," then there is no requirement that she be supervised on a one to one level during non-mealtime hours

[5] It is clear from the video recording from the kitchen and from the back hallway that Brenda did not have anything in her hands. Brenda walked right past the camera as she walked down the hallway after leaving the kitchen and her hands are clearly observable on the video.

(O'Neal 33/18-23). Significantly, Mr. O'Neal conceded that HDCs have some residents that need someone standing there next to them 24/7 to intervene, but Brenda Mize was not one of them (O'Neal 34/6-11).

Mr. O'Neal agreed that if the IPP here stated that Brenda was only to be supervised during "mealtimes," then the complaint report by OLTC was wrong (O'Neal 34/13-19). He testified "[i]f we [OLTC] said that she was on enhanced supervision when she wasn't, that would be in error." (O'Neal 34/19-21).

Mr. O'Neal then testified that page 21 of the IPP established the levels of supervision for Brenda during her daily routine (O'Neal 76/13-16), not page 13 as he originally thought at the time of the survey. He stated the only time "enhanced supervision" was listed on page 21 was for "mealtime." (O'Neal 76/21-25). Consequently, the survey results were wrong on this point, as well, and all of the survey deficiencies or "tags" issued by OLTC citing supervision based upon eating or being present in the kitchen were incorrect based upon the testimony of the OLTC surveyor.

Next, Mr. O'Neal stated a deficiency was issued on the survey because not all direct care staff were currently certified in CPR (O'Neal 58/21-23). However, when questioned further, Mr. O'Neal conceded that the standards he was to apply only required that there be *sufficient numbers* of staff to provide the CPR care, and not that *all* staff must be certified as originally cited in the survey (O'Neal 58/20-59/2). He testified that at least one, and possibly more, of the staff responding to Brenda's emergency were, in fact, currently certified in CPR (O'Neal 38/16-21). He confirmed that it took only one certified and trained staff to do the CPR and that there was one such staff responding to Brenda (O'Neal 39/24-40/4; 41/17-20).

Mr. O'Neal stated that the survey further found non-compliance for CPR because the staff were unable to clear the airway and failed to give breaths to Brenda at a ratio of 30 chest compressions to two breaths (O'Neal 42/4-14). He thought that staff did not do proper CPR (O'Neal 46/19) because there were too many chest compressions in relation to rescue breaths (O'Neal 46/20-23) and staff took breaks between compressions (50/14-18).[6] However, he agreed that one way to dislodge an unconscious victim with a severely blocked or totally blocked airway would be to perform chest compressions (O'Neal 47/4-8). He also agreed that the chest compressions work as would the Heimlich with pressure to dislodge the blockage (O'Neal 47/9-12). He stated that none of it matters if the airway is not cleared (O'Neal 42/14). **Mr. O'Neal agreed that if a person is totally or severely blocked, no air will get through** (O'Neal 43/5-10).

Mr. O'Neal also agreed that the American Heart Association guidelines on CPR are just that, guidelines (O'Neal 44/22-25). He agreed that the guidelines are not law or chiseled in concrete (O'Neal 45/1-5). There are variations in CPR as needed for the circumstances (O'Neal 49/6-9).

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[6] Mr. O'Neal testified that although the surveyors were aware that an automatic electronic defibrillator ("AED") was used (50/19-22), which gives oral instructions for the rescuers to stop CPR while it assesses and then tells them what to do (O'Neal 51/11-12; 53/17-19), he did not know when the AED was actually placed on Brenda Mize (O'Neal 52/21-24). He also stated that although each reassessment by the AED can take from 10 to 25 seconds (53/23), he felt that none of the pauses in CPR were on account of the AED instructions to responders (O'Neal 53/24-54/1). Mr. O'Neal then admitted that he failed to know how long it took to get the AED (O'Neal 54/14-15) and was unsure how often the AED cycle reassessed the patient (53/8-10). He agreed that the **survey report citing the violation completely failed to attribute <u>any</u> pause in CPR to the AED** (O'Neal 55/1-6) **despite his knowledge an AED was used during the rescue efforts** (O'Neal 50/19-22).

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Mr. O'Neal stated that another non-compliance issue cited in the survey was because the facility did not have an AED readily available and because some staff was unsure whether there was a suction machine (O'Neal 66/7-9). When questioned further, Mr. O'Neal admitted that there actually was no requirement that the facility have a suction machine or that the AED be housed in the home (O'Neal 66/11-18). He stated the HDC was required to have an AED on campus, and that they did have one on campus (O'Neal 66/19-22). Dr. Schexnayder's opinion about the uselessness of a suction machine to clear a totally blocked airway was already discussed above.

Consequently, Claimant's reliance of the survey results is significantly misplaced. The survey was totally flawed, based upon incorrect facts, wrong interpretations, wrong assumptions and misapplied facility compliance standards. The surveyor simply got it all wrong and testified as to the mistakes when questioned by Respondent.

Conclusion

For the reasons stated above, Respondent, DDS, moves this Commission to deny the claim for wrongful death due to the absence of negligence by HDC staff in (1) the supervision requirements of the Individual Program Plan ("IPP") and (2) the CPR administered to Brenda in the effort to save her life. The assertion that the CPR administered by staff was negligent because rescue breathing was not performed in strict accordance with either the American Heart Association's 30-2 compression to breath ratio or the American Red Cross' 30-2 compression to breath ratio is without merit. All experts here agree that rescue breathing was ineffective until Brenda's airway blockage was cleared. All the experts here also agree that the only way to save Brenda was to first dislodge the airway blockage through the chest compressions, which the

HDC staff performed. Though there was an unfortunate outcome here, it did not establish liability in the absence of actionable negligence by the HDC staff.

Therefore, Respondent, DDS, moves that the claim be denied and it be relieved from any liability.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
Division of Developmental Disabilities Services

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CERTIFICATE OF SERVICE

This is to certify that I mailed a copy of the foregoing Brief, postage prepaid, this 7th day of June, 2013 to:

Darren O'Quinn, Esquire
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Little Rock, AR 72205

Richard Rosen
Rich Rosen

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STATE CLAIMS COMMISSION DOCKET
OPINION

Amount of Claim $ 1,000,000.00 **Claim No.** 13-0865-CC

Attorneys

Brett Mize, as Special Admin, of the Estate of Brenda Mize, Deceased — **Claimant**

Darren O'Quinn, Attorney — **Claimant**

vs.

DHS/Division of Developmental Disabilities Services — **Respondent**

Breck Hopkins, Chief Counsel
Brenda Jackson, Accts. Payable
~~Richard Rosen, Attorney~~ — **Respondent**
Jerry Berry, Fiscal Officer

State of Arkansas

Date Filed June 26, 2014

Type of Claim Mental Anguish, Wrongful Death, ~~Pain & Suffering, Negligence,~~ Failure to follow Procedure, Refund of Expenses

FINDING OF FACTS

This claim was filed for mental anguish, wrongful death, pain and suffering, negligence, failure to follow procedure and refund of expenses in the amount of $1,000,000.00 against the Department of Human Services/Division of Developmental Disabilities Services. Present at a hearing May 9, 2014, was the Claimant, represented by Darren O'Quinn, Attorney and the Respondent, represented by Richard Rosen, Attorney.

The Arkansas State Claims Commission unanimously finds negligence on the part of the Respondent. The Respondent failed to follow the standard of care found in the treatment plan of the deceased concerning her eating habits. This was present in the deceased IPP (Individual Patient Plan), which set out a road map for her treatment and supervision. Her food intake was to be monitored at all times and her food was to be cut into very small pieces prior to being given to her.

In this instance there was a clear failure to supervise. The deceased had dysphagia, which is a condition in which an individual has difficulty in swallowing and she had a long history of excessive eating. When she was unsupervised around food she would stuff all she could get in her hands into her mouth and hide that fact from her care givers.

The deceased was found in her group home kitchen with food wrappers near her. The staff member who found her told the deceased to return to her room, but did not check her mouth to see what might be there. This was a supervisory failure with tragic consequences.

Soon after returning to her room, the deceased came out of her room choking. Staff saw her and attempted to dislodge the assumed blockage of her throat. However, the method used in this attempt was not the standard Heimlich method. It was not an appropriate method for clearing the throat. The EMT's arrived shortly thereafter, were able to clear the deceased throat and used the Heimlich procedure. The deceased was taken to a hospital where she soon died.

The Respondent clearly failed to act when there was a duty to act. The Arkansas State Claims Commission unanimously awards the Claimant the amount of $600,000.00. While the probate court handling the deceased estate will decide how this award will be divided, the Claims Commission recommends that it be divided equally among the father, sister and two brothers of the deceased.

Upon consideration of all the facts as stated above the Claims Commission hereby **unanimously allows the Claimant the amount of $600,000.00 and will include the claim in a claims bill to be submitted to the 90th General Assembly, Arkansas State Legislature 2015 for subsequent approval and payment.**

IT IS SO ORDERED.

(See Back of Opinion Form)

CONCLUSION

Upon consideration of all the facts, as stated above, **the Claims Commission hereby unanimously allowed this claim in the amount of $600,000.00 and will include the claim in a claims bill to be submitted to the 90th General Assembly, Arkansas State Legislature 2015 for subsequent approval and payment.**

Date of Hearing May 8, 2014

Date of Disposition May 8, 2014

Chairman

Commissioner

Commissioner

**Appeal of any final Claims Commission decision is only to the Arkansas General Assembly as provided by Act #33 of 1997 and as found in Arkansas Code Annotated §19-10-211.