19.

Resident: Herbert H.
State: Pennsylvania
Type of Facility: Nursing Home
Residency: 4/17/01 – 10/31/01

THE BEFORE PICTURE

An introduction to Herbert H.

- Age: 76
- Life's occupation: Supervisor, U.S. Postal Service
- 2 children, 4 grandchildren
- Decorated U.S. Army veteran
- Loved to golf and bowl

Facility assessment of Herbert H. upon admission:

- Parkinson's Disease
- Dementia
- Swallowing difficulty
- Received nutrition via a feeding tube

A PROFILE IN NEGLECT

How Herbert H. was neglected:

- From May 19, 2001 through June 16, 2001, nursing staff documented that Mr. H. either pulled out his feeding tube or pulled at the tube and its dressing several times. On two occasions, the tube had to be reinserted at the hospital.
- Although Mr. H. had repeatedly pulled out his feeding tube, the facility failed to address this behavior or develop any interventions to prevent his removal of the feeding tube.
- At 4:30 p.m. on October 30, 2001, Mr. H. pulled out his feeding tube while in the shower. There was bleeding from the insertion site.
- Despite the fact that bleeding had occurred and that on two previous occasions his tube had required reinsertion at the hospital, the Director of Nursing reinserted the tube. The Director of Nursing documented that the reinsertion was "traumatic" because Mr. H. "stiffened" during the process.
- According to a Pennsylvania Department of Public Health investigation, the Director of Nursing did not verify the positioning of the tube in accordance with facility policy. As a result, she failed to recognize that she had in fact incorrectly placed the tube into the lining of Mr. H.'s stomach.
- Mr. H. continued to be fed via the misplaced feeding tube.
- Nursing staff did no further monitoring of Mr. H. until requested to do so at 8:00 p.m. by Mr.

H.'s family. According to the nurse's notes, Mr. H. was cold, moaning, crying out, grimacing and in pain. A large amount of blood had soaked through his dressing at the feeding tube site.

- The nurse stopped the tube feeding and administered Tylenol for pain via the feeding tube. There is no documentation to show that she verified the placement of the feeding tube or that she notified the doctor about Mr. H.'s change in condition.
- Nursing staff did not monitor or assess Mr. H. again until summoned for the second time by the family, who stated that Mr. H. was "all wet and clammy."
- The nurse observed that Mr. H. continued to cry out in pain and contacted the doctor, who prescribed Darvocet* for severe pain. The Darvocet was administered to Mr. H. via the feeding tube.
- By 10:30 p.m., Mr. H. was experiencing increased pain, and his abdomen was "tight." The nurse called the doctor, who then ordered that Mr. H. be sent to the hospital for evaluation of the feeding tube placement.
- Tests conducted at the hospital found that the Director of Nursing had reinserted the feeding tube incorrectly. As a result, the food and medications that nurses had given repeatedly via the feeding tube had gone into Mr. H.'s peritoneum*, rather than his stomach, causing peritonitis*.
- Mr. H. continued to suffer pain while at the hospital and died at 1:59 p.m. on October 31, 2001. The cause of death was listed as blood in the peritoneum due to perforation of the feeding tube tract.

The human cost of neglect:

- Horrific pain and suffering for over 21 hours
- Peritonitis
- Death

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.................................... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .... **No**
- Did the survey agency place the facility on state monitoring status?.................. **No**
- Was the facility's license placed on probationary status or revoked for this neglect?.................................... **No**
- Was this neglect criminally prosecuted? .... **No**
- Was action taken by the nurse licensing board? .... **No**