English placement essay

Nearly 20 years ago, Raymond received severe head trauma from a car accident which left IM in a coma for nearly a month. Eventually, Raymond recovered but he had difficulty, especially with his memory. Harriet becomes Raymond primary caregiver. Harrier'shealthbegan to decline over the years eventually suffering a stroke and a broken hip requiring her placement in skillednursinghome. Thefamilyfound themselves trying to determine what arrangements their mother had made for her care as well as Raymond.

They found that she neglected to address any of their affairs; no powers of attorney, no living wills, no wills and very small nest egg. It was to long after Harriet placement in the home that Raymond is placed thedementiaward of the same facility as Harriet. Because of the lack of planning Raymond son had to be declared is father's legal guardian by the Courts. Although the nursing home claimed the fourth floor was a dementia unit, it was little more than a limited access skilled nursing unit. Patients were permitted to wander the ward with little or no supervision.

The family was not happy about the situation but with limited financial resources there was no choice. On February 28th, 2011, Raymond was wandering the halls of the unit, one can only surmise what occurred next. According to a subsequent state investigation, the wing was left unsupervised. An amputee patient fell out of his wheelchair. A life member of the volunteer fire department Raymond heard the wonder alarm sounding and intuitively he attempted open the large nutritional door to the patient's room.

The patient was lying on the floor directly behind the door. The door would not open, so Raymond continued to push on the doors trying to be of assistance. Eventually, the staff heard the alarm and responded to find Raymond in the hall and the patient on the floor with head trauma. After the incident, the family received a call from the nursing home stating that Raymond need to go to the hospital psychiatric unit. The family was not alarmed as this had happened a few times before.

The home failed to elaborate. The morning news told the story of an incident of a dementia patient assaulting another. The following evening the news was of a dementia patient being charged with aggravated assault with the District Attorney office considering homicide charges. The family had to obtain a criminal attorney for Raymond, who had already been declared legal incompetent by the courts. It seems the nursing home had not mentioned that to the charging officer or the District Attorney's office.

They also had to obtain a civil attorney because the victim's family had indicated they were going to sue all the parties involved. Raymond could be of little help in his defense and became confused easily reverting to his earliestmemories. Investigations were being conducted into the events that led to this tragedy. The district attorney's office hired a forensic psychiatrist to determine if Raymond was competent and the state department of public welfare was conducting its own investigation. Meanwhile, being unified too hospital psychiatric unit Raymond health declined quickly.

He refused to feed himself and became frustrated if others offer to feed himself; a natural progression of dementia. Because of Raymond overall

health a feeding tube was rejected by the family. On the evening of April 30, 2011, Raymond died alone in the same hospital as his victim had two months earlier. The following day the district attorney's office stated that Raymond would not have been charged with any criminal charges. Six weeks later the nursing home suffered one of the largest fine in the history of the State as well as being placed on a provisional license.