# The Commonwealth of Massachusetts
## Disabled Persons Protection Commission

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October 10, 2017

Anna Baglaneas
17 Haven Avenue
Rockport, MA 01966

Re: Request for DPPC Records
DPPC Case # 155957/156003

Dear Ms. Baglaneas:

Enclosed please find the records that you requested from the Disabled Persons Protection Commission ("DPPC") per letter received on October 5th, 2017. The enclosed documents have been appropriately redacted (blacked out) as DPPC is obligated to protect confidential and personally identifying information regarding reporters and third party data subjects pursuant to G.L. c. 4, § 7(26)(a), G.L. c. 66A, G.L. c. 19C, §3, and 118 CMR 9.00, et seq.

If you have any questions regarding this response, please contact our office at 617-727-6465.

Sincerely,

DPPC Document Security and Retention Unit

Enclosure: 19C Report

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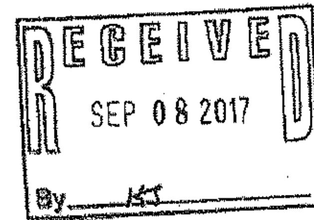
# Disabled Persons Protection Commission

## M.G.L. c. 19C / 118 CMR Investigation Report




**Alleged Victim: IOANNIS BAGLANEAS**
**DPPC Case Number: 155957, 156003**
**DDS Case Number: 03-NENS-17-0112**
**Investigation Agency: DDS**

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**Date of Incident: 04/15/2017**

**Allegation Investigated: Intake #155957: When the reporter picked up the ALV on 4/15/17 the group home had let the ALV's illness get so bad that the reporter took him to the ER where he was immediately admitted. The ALV has severe pneumonia and is on a ventilator. On 4/13/17 staff took the ALV to [redacted]. The reporter said that she requested that they tell her what [redacted] said, and was told that the ALV had allergies. This was not the correct information. The ALV is in ICU in critical condition and might die. The reporter said that if the ALV would have stayed at the group home that Saturday night the ALV would have been dead by Sunday morning.**
**The ALV's caretaker should have followed [redacted] instructions in providing adequate medical care.**

**Intake #156003: ALV had previously been taken to [redacted] by his group home staff because he was experiencing some breathing issues, and had been returned to group home. The ALV went home to visit his family and his family had to bring him to the ER again because ALV felt ill. If Bass River group home had done a better job of ensuring the ALV had been taken to a better medical facility then the ALV wouldn't have had to be rushed to the ER by his family while home visiting.**

► **Category of abuse committed by the Alleged Abuser:** Omission

**Injury sustained by the Alleged Victim:**
**Physical Injuries:**
**First:** Impairment of an organ
**Second:** Impairment of a bodily system

**Emotional Injuries:**
**First:**
**Second:**

**Abuse Per Se:**
**If "other" or more than two types of injury explain:** The ALV was diagnosed with the following: Bronchitis, Aspiration Pneumonia, Hypoxic Respiratory Failure secondary to the Aspiration Pneumonia, Sepsis Hypoxia, Hypertensive, Oxygen Level at 53%



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► **Description of the act and/or omission of the Alleged Abuser that caused the injury sustained by the Alleged Victim:**-Although there is insufficient evidence to conclude that failure to administer the prescribed medication exacerbated the ALV's medical conditions, there is sufficient evidence that the ALAB1, the ALAB2, the ALAB3, the ALAB4, the ALAB5, the ALAB6, and the ALAB7 all committed omission in their care of the ALV, causing serious physical injury to the ALV. The failure of staff to ensure that the ALV was using the doctor ordered CPAP machine directly contributed to the ALV's serious life threatening medical condition. C2 stated that is was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. C2 further stated that it was his medical opinion that the failure to use the CPAP machine did exacerbate the ALV's Aspiration Pneumonia causing the ALV to suffer respiratory failure. In addition, the failure to ensure the ALV used the CPAP regularly as ordered, would exacerbate the ALV's sleep apnea symptoms, causing life threatening medical issues for the ALV. ALAB1 and ALAB6 both stated they were aware that staff were not using the ALV's CPAP machine and were also aware that staff were not placing the ALV's CPAP breathing mask on but failed to inform anyone of this safety concern. ALAB7 was made aware that the ALV was not utilizing his CPAP machine on 3/13/2017 from an email sent to her by I1 but failed to follow up with Oak Ave staff about this concern. Thus, abuse is substantiated.

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► **Facts pertinent to the allegation(s) investigated:** -The ALV is a 29 year old man who is diagnosed with Down Syndrome, Sleep Apnea, and Apraxia. The ALV requires the use of a CPAP machine while sleeping to treat the Sleep Apnea. This CPAP machine is doctor ordered and monitored by the physician with the CPAP chip. During the time frame in question, the ALV resided in a group home operated by Bass River Inc. at 15 Oak Ave in Peabody, MA. He attended Life Choices day program and had regular visits with family. The ALV was not on 1:1 or any special supervision. The ALV reportedly has no previous history of aspiration and/or aspiration pneumonia. The ALV also does not have a history of a swallowing disorder. Testing completed at the hospital indicated that the ALV does not have a medical diagnosis of Dysphasia or any swallowing issues. It should be noted that the overnight staff ratio is 2 asleep staff, with no awake. The staff are scheduled to go to sleep at 10PM and wake at 6AM. The ALV has extremely limited communication skills and is not a reliable reporter of events due to this limitation, as the ALV will generally smile and nod or say yes to anything that is asked of him. Records indicate that the ALV lived with his family until June 2016, when he moved to the Bass River Inc. group home.

-On 4/13/2017, the ALV was taken to [redacted] by I6([redacted]) for cold like symptoms and he was diagnosed with an upper respiratory infection and bronchitis. C2 ([redacted] prescribed the ALV Mucinex 600mg to be taken twice a day as well as Robitussin 5ml as a PRN. Medication sheet reveals that the Mucinex medication was given at 8PM on 4/13/17 and 8AM on 4/14/17. The medication sheet also reveals that the Mucinex was not given to the ALV as ordered on 4/14/17 at 8PM and 4/15/17 at 8AM. In addition, there is no Robitussin medication sheet to verify if this medication was given at all. On 4/15/17, the ALV was picked up at Special Olympics track practice by I1(mother) at 11:30AM for a scheduled holiday w eekend visit (Easter weekend). I1 stated that the LOA (Leave of Absence) medications given to her did not include the Robitussin cough syrup nor did she get the doctor prescribed travel CPAP machine. Upon return to I1's home, the ALV was showing signs of serious distress, he was wheezing, coughing, and his skin was "dusky". Subsequently, I1 drove the ALV to Addison Gilbert Hospital Emergency Room.

-Medical records from Addison Gilbert Hospital reveal that the ALV arrived to the hospital on 4/15/17 presenting with weakness, lethargy, dyspnea, cough, phlegm, and an oxygen level of 53%. The ALV was admitted and medical testing revealed the ALV had Pneumonia and Progressive Hypoxic Respiratory Failure. While hospitalized, the ALV worsened and he was placed in ICU. The ALV was in critical condition and became hypertensive, thus he was intubated.

-The ALV was subsequently medflighted to Massachusetts General Hospital on 4/23/17. Medical records from Massachusetts General Hospital (MGH) reveal that the ALV was diagnosed with Aspiration Pneumonia, Sepsis Hypoxic, and Hypoxic Respiratory Failure secondary to the Aspiration Pneumonia. The ALV remained intubated and was prescribed several antibiotics to treat the infections. The ALV's condition did improve and he was subsequently discharged from MGH on 5/5/17 and was transferred to a rehabilitation hospital. The ALV has since been released and is currently living with I1.

-I1 (ALV's Mother/Guardian) stated that she was informed that the ALV had been taken to [redacted] on 4/13/17. I1 explained that she was informed by the ALAB6 [redacted]) that the ALV was fine and only had allergies. I1 stated that she had seen the ALV on 4/9/17 and the ALV was healthy when she visited him. I1 revealed that she received phone calls from the ALAB1 ([redacted] [redacted] on 4/13/17 and 4/14/17 that the ALV was not going to his wrestling match and swim practice because he wasn't feeling well. I1 stated that she ha d a scheduled visit with the ALV on



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4/15/17 for the Easter weekend. I1 went to pick the ALV up at track practice. When she arrived, ALAB5 ([redacted]) approached her and gave her the ALV's belongings. The ALAB5 then informed I1 that the ALV was sick. I1 explained that the ALAB5 failed to give her the travel CPAP machine or the prescribed Robitussin cough syrup. I1 brought the ALV back to her home and had the ALV lay down to see if he would feel better. When I1 realized that the ALV was having significant trouble breathing she brought the ALV to the hospital where he was admitted to ICU, intubated, and was in critical condition. I1 stated that the ALV has no history of aspiration pneumonia, however does have a history of sleep apnea. I1 explained that she had sent an email to the ALAB7 on 3/13/2017 requesting that the group home use the CPAP machine, as the CPAP chip revealed the machine wasn't being utilized. Consultation report from [redacted] also reveals that [redacted] also requested the house staff ensure the ALV uses the machine.

-I2 ([redacted]) stated that on the morning of 4/14/2017, the ALV was sick and did not look well. I2 stated that when ALAB6 picked the ALV up, she reported to ALAB6 her observations regarding the ALV and recommended that ALAB6 take the ALV to [redacted] for further evaluation. According to I2, ALAB6 acknowledged this statement and was told by ALAB6 that the situation was being addressed.

-I3 ([redacted]) was coaching the ALV during track practice on the morning of 4/15/2017. I3 stated that the ALAB5 failed to inform him that the ALV was seriously ill. According to I3, the ALV was extremely lethargic, coughing, and having difficulty breathing and red in the face. I3 attempted to have the ALV walk 15 feet, which the ALV could not do. As a result, I3 removed the ALV from practice and had him sit down. I3 further stated that the ALAB5 sat in the stands and ignored the ALV. As such, she was unaware that the ALV was having difficulty breathing, running, walking, sitting down. I3 stated that the ALV should never have been brought to practice being so ill. I3 stated he was not informed properly of the severity of the ALV's illness and had he been properly informed, he would not have allowed the ALV to participate that day.

-I4 ([redacted]) and I5 ([redacted]) both stated that they first observed the ALV display cold like symptoms on 4/12/2017 but that the ALV was energetic and physically appeared at his baseline. I4 stated that on 4/12/2017, the ALV presented with a cough. At that time, she took a set of vital signs and the ALV's lungs were clear but did report he had a runny nose. I4 stated the ALV ate lunch that day as he typically does (no special diet or supervision required) and the ALV did not present with any concerning medical issues. On 4/13/2017, I4 called the ALV's residence to inquire where the ALV was and spoke with ALAB1 who informed her that the ALV was not feeling well and that he was staying home. I4 recommended to ALAB1 that the ALV should be seen by [redacted] (which was done that afternoon). I5 stated on 4/14/2017, the ALV arrived to the day program after his job coaching that morning and she observed the ALV to be coughing more than he was on 4/12/2017 but not to the point of it being an emergency. I5 stated that as the day progressed, the ALV's symptoms seemed to be getting worse and he was moving more slowly. I5 stated she wrote a note in the ALV's communication book to alert the residence of his symptoms.

-I6[redacted] in her initial interview with this investigator stated that the ALV awoke on 4/13/2017 and didn't seem well; was coughing and had red eyes. I6 stated she made an appointment for the ALV with [redacted] for that afternoon and was also the staff who took the ALV [redacted]. At the appointment, I6 stated the ALV was given a nebulizer treatm ent and a prescription for Mucinex and Robitussin PRN. No x-rays were taken. I6 stated she left at 5pm on 4/13/2017 and that was the last interaction she had with the ALV. It should be noted that



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this investigator attempted to make contact with I6 for a formal interview but I6 failed to respond to any and all attempts.

-I7 was interviewed by this investigator and C1. I7 stated that he heard the ALV get up in the middle of the night right before the ALV became sick, on 4/9/17. I7 explained that there was a peanut butter cake in the kitchen and the ALV ate the entire cake. Progress notes obtained confirm that a cake was made for the ALV on 4/9/17. I7 stated that the ALV was really sick during the week and had been taken to the doctor. I7 stated that the ALV was coughing and red in the face. I7 explained that he heard the ALAB7 tell the ALAB1 that there will be "consequences" if he cooperated with investigations.

-The ALAB1 ( was interviewed by this investigator and C1. ALAB1 stated that he worked with the ALV from 4/11/2017-4/15/2017 The ALAB1 admitted that he failed to ensure that the Mucinex was given on 4/14/2017 and 4/15/2017. The ALAB1 explained that although the medication sheet for the Robitussin that was prescribed is missing, he did administered the PRN cough syrup on several occasions. The ALAB1 stated that he witnessed the ALAB7 come to the home and meet with the ALAB6. During that meeting, the ALAB7 took the ALV's records and also took the medication records. The ALAB1 explained that he always ensured that the ALV was wearing the CPAP machine, and when the ALV would take it off, he would put it back on. However, the ALAB1 admitted th at he was aware that other staff in the home did not have the ALV wear the CPAP machine. When questioned if he reported this or attempted to bring any attention to this safety matter, the ALAB1 responded he did not. The ALAB1 stated that during the time frame in question, he called to report that the ALV was not feeling well and needed to stay home from swimming on 4/13/2017 and the wrestling match on 4/14/2017. When questioned who he spoke with he responded he didn't know. When questioned if he documented this, he responded that he did in the communication log.

-The ALAB2, ALAB3, and ALAB4 (.) were interviewed by this investigator and C1. . All stated that they had been trained on the ALV's need for the use of his CPAP machine while sleeping. All admitted that they had ensured the ALV was going to sleep on 4/9/17, 4/10/17, 4/11/17, 4/12/17, 4/13/2017, and 4/14/2017. When questioned if they ensured the ALV was wearing his CPAP machine, per doctor's orders, all admitted they did not. All stated the ALV will frequently take the machine off; as such they did not bother to attempt to put the machine on him or encourage him to do so. ALAB2, ALAB3 and ALAB4 further acknowledged that when ALV was getting ready for bed during the week in question, they witnessed the ALV to have cold like symptoms with coughing and exacerbated breathing. ALAB2, ALAB3 and ALAB4 denied that they had any firsthand knowledge of the ALV's medications as none had administered medications during the time frame in question. All admitted that the group home was closing for the weekend, thus the ALV needed go to track practice regardless of how he was feeling.

-ALAB5 ( was interviewed by this investigator and C1.

ALAB5 admitted that the ALV does have a tendency to wake up and wander the house in the middle of the night. She also admitted that the ALV has a history of eating large amounts of food in the middle of the night.



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ALAB5 stated that she did hear him wander the house on 4/9/17, however did not get up to redirect him back to bed. She further did not help him put is CPAP mask on, because the ALV will just take it off, so "I don't bother." ALAB5 admitted that she took the ALV to track practice on Saturday 4/15/2017. The ALAB5 acknowledged that the ALV was very ill, however because there was no staff scheduled for the holiday weekend, the ALAB5 did not make any calls or notify any superiors that the ALV was ill. ALAB5 stated that I1 met her at the track in Gloucester around 11:30am and she retrieved the ALV's overnight bag and medications and delivered them to I1 stating to I1 that the ALV was not feeling well. The ALAB5 acknowledged that the house was closing for the holiday weekend, thus the ALV needed to go to track practice regardless of how he was feeling. ALAB5 further acknowledged that she didn't take the travel CPAP machine with her as required. She further admitted that she saw the Robitussin cough syrup in the medication closet and left it there.

-ALAB6 ( acknowledged to this investigator and C1 that she was aware that the ALV was not feeling well from 4/11/2017-4/15/2017. ALAB6 admitted that she received an after hours phone call from an employee that the ALV was not feeling well (could not provide time and date). ALAB6 stated that this call occurred after the ALV had already been to ALAB6 directed the staff person to call because she was out with (ALAB6 could not name the employee or who was ). ALAB6 admitted that she never followed up with the status of the ALV's health after this notification. ALAB6 never requested a program nurse check the ALV or scheduled a new Dr. Appointment for further follow up with . Furthermore, ALAB6 admitted that the ALV's day program informed her on 4/14/2017 that the ALV was very ill and needed to be seen by a physician immediately. ALAB6 admitted she failed to follow up with this recommendation from the day program. . ALAB6 also acknowledged that she is aware that the ALV requires the nightly use of his CPAP machine and is further aware that the ALV takes the mask off and that staff do not ensure that the CPAP mask is on the ALV. The ALAB6 stated that she was also aware that it had been a concern from and I1 that the ALV wears the mask. The ALAB6 admitted that she did tell I1 that the ALV was diagnosed with allergies, as she became confused during the conversation and was thinking of another individual.

-ALAB7 ( acknowledged to this investigator and C1 that she was aware that the ALV was not feeling well on 4/13/2017 and 4/14/2017 but was unaware of all the symptoms he was displaying. ALAB7 acknowledged that she was aware that the ALV required the nightly use of a CPAP machine for his breathing, however denied that she was aware that the ALV was not using the machine. ALAB7 was then shown an email sent to her by I1. I1 writes to the ALAB7 on 3/13/2017, "I just got a message from . He gets the sleep reports from (ALV's) machine, it has a modem in it, and he has said that according to the reports from the machine that (ALV) is not wearing his CPAP. It is extremely important that (ALV) wear his CPAP as he has been diagnosed, by an extensive sleep study at Mass General, with sleep apnea which can lead to many health complications if not treated with the CPAP machine. It is extremely important that he wear the mask at night for at least 5 hours a night." ALAB7 did not deny that she received this email, however stated she must have forgotten to address the issue with staff. ALAB7 further acknowledged that she and the ALAB6 should have had a nurse coordinator go



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to the residence to ensure the ALV's prescribed medication was properly documented and was being administered by staff, per the doctor's order. ALAB7 admitted that she removed many documents from the residence before the investigators could review these documents. ALAB7 apologized and stated that she did not purposely interfere with the investigation nor did she destroy any documents. ALAB7 could not produce all the documents that the investigator requested.

-It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame (2/1/2017-4/14/17). This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; January 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements; March 2017-the CPAP was used 6 times per doctor's order requirements; April 2017- the CPAP was used one time per the doctor's order requirements.

-Although the ALV was kept home from swimming and wrestling because of his illness, he was sent to track practice on 4/15/17. ALAB1, ALAB2, ALAB3, ALAB4, ALAB5, ALAB6 all admitted that the ALV was sent because the group home was closing down for the holiday weekend and there were no staff to care for him.

-C2 (█████) stated that the ALV was treated on 4/13/17 and diagnosed with an upper respiratory infection/Bronchitis. A nebulizer treatment was performed on the ALV to clear his airway. In addition, the ALV was prescribed Mucinex 600MG 2X a day and Robitussin PRN, every 4 hours as needed. C2 stated that staff were instructed that the ALV should be brought back to be examined if the ALV's condition worsened. C2 confirmed that the ALV and his staff did not return to the office or make any follow up phone calls regarding the ALV's status.

-C2 and C3 (█████████████) stated that although there was documentation of missed doses of Mucinex, it was their medical opinion that the failure to administer the prescribed medications did not exacerbate the ALV's medical condition (Aspiration Pneumonia). It should be noted that the ALV does not have a medical history of aspiration pneumonia, nor does the ALV have a swallowing disorder. Medical testing ruled out that the ALV has Dysphasia.

-C2 stated that it was his medical opinion that the failure to ensure the ALV was using the CPAP machine did exacerbate the ALV's breathing condition and pneumonia symptoms. C2 stated that it was his medical opinion that the failure to utilize the doctor ordered CPAP machine did affect the ALV's breathing and also did decrease the ALV's oxygen levels. Causing the ALV's pneumonia to exacerbate to hypoxic respiratory failure. C2 stated that the failure to use the CPAP machine contributed to his over all low oxygen levels even prior to being hospitalized. On 2/1/17- C2 wrote to the house to "please enforce his regular nightly CPAP us as he has documented sleep apnea." C2 stated that a written request was sent to the group home on 2/1/17 because the ALV continuously displayed low oxygen levels when he was examined. C2 stated that the staff failure to ensure the ALV was using the doctor ordered CPAP machine nightly did exacerbate the ALV's sleep apnea symptoms. Without the nightly use of the CPAP machine, the ALV's breathing would stop while



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sleeping, his blood pressure and heart rate would rise, and the ALV's red blood cell count in his oxygen would decrease. This failure would cause the ALV's breathing to exacerbate regularly. C2 stated that these medical issues are life threatening if the CPAP is not used as ordered.

C2 further stated that it was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. C2 stated that when the ALV's CPAP machine is not utilized as ordered, the ALV would be "groggy and not alert throughout the waking hours." C2 explained that it was his medical opinion that the staff failure to follow the doctor's order did directly effect the ALV's brain function in a negative manner causing the ALV not to chew or swallow properly and therefore causing the ALV to aspirate.

-Although there is insufficient evidence to conclude that failure to administer the prescribed medication exacerbated the ALV's medical conditions, there is sufficient evidence that the ALAB1, the ALAB2, the ALAB3, the ALAB4, the ALAB5, the ALAB6, and the ALAB7 all committed omission in their care of the ALV, causing serious physical injury to the ALV. The failure of staff to ensure that the ALV was using the doctor ordered CPAP machine directly contributed to the ALV's serious life threatening medical condition. C2 stated that is was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame (2/1/2017-4/14/17). This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; January 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements; March 2017-the CPAP was used 6 times per doctor's order requirements; April 2017- the CPAP was used one time per the doctor's order requirements. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. C2 further stated that it was his medical opinion that the failure to use the CPAP machine did exacerbate the ALV's Aspiration Pneumonia causing the ALV to s uffer respiratory failure. In addition, the failure to ensure the ALV used the CPAP regularly as ordered, would exacerbate the ALV's sleep apnea symptoms, causing life threatening medical issues for the ALV. ALAB1 and ALAB6 both stated they were aware that staff were not using the ALV's CPAP machine and were also aware that staff were not placing the ALV's CPAP breathing mask on but failed to inform anyone of this safety concern. ALAB7 was made aware that the ALV was not utilizing his CPAP machine on 3/13/2017 [redacted] but failed to follow up with Oak Ave staff about this concern. Thus, abuse is substantiated.



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**M.G.L. c. 19C / 118 CMR Conclusion**

Based on information gathered by the Investigator there is sufficient evidence to conclude that ALV is victim of abuse, as it is defined by M.G.L. c. 19C and/or 118 CMR, by ALAB1, ALAB2, ALAB3, ALAB4, ALAB5, ALAB6, ALAB7. Therefore, DPPC cases #155957 & 156003 are substantiated.

-Although there is insufficient evidence to conclude that failure to administer the prescribed medication exacerbated the ALV's medical conditions, there is sufficient evidence that the ALAB1, the ALAB2, the ALAB3, the ALAB4, the ALAB5, the ALAB6, and the ALAB7 all committed omission in their care of the ALV, causing serious physical injury to the ALV. The failure of staff to ensure that the ALV was using the doctor ordered CPAP machine directly contributed to the ALV's serious life threatening medical condition. C2 stated that is was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame (2/1/2017-4/14/17). This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; January 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements; March 2017-the CPAP was used 6 times per doctor' s order requirements; April 2017- the CPAP was used one time per the doctor's order requirements. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. C2 further stated that it was his medical opinion that the failure to use the CPAP machine did exacerbated the ALV's Aspiration Pneumonia causing the ALV to suffer respiratory failure. In addition, the failure to ensure the ALV used the CPAP regularly as ordered, would exacerbate the ALV's sleep apnea symptoms, causing life threatening medical issues for the ALV. ALAB1 and ALAB6 both stated they were aware that staff were not using the ALV's CPAP machine and were also aware that staff were not placing the ALV's CPAP breathing mask on but failed to inform anyone of this safety concern. ALAB7 was made aware that the ALV was not utilizing his CPAP machine on 3/13/2017 [redacted] but failed to follow up with Oak Ave staff about this concern. Thus, abuse is substantiated.



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**EOHHS Agency Regulatory Conclusion Section**

**Has a regulatory investigation been completed?** Yes

**Regulatory Conclusions:** Based on the evidence gathered by the Investigator during the investigation of DDS Case #03-NENS-17-0112, there is sufficient evidence to conclude that ALV was mistreated as the result of an act and/or omission by his caretaker, ALAB1, ALAB2, ALAB3, ALAB4, ALAB5, ALAB6, and ALAB7. Therefore, mistreatment as defined by 115 CMR 9.00 is substantiated.

-There is sufficient evidence that the ALAB1, the ALAB2, the ALAB3, the ALAB4, the ALAB5, the ALAB6, and the ALAB7 all committed mistreatment in their care of the ALV, causing serious physical injury to the ALV. The failure of staff to ensure that the ALV was using the doctor ordered CPAP machine directly contributed to the ALV's serious life threatening medical condition. As C2 stated that it was his medical opinion that the failure to use the CPAP machine did exacerbate the ALV's Aspiration Pneumonia causing the ALV to suffer respiratory failure. It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame (2/1/2017-4/14/17). This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; January 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements; March 2017-the CPAP was used 6 times per doctor's order requirements; April 2017- the CPAP was used one time per the doctor's order requirements. C2 stated that is was his medical opi nion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. ALAB1 further committed mistreatment when he failed to administer the Robitussin and Mucinex medication as prescribed by [redacted]. ALAB6 committed mistreatment when she did not follow through on the recommendation of I2 to seek medical attention for the ALV, did not verify medication orders were completed, and did not check the ALV's medical status after she was informed by the day program that the ALV needed medical attention. ALAB7 violated MAP/DDS regulations when she removed the Robitussin and Mucinex from the residence without following proper MAP policy. In addition, the ALV was sent to track practice on 4/15/17 when he was sick only because the group home was closing. Thus, mistreatment is substantiated.



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**Provide facts to support the conclusion:** -The ALV is a 29 year old man who is diagnosed with Down Syndrome, Sleep Apnea, and Apraxia. The ALV requires the use of a CPAP machine while sleeping to treat the Sleep Apnea. This CPAP machine is doctor ordered and monitored [redacted] [redacted] with the CPAP chip. During the time frame in question, the ALV resided in a group home operated by Bass River Inc. at 15 Oak Ave in Peabody, MA. He attended Life Choices day program and had regular visits with family. The ALV was not on 1:1 or any special supervision. The ALV reportedly has no previous history of aspiration and/or aspiration pneumonia. The ALV also does not have a history of a swallowing disorder. Testing completed at the hospital indicated that the ALV does not have a medical diagnosis of Dysphasia or any swallowing issues. It should be noted that the overnight staff ratio is 2 asleep staff, with no awake. The staff are scheduled to go to sleep at 10PM and wake at 6AM. The ALV has extremely limited communication skills and is not a reliable reporter of events due to this limitation, as the ALV will generally smile and nod or say yes to anything that is asked of him. Records indicate that the ALV lived with his family until June 2016, when he moved to the Bass River Inc. group home.

-On 4/13/2017, the ALV was taken to [redacted] by I6([redacted] for cold like symptoms and he was diagnosed with an upper respiratory infection and bronchitis. C2 ([redacted] prescribed the ALV Mucinex 600mg to be taken twice a day as well as Robitussin 5ml as a PRN. Medication sheet reveals that the Mucinex medication was given at 8PM on 4/13/17 and 8AM on 4/14/17. The medication sheet also reveals that the Mucinex was not given to the ALV as ordered on 4/14/17 at 8PM and 4/15/17 at 8AM. In addition, there is no Robitussin medication sheet to verify if this medication was given at all. On 4/15/17, the ALV was picked up at Special Olympics track practice by I1(mother) at 11:30AM for a scheduled holiday w eekend visit (Easter weekend). I1 stated that the LOA (Leave of Absence) medications given to her did not include the Robitussin cough syrup nor did she get the doctor prescribed travel CPAP machine. Upon return to I1's home, the ALV was showing signs of serious distress, he was wheezing, coughing, and his skin was "dusky". Subsequently, I1 drove the ALV to Addison Gilbert Hospital Emergency Room.

-Medical records from Addison Gilbert Hospital reveal that the ALV arrived to the hospital on 4/15/17 presenting with weakness, lethargy, dyspnea, cough, phlegm, and an oxygen level of 53%. The ALV was admitted and medical testing revealed the ALV had Pneumonia and Progressive Hypoxic Respiratory Failure. While hospitalized, the ALV worsened and he was placed in ICU. The ALV was in critical condition and became hypertensive, thus he was intubated.

-The ALV was subsequently medflighted to Massachusetts General Hospital on 4/23/17. Medical records from Massachusetts General Hospital (MGH) reveal that the ALV was diagnosed with Aspiration Pneumonia, Sepsis Hypoxic, and Hypoxic Respiratory Failure secondary to the Aspiration Pneumonia. The ALV remained intubated and was prescribed several antibiotics to treat the infections. The ALV's condition did improve and he was subsequently discharged from MGH on 5/5/17 and was transferred to a rehabilitation hospital. The ALV has since been released and is currently living with I1.

-I1 (ALV's Mother/Guardian) stated that she was informed that the ALV had been taken to [redacted] on 4/13/17. I1 explained that she was informed by the ALAB6 ([redacted]) that the ALV was fine and only had allergies. I1 stated that she had seen the ALV on 4/9/17 and the ALV was healthy when she visited him. I1 revealed that she received phone calls from the ALAB1 ([redacted] [redacted] on 4/13/17 and 4/14/17 that the ALV was not going to his wrestling match and swim practice because he wasn't feeling well. I1 stated that she ha d a scheduled visit with the ALV on



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4/15/17 for the Easter weekend. I1 went to pick the ALV up at track practice. When she arrived, ALAB5 ([redacted]) approached her and gave her the ALV's belongings. The ALAB5 then informed I1 that the ALV was sick. I1 explained that the ALAB5 failed to give her the travel CPAP machine or the prescribed Robitussin cough syrup. I1 brought the ALV back to her home and had the ALV lay down to see if he would feel better. When I1 realized that the ALV was having significant trouble breathing she brought the ALV to the hospital where he was admitted to ICU, intubated, and was in critical condition. I1 stated that the ALV has no history of aspiration pneumonia, however does have a history of sleep apnea. I1 explained that she had sent an email to the ALAB7 on 3/13/2017 requesting that the group home use the CPAP machine, as the CPAP chip revealed the machine wasn't being utilized. Consultation report from [redacted] also reveals that [redacted] also requested the house staff ensure the ALV uses the machine.

-I2 ([redacted]) stated that on the morning of 4/14/2017, the ALV was sick and did not look well. I2 stated that when ALAB6 picked the ALV up, she reported to ALAB6 her observations regarding the ALV and recommended that ALAB6 take the ALV to [redacted] for further evaluation. According to I2, ALAB6 acknowledged this statement and was told by ALAB6 that the situation was being addressed.

-I3 ([redacted]) was coaching the ALV during track practice on the morning of 4/15/2017. I3 stated that the ALAB5 failed to inform him that the ALV was seriously ill. According to I3, the ALV was extremely lethargic, coughing, and having difficulty breathing and red in the face. I3 attempted to have the ALV walk 15 feet, which the ALV could not do. As a result, I3 removed the ALV from practice and had him sit down. I3 further stated that the ALAB5 sat in the stands and ignored the ALV. As such, she was unaware that the ALV was having difficulty breathing, running, walking, sitting down. I3 stated that the ALV should never have been brought to practice being so ill. I3 stated he was not informed properly of the severity of the ALV's illness and had he been properly informed, he would not have allowed the ALV to participate that day.

-I4 ([redacted]) and I5 [redacted]) both stated that they first observed the ALV display cold like symptoms on 4/12/2017 but that the ALV was energetic and physically appeared at his baseline. I4 stated that on 4/12/2017, the ALV presented with a cough. At that time, she took a set of vital signs and the ALV's lungs were clear but did report he had a runny nose. I4 stated the ALV ate lunch that day as he typically does (no special diet or supervision required) and the ALV did not present with any concerning medical issues. On 4/13/2017, I4 called the ALV's residence to inquire where the ALV was and spoke with ALAB1 who informed her that the ALV was not feeling well and that he was staying home. I4 recommended to ALAB1 that the ALV should be seen by [redacted] (which was done that afternoon). I5 stated on 4/14/2017, the ALV arrived to the day program after his job coaching that morning and she observed the ALV to be coughing more than he was on 4/12/2017 but not to the point of it being an emergency. I5 stated that as the day progressed, the ALV's symptoms seemed to be getting worse and he was moving more slowly. I5 stated she wrote a note in the ALV's communication book to alert the residence of his symptoms.

-I6([redacted] in her initial interview with this investigator stated that the ALV awoke on 4/13/2017 and didn't seem well; was coughing and had red eyes. I6 stated she made an appointment for the ALV with [redacted] for that afternoon and was also the staff who took the ALV to [redacted]. At the appointment, I6 stated the ALV was given a nebulizer treatm ent and a prescription for Mucinex and Robitussin PRN. No x-rays were taken. I6 stated she left at 5pm on 4/13/2017 and that was the last interaction she had with the ALV. It should be noted that



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this investigator attempted to make contact with I6 for a formal interview but I6 [redacted] failed to respond to any and all attempts.

-I7 was interviewed by this investigator and C1. I7 stated that he heard the ALV get up in the middle of the night right before the ALV became sick, on 4/9/17. I7 explained that there was a peanut butter cake in the kitchen and the ALV ate the entire cake. Progress notes obtained confirm that a cake was made for the ALV on 4/9/17. I7 stated that the ALV was really sick during the week and had been taken to [redacted] I7 stated that the ALV was coughing and red in the face. I7 explained that he heard the ALAB7 tell the ALAB1 that there will be "consequences" if he cooperated with investigations.

-The ALAB1 ([redacted].) was interviewed by this investigator and C1. ALAB1 stated that he worked with the ALV from 4/11/2017-4/15/2017 [redacted]. [redacted]. The ALAB1 admitted that he failed to ensure that the Mucinex was given on 4/14/2017 and 4/15/2017. The ALAB1 explained that although the medication sheet for the Robitussin that was prescribed is missing, he [redacted] administered the PRN cough syrup on several occasions. The ALAB1 stated that he witnessed the ALAB7 come to the home and meet with the ALAB6. During that meeting, the ALAB7 took the ALV's records and also took the medication records. The ALAB1 explained that he always ensured that the ALV was wearing the CPAP machine, and when the ALV would take it off, he would put it back on. However, the ALAB1 admitted that he was aware that other staff in the home did not have the ALV wear the CPAP machine. When questioned if he reported this or attempted to bring any attention to this safety matter, the ALAB1 responded he did not. The ALAB1 stated that during the time frame in question, he called [redacted] to report that the ALV was not feeling well and needed to stay home from swimming on 4/13/2017 and the wrestling match on 4/14/2017. When questioned who he spoke with he responded he didn't know. When questioned if he documented this, he responded that he did in the communication log.

-The ALAB2, ALAB3, and ALAB4 ([redacted].) were interviewed by this investigator and C1. [redacted] All stated that they had been trained on the ALV's need for the use of his CPAP machine while sleeping. All admitted that they had ensured the ALV was going to sleep on 4/9/17, 4/10/17, 4/11/17, 4/12/17, 4/13/2017, and 4/14/2017. When questioned if they ensured the ALV was wearing his CPAP machine, per doctor's orders, all admitted they did not. All stated the ALV will frequently take the machine off; as such they did not bother to attempt to put the machine on him or encourage him to do so. ALAB2, ALAB3 and ALAB4 further acknowledged that when ALV was getting ready for bed during the week in question, they witnessed the ALV to have cold like symptoms with coughing and exacerbated breathing. ALAB2, ALAB3 and ALAB4 denied that they had any firsthand knowledge of the ALV's medications as none had administered medications during the time frame in question. All admitted that the group home was closing for the weekend, thus the ALV needed go to track practice regardless of how he was feeling.

-ALAB5 ([redacted] was interviewed by this investigator and C1. [redacted]
ALAB5 admitted that the ALV does have a tendency to wake up and wander the house in the middle of the night. She also admitted that the ALV has a history of eating large amounts of food in the middle of the night. [redacted]



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ALAB5 stated that she did hear him wander the house on 4/9/17, however did not get up to redirect him back to bed. She further did not help him put is CPAP mask on, because the ALV will just take it off, so "I don't bother." ALAB5 admitted that she took the ALV to track practice on Saturday 4/15/2017. The ALAB5 acknowledged that the ALV was very ill, however because there was no staff scheduled for the holiday weekend, the ALAB5 did not make any calls or notify any superiors that the ALV was ill. ALAB5 stated that I1 met her at the track in Gloucester around 11:30am and she retrieved the ALV's overnight bag and medications and delivered them to I1 stating to I1 that the ALV was not feeling well. The ALAB5 acknowledged that the house was closing for the holiday weekend, thus the ALV needed to go to track practice regardless of how he was feeling. ALAB5 further acknowledged that she didn't take the travel CPAP machine with her as required. She further admitted that she saw the Robitussin cough syrup in the medication closet and left it there.

-ALAB6 ( .) acknowledged to this investigator and C1 that she was aware that the ALV was not feeling well from 4/11/2017-4/15/2017. ALAB6 admitted that she received an after hours phone call from an employee that the ALV was not feeling well (could not provide time and date). ALAB6 stated that this call occurred after the ALV had already been to ALAB6 directed the staff person to call because she was out with (ALAB6 could not name the employee or who was on-call). ALAB6 admitted that she never followed up with the status of the ALV's health after this notification. ALAB6 never requested check the ALV or scheduled a new Dr. Appointment for further follow up with . Furthermore, ALAB6 admitted that the ALV's day program informed her on 4/14/2017 that the ALV was very ill and needed to be seen by a physician immediately. ALAB6 admitted she failed to follow up with this recommendation from the day program. . . ALAB6 also acknowledged that she is aware that the ALV requires the nightly use of his CPAP machine and is further aware that the ALV takes the mask off and that staff do not ensure that the CPAP mask is on the ALV. The ALAB6 stated that she was also aware that it had been a concern from and I1 that the ALV wears the mask. The ALAB6 admitted that she did tell I1 that the ALV was diagnosed with allergies, as she became confused during the conversation and was thinking of another individual.

-ALAB7 ( acknowledged to this investigator and C1 that she was aware that the ALV was not feeling well on 4/13/2017 and 4/14/2017 but was unaware of all the symptoms he was displaying. ALAB7 acknowledged that she was aware that the ALV required the nightly use of a CPAP machine for his breathing, however denied that she was aware that the ALV was not using the machine. ALAB7 was then shown an email sent to her by I1. I1 writes to the ALAB7 on 3/13/2017, "I just got a message from . He gets the sleep reports from (ALV's) machine, it has a modem in it, and he has said that according to the reports from the machine that (ALV) is not wearing his CPAP. It is extremely important that (ALV) wear his CPAP as he has been diagnosed, by an extensive sleep study at Mass General, with sleep apnea which can lead to many health complications if not treated with the CPAP machine. It is extremely important that he wear the mask at night for at least 5 hours a night." ALAB7 did not deny that she received this email, however stated she must have forgotten to address the issue with staff. ALAB7 further acknowledged that she and the ALAB6 should have had a nurse coordinator go



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to the residence to ensure the ALV's prescribed medication was properly documented and was being administered by staff, per the doctor's order. ALAB7 admitted that she removed many documents from the residence before the investigators could review these documents. ALAB7 apologized and stated that she did not purposely interfere with the investigation nor did she destroy any documents. ALAB7 could not produce all the documents that the investigator requested.

-It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame of 2/1/2017-4/14/17. This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; January 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements ; March 2017-the CPAP was used 6 times per doctor's order requirements; April 2017- the CPAP was used one time per the doctor's order requirements.

-Although the ALV was kept home from swimming and wrestling because of his illness, he was sent to track practice on 4/15/17. ALAB1, ALAB2, ALAB3, ALAB4, ALAB5, ALAB6 all admitted that the ALV was sent because the group home was closing down for the holiday weekend and there were no staff to care for him.

-C5 (DDS Northeast Region MAP Coordinator) stated that it is against MAP policy to remove medications from a residence unless proper MAP policy is followed. According to MAP Policy No. & Issue 10-10 Transfer/Transport of Medication section 4-E "a dated medication-release document has been signed by a licensed/Certified staff, from both the preceding DPH MAP registered site and the subsequent DPH MAP registered site; listing the inventory of all the medications, including the amount transferred, between sites". Regarding the Mucinex and Robitussin PRN that were removed by ALAB7, a dated medication-release document was not done, therefore, ALAB7 failed to follow MAP policy.

-C2 ([redacted]) stated that the ALV was treated on 4/13/17 and diagnosed with an upper respiratory infection/Bronchitis. A nebulizer treatment was performed on the ALV to clear his airway. In addition, the ALV was prescribed Mucinex 600MG 2X a day and Robitussin PRN, every 4 hours as needed. C2 stated that staff were instructed that the ALV should be brought back to be examined if the ALV's condition worsened. C2 confirmed that the ALV and his staff did not return to the office or make any follow up phone calls regarding the ALV's status.

-C2 and C3 ([redacted]) stated that although there was documentation of missed doses of Mucinex, it was their medical opinion that the failure to administer the prescribed medications did not exacerbate the ALV's medical condition (Aspiration Pneumonia). It should be noted that the ALV does not have a medical history of aspiration pneumonia, nor does the ALV have a swallowing disorder. Medical testing ruled out that the ALV has Dysphasia.

-C2 stated that it was his medical opinion that the failure to ensure the ALV was using the CPAP machine did exacerbate the ALV's breathing condition and pneumonia symptoms. C2 stated that it



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was his medical opinion that the failure to utilize the doctor ordered CPAP machine did affect the ALV's breathing and also did decrease the ALV's oxygen levels. Causing the ALV's pneumonia to exacerbate to hypoxic respiratory failure. C2 stated that the failure to use the CPAP machine contributed to his overall low oxygen levels even prior to being hospitalized. On 2/1/17- C2 wrote to the house to "please enforce his regular nightly CPAP us as he has documented sleep apnea." C2 stated that a written request was sent to the group home on 2/1/17 because the ALV continuously displayed low oxygen levels when he was examined. C2 stated that the staff failure to ensure the ALV was using the doctor ordered CPAP machine nightly did exacerbate the ALV's sleep apnea symptoms. Without the nightly use of the CPAP machine, the ALV's breathing would stop while sleeping, his blood pressure and heart rate would rise, and the ALV's red blood cell count in his oxygen would decrease. This failure would cause the ALV's breathing to exacerbate regularly. C2 stated that these medical issues are life threatening if the CPAP is not used as ordered.

C2 further stated that it was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. C2 stated that when the ALV's CPAP machine is not utilized as ordered, the ALV would be "groggy and not alert throughout the waking hours." C2 explained that it was his medical opinion that the staff failure to follow the doctor's order did directly effect the ALV's brain function in a negative manner causing the ALV not to chew or swallow properly and therefore causing the ALV to aspirate.

-There is sufficient evidence that the ALAB1, the ALAB2, the ALAB3, the ALAB4, the ALAB5, the ALAB6, and the ALAB7 all committed mistreatment in their care of the ALV, causing serious physical injury to the ALV. The failure of staff to ensure that the ALV was using the doctor ordered CPAP machine directly contributed to the ALV's serious life threatening medical condition. C2 stated that it was his medical opinion that the failure to use the CPAP machine did exacerbate the ALV's Aspiration Pneumonia causing the ALV to suffer respiratory failure. C2 stated that is was his medical opinion that the failure of staff to use the CPAP machine as required by the doctor's order more likely than not caused the ALV to aspirate while eating or sleeping, directly causing the aspiration pneumonia. It is important to note that the ALAB1, the ALAB2, the ALAB3, the ALAB4, and the ALAB5 all worked various overnight shifts in the group home during the time frame (2/1/2017-4/14/17). This investigator received documentation of the usage of the CPAP machine from 10/26/2016-4/23/2017. Of the 180 possible days that the ALV should have been using the CPAP machine, there were only 36 days that it was used per doctor's order requirements. The ALV only utilized the CPAP machine 20% of the time during 10/26/2016-4/23/2017. Since the ALV has moved back home with I1, the Compliance report states the machine is being used 88% of the time. The Compliance report reveals that in December 2016- the CPAP was not used per the doctor's order requirement; Janua ry 2017- the CPAP was used 1 night per the doctor's order requirement; February 2017- the CPAP was used 3 nights per the doctor's order requirements; March 2017-the CPAP was used 6 times per doctor's order requirements; April 2017- the CPAP was used one time per the doctor's order requirements. C2 explained the ALV could have either aspirated on food or fluids built up in his throat from not using the CPAP machine. C2 explained that there is a direct link between sleep apnea and aspiration pneumonia, when the sleep apnea is not treated with the CPAP mask. ALAB1 further committed mistreatment when he failed to administer the Robitussin and Mucinex medication as prescribed by [redacted]. ALAB6 committed mistreatment when she did not



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follow through on the recommendation of I2 to seek medical attention for the ALV, did not verify medication orders were completed, and did not check the ALV's medical status after she was informed by the day program that the ALV needed medical attention. ALAB7 violated MAP/DDS regulations when she removed the Robitussin and Mucinex from the residence without following proper MAP policy. In addition, the ALV was sent to track practice on 4/15/17 when he was sick only because the group home was closing. Thus, mistreatment is substantiated.

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▶ **Individuals Interviewed or Contacted by Investigator:**
**Provide redaction code, name, title or relationship to Alleged Victim, method of contact and date for each person interviewed:**

| Name and Position | Agency | Redaction Code | Redacted Number | Date | Telephone Interview? |
|---|---|---|---|---|---|
| [redacted] | Bass River Inc. | ALAB | 1 | 04/19/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 1 | 06/19/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 2 | 05/16/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 3 | 05/16/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 4 | 04/21/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 4 | 06/13/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 5 | 06/19/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 6 | 04/19/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 6 | 04/20/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 6 | 06/14/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 7 | 04/19/2017 | No |
| [redacted] | Bass River Inc. | ALAB | 7 | 08/15/2017 | No |
| Anna Eves, Mother/Guardian | | I | 1 | 04/19/2017 | Yes |
| Anna Eves, Mother/Guardian | | I | 1 | 04/21/2017 | No |
| Anna Eves, Mother/Guardian | | I | 1 | 04/26/2017 | Yes |
| Anna Eves, Mother/Guardian | | I | 1 | 04/28/2017 | No |
| Anna Eves, Mother/Guardian | | I | 1 | 07/28/2017 | Yes |

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| | | | | | |
|---|---|---|---|---|---|
| | Community Enterprises Inc. | I | 2 | 04/24/2017 | Yes |
| | Cape Ann Special Olympics | I | 3 | 08/14/2017 | Yes |
| | EMARC | I | 4 | 04/20/2017 | Yes |
| | EMARC | I | 4 | 04/24/2017 | No |
| | EMARC | I | 5 | 04/24/2017 | No |
| | Bass River Inc. | I | 6 | 04/20/2017 | No |
| | | I | 7 | 06/08/2017 | No |
| Senior Investigator Heather Mooskian | DDS Investigations | C | 1 | 04/21/2017 | No |
| Senior Investigator Heather Mooskian | DDS Investigations | C | 1 | 08/15/2017 | No |
| | Cape Ann Medical Center | C | 2 | 05/18/2017 | Yes |
| | Cape Ann Medical Center | C | 2 | 08/14/2017 | Yes |
| | Cape Ann Medical Center | C | 2 | 09/05/2016 | Yes |
| , | Cape Ann Medical Center | C | 2 | 09/06/2017 | Yes |
| | Addison Gilbert Hospital | C | 3 | 04/21/2017 | No |
| Acting Area Director Tom Marshall | DDS NSAO | C | 4 | 04/21/2017 | Yes |
| Gina Hunt, DDS Northeast Region MAP Coordinator | DDS | C | 5 | 05/15/2017 | No |
| | Bass River Inc. | C | 6 | 04/21/2017 | Yes |

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***Redaction Code Key***

**ALV - Alleged Victim (required)**
**ALAB - Alleged Abuser**
**OI - Other Individual**
**I - Denotes person interviewed during this investigation**
**C - Denotes person contacted for collateral or expert/professional opinion.**
**R - Denotes person referred to in the report that was not questioned.**
*** - Denotes telephone interview**
****- Email contact**



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► **It does not appear that the abuse report constitutes a malicious "False Report."**
*118 CMR Definition: False Report - a report of abuse which at the time it is made is known by the reporter not to be true and is maliciously made for: the purpose of harassing, embarrassing or harming another person; the personal financial gain of the reporter; acquiring custody of the person with a disability; or the personal benefit of the reporter in any other private dispute involving a person with a disability. The term False Report does not include a report of abuse of a person with a disability that is made in good faith to the Commission and subsequently is unsubstantiated or screened out for lack of jurisdiction under M.G.L. c. 19C.*

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▶ **Protective Service Actions Taken and/or Recommended (required when abuse is substantiated):** -The ALV was taken to Addison Gilbert hospital where he was admitted and intubated with a diagnosis of Aspiration pneumonia and respiratory failure. The ALV was subsequently transferred to Massachusetts General Hospital. The ALV was then admitted to Spaulding rehabilitation hospital.

-The ALV has since been removed from the group home by I1. He is currently living with I1 at I1's home. It is recommended that the DDS Area Office work with the ALV and I1 to find suitable placement for the ALV. It is also recommended that the Area Office offer any supports necessary to I1 and the ALV while the ALV remains in I1's home.

▶ **Additional Findings of Risk:** -All direct care staff admitted that the ALV does get up in the middle of the night and wanders downstairs for food and drink. All staff interviewed stated that because they are sleeping staff, they do not get up and redirect the ALV back to bed.

-All direct care staff admitted that a peer of the ALV who resides at Oak Ave also uses a CPAP machine overnight.

-Direct care staff who had been MAP trained stated that because they were not permanent full time employees of the group home it was not their responsibility to administer medications.

-Medications and records were removed from the home and although many staff referenced certain records, these records were never found by the investigator.

-Although the ALAB7 changed her statement during the formal interview, she informed this investigator initially that the staff from the group home would not speak to her, per her directive. This was corroborated by staff when the investigator went to the home.

-ALAB6 and direct care staff all stated that ALAB6 is rarely in the home, as she is either at the office or in meetings. ALAB6 could not list the meetings to this investigator that would take up her entire days.

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► **Additional Recommendations and/or Actions Already Completed (required when additional risk is identified):** -With testimony that the ALV and his peers waking and wandering the home, poses a serious risk to the residents of the home. It is recommended that the Area Office review the staffing levels of the home. As the home has only asleep staff on the overnight shift.

-It is recommended that the Area Office further review the overnight staff levels at the home as a peer of the ALV also uses a CPAP machine overnight and with only asleep overnight staff, this can pose a risk if the CPAP machine is not being used properly.

-It is recommended that the agency have MAP training for all it's employees and all MAP certified employees are re-inserviced of their responsibility to administer medications.

-It is recommended that the Area Office take any action deemed necessary to ensure that records and medications are not removed from the home, as this was an impediment to the investigation.

-It is further recommended that the Area Office consider having the DDS QE Department evaluate the residence and it's license to operate as a DDS group home.

-It is recommended that any and all action be taken to ensure that Bass River Inc. and it's employees cooperate with investigations. It is further recommended that the Area Office take any and all action necessary to ensure that the house is properly supervised, [redacted]

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**Alleged Victim (Alv) Name**: BAGLANEAS, IOANNIS
**Address:** 15 Oak Ave, Peabody, MA, 01960
**Date of Birth:** 04/08/1988
**Social Security Number:** XXX-XX-9128
**Is the Alleged Victim a "Disabled Person" as defined by M.G.L. Chapter 19C &/or 118 CMR?:** Yes
**If no, please list the facts that support this determination:**

*118 CMR Definition: a person between the ages of eighteen and fifty-nine, inclusive, who is intellectually disabled, as used in M.G.L. c. 123B, § 1, or who is otherwise mentally or physically disabled, and, such mental or physical disability prevents or restricts the individual's ability to provide for his own daily living needs; provided, however, that a person who is temporarily dependent upon a medically prescribed device or procedure to solely treat a transitory physical ailment or injury shall not be considered a disabled person for the purposes of M.G.L. c. 19C unless that person otherwise meets the definition of a disabled person. The term The term "person with a disability" may be used in place of the term "disabled person" without changing the meaning of either.*

**Pertinent information regarding the Alleged Victim:** -The ALV is a 29 year old man who is diagnosed with Down Syndrome, Sleep Apnea, and Apraxia. The ALV requires the use of a CPAP machine every night for at least 5 hours to treat the Sleep Apnea. This CPAP machine is doctor ordered and monitored by [redacted] with the CPAP chip. The ALV relies on staff to assist him with all his daily living needs. He requires assistance with the administration of medication, ADL skill, money management and supervision in the community. The ALV is on a regular diet with no special modifications needed. The ALV does not require 1:1 or any special supervision.

► **Was the Alleged Victim interviewed?** No
**If no, explain why not.** An attempt was made to interview the ALV but was unsuccessful due to the ALV's extremely limited communication skills. The ALV can nod and say yes, however is not a reliable reporter of events. Although the ALV has the ability to nod no, most often he will nod yes when questions are asked of him.
**Does the Alleged Victim have a Guardian?** Yes
**Guardian Information:**
**Name:** BAGLANEAS-EVES,ANNA
**Address:** 17 HAVEN AVE, ROCKPORT, MA, 01966
**Telephone Number:** 978-546-7147
**Type of Guardianship:** Full Guardian

**Other Individual (OI) Name**:
**Address**:
**Date of Birth**:
**Social Security Number**:
**Is the OI a person with a disability as defined by M.G.L. c. 19C?**
**Disability**:
**Does the OI have a Guardian?**
**Guardian Information**:
Name:
Address:
Telephone Number:

**Pertinent information regarding the OI**:



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**Alleged Abuser (Alab) Name:** [redacted]
**Home Address:** [redacted]
**Telephone Number:**
**Date of Birth:** [redacted]
**Social Secnrity Number:** XXX-XX-[redacted]
**Relationship to Alleged Victim:** [redacted]
**Employer:** Bass River Inc., 15 Oak Ave., Peabody, MA, 01960

**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*

**Pertinent information regarding the Alleged Abuser:** [redacted]

-It should be noted that the ALAB1 was interviewed on 6/19/17 with C1 present. A rights form was given to the ALAB1.

▶ **Was the Alleged Abuser interviewed?** Yes **Date:** 04/19/2017
**If no, explain why not.**

**Alleged Abuser (Alab) Name:** [redacted]
**Home Address:** [redacted]
**Telephone Number:**
**Date of Birth:** [redacted]
**Social Security Number:**
**Relationship to Alleged Victim:** [redacted]
**Employer:** Bass River Inc., Peabody, MA, 01960

**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*



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**Pertinent information regarding the Alleged Abuser**: [redacted]

A rights form was given to the ALAB2.

▶ **Was the Alleged Abuser interviewed?** Yes **Date:** 05/16/2017
**If no, explain why not.**

**Alleged Abuser (Alab) Name**:
**Home Address**:
**Telephone Number**:
**Date of Birth**:
**Social Security Number**:
**Relationship to Alleged Victim**:
**Employer**: Bass River Inc., 15 Oak Ave., Peabody, MA, 01960

**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:**

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*

**Pertinent information regarding the Alleged Abuser**:

-It should be noted that the investigator and C1 ended the interview, as the ALAB3 became uncooperative and failed to answer numerous questions. A rights form was given to the ALAB3.

▶ **Was the Alleged Abuser interviewed?** Yes **Date:** 05/16/2017
**If no, explain why not.**

**Alleged Abuser (Alab) Name**:
**Home Address**:
**Telephone Number**:
**Date of Birth**:
**Social Security Number**: XXX-XX-
**Relationship to Alleged Victim**:
**Employer**: Bass River Inc., 15 Oak Ave., Peabody, MA, 01960



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**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*

**Pertinent information regarding the Alleged Abuser:** [redacted]

It should be noted that the ALAB4 was first interviewed on 4/21/17 and then again 6/13/17 with C1 present. A rights was given to the ALAB4.

► **Was the Alleged Abuser interviewed?** Yes **Date:** 04/21/2017

**If no, explain why not.**

**Alleged Abuser (Alab) Name:** [redacted]
**Home Address:** [redacted]
**Telephone Number:**
**Date of Birth:** [redacted]
**Social Security Number:**
**Relationship to Alleged Victim:** [redacted]
**Employer:** Bass River Inc., 15 Oak Ave., Peabody, MA, 01960

**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*

**Pertinent information regarding the Alleged Abuser:** [redacted]

A rights form was given to the ALAB5.

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▶ Was the Alleged Abuser interviewed? Yes Date: 06/19/2017
**If no, explain why not.**

**Alleged Abuser (Alab) Name:** [redacted]
**Home Address:** [redacted]
**Telephone Number:**
**Date of Birth:** [redacted]
**Social Security Number:**
**Relationship to Alleged Victim:** [redacted]
**Employer:** Bass River Inc., 15 Oak Ave., Peabody, MA, 01960
**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes
**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*
**Pertinent information regarding the Alleged Abuser:** [redacted]

It should be noted that the ALAB6 was interviewed 3 times, first on 4/19/17 and also on 4/20/17 and 6/14/17 (with C1 present). A rights form was given to the ALAB6.
▶ Was the Alleged Abuser interviewed? Yes Date: 04/19/2017
**If no, explain why not.**

**Alleged Abuser (Alab) Name:** [redacted]
**Home Address:** [redacted]
**Telephone Number:**
**Date of Birth:** [redacted]
**Social Security Number:** XXX-XX-[redacted]
**Relationship to Alleged Victim:** [redacted]
**Employer:** Bass River Inc., 437 essex St., MA



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**Does the Alleged Abuser meet the definition of a "caretaker" as defined by M.G.L. Chapter 19C &/or 118 CMR?** Yes

**If Alab does meet the definition, provide at least one example of care provided. If Alab does not meet the definition, list facts that support this determination:** [redacted]

*118 CMR Definition: any state agency or any individual responsible for the health and welfare of person with a disability by providing for or directly providing assistance in meeting a daily living need regardless of the location within which such assistance occurs. Minor children and adults adjudicated incompetent by a court of law shall not be deemed to be caretakers.*

**Pertinent information regarding the Alleged Abuser:** [redacted]

-It should be noted that the ALAB7 was also interviewed on 8/15/17, with C1 present. A rights form was given to the ALAB7.

► **Was the Alleged Abuser interviewed?** Yes **Date:** 04/19/2017
**If no, explain why not.**

► **Was the Reporter interviewed?** Yes
**If no, explain why not.**

► **Was an agency representative interviewed?** Yes
**If no, explain why not.**

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▶ **Site of Abuse: 15 Oak Ave. Peabody, MA**

▶ **Name of Vendor if Site of Abuse is a vendor: Bass River Inc.**

▶ **Pertinent Information regarding the Site of Abuse:** -Several visits to the site were made by this investigator and C1. Upon the first site visit, the ALV's medications were removed from the residence. In addition, records were also removed and/or unaccounted for when investigators tried to obtain records.

An exhaustive search of the records from the home was conducted by this investigator and C1. The following records were never obtained(although requested numerous times): daily after hours on-call shift report, pertinent emails during time frame in question, daily shift report, ISP paperwork, Robitussin medication sheet, medication notification sign sheet, various staff schedules, staff communication book records. As all staff with the exception of the ALAB7 stated that they had knowledge that many of these records existed.

▶ **Photographs /Physical /Other Evidence:** -Picture of ALV on 4/9/17
-Voicemail from the ALAB6 to II on 4/13/17.

| ▶ Documents Reviewed: | Date(s): |
|---|---|
| ☐ Accident Report | |
| ☐ Activity Report | |
| ☒ Admission Report | 04/15/2017 |
| ☐ Ambulance Log/ Trip Sheet | |
| ☐ Audio Recording | |
| ☒ Communication Book | 04/28/2017 |
| ☐ Death Report | |
| ☐ Discharge Summary | |
| ☒ Doctor's Orders/ Note | 04/13/2017 |
| ☐ Facility Security Log | |
| ☐ Hospital Record | |
| ☐ Human Rights Complaint | |
| ☐ Human Rights Report | |
| ☒ Incident Report | 04/15/2017 |
| ☐ Individual Day Program Agency Record | |
| ☐ Individual Education Plan | |
| ☐ Individual Residential Agency Record | |
| ☐ Individual Service Agency Record | |
| ☒ Individual Service Plan | 08/25/2016 |
| ☐ Individual Treatment Plan | |
| ☐ Injury Report | |
| ☐ Level of Supervision Form | |
| ☐ Medical Examiner's Report | |
| ☐ Medical Record | |
| ☒ Medication Error Report/ Form | 04/14/2017 |
| ☐ On-Call Record/ Schedule | |
| ☐ Personnel File | |
| ☐ Policies and Procedures | |
| ☐ Previous Abuse Investigation Report | |
| ☐ Previous Hotline Report | |
| ☒ Progress Notes | 04/20/2017 |
| ☐ Police Report | |
| ☐ Psychiatric Evaluation/ Report | |
| ☐ Psychological Evaluation/ Report | |
| ☐ Psychosocial Evaluation/ Report | |
| ☐ Quality Assurance Report/ Evaluation | |
| ☐ Restraint/ Seclusion Form | |
| ☒ Staff Assignment Schedule | 04/20/2017 |
| ☒ Staff Communication Log | 04/20/2017 |
| ☐ Video Recording | |

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**Additional Documents Reviewed:** DPPC intake #155957 and #156003
Meditech notes
Confidential Record
Medication sheets
Doctors medication orders
PCP consultation notes
Addison Gilbert Hospital medical records
Massachusetts General Hospital medical records
Spaulding Rehabilitation Hospital medical records
CPAP machine compliance report received from I1 on 4/26/2017 & 6/19/17
Some written statements

**Criminal Investigation and Prosecution Status:**
**Was a criminal investigation conducted?** No
**Were criminal charges filed?** No
**Type of charge filed:**
**If other explain:**
**Prosecution result:**
**If other explain:**

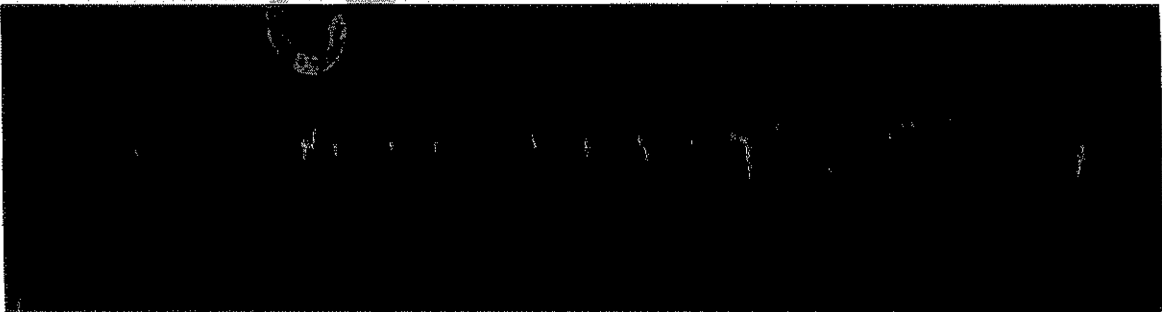
**The assigned investigator and their supervisor certify that to the best of their knowledge the information contained in this M.G.L. c. 19C investigation report for DPPC case number 155957, 156003 is accurate.**

| SANTOS, KRISTA | 08/28/2017 |
|---|---|
| **Investigator Name (print or type)** | **Date Report Submitted to Supervisor** |
| MOOSKIAN, HEATHER | 08/31/2017 |
| **Supervisor Name (print or type)** | **Date Report Approved by Supervisor** |

**This report was submitted by** SANTOS, KRISTA **on** 08/28/2017.

**This report was approved by** MOOSKIAN, HEATHER **on** 08/31/2017.

**This report was finalized by** MOOSKIAN, HEATHER **on** 09/08/2017.





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