



Resident: Katherine J.
State: Arizona
Type of Facility: Nursing Home
Residency: 6/22/2001 – 7/1/2001

THE BEFORE PICTURE

An introduction to Katherine J.

- Age: 72
- Life's occupation: Mother and homemaker
- Enjoyed cooking and sewing
- Volunteered with several organizations

Facility assessment of Katherine J. upon admission:

- Stage II* pressure sore on buttocks
- Type II diabetes
- Vitamin B12 deficiency
- Congestive heart failure*

A PROFILE IN NEGLECT

How Katherine J. was neglected:

- Mrs. J. was admitted to the nursing home on June 22, 2001, following an episode of loss of consciousness at her home, where she had been living independently, and a subsequent four-day hospitalization.
- She was not evaluated by either a registered nurse or physician at the nursing home until June 25, 2001, her fourth day at the facility.
- The hospital discharge summary noted a small blister with a reddened area on Mrs. J.'s buttocks. In the assessment done June 25, the nursing home admission nurse noted a vastly different description of the sore on Mrs. J.'s buttocks, indicating it was a large, foul-smelling, 11 inch x 13 inch pressure sore covering both buttocks.
- Physician orders for an egg crate mattress and, later, a pressure relief mattress for Mrs. J., were not followed.
- Mrs. J.'s son testified that he found his mother lying on her back whenever he visited, which was daily, even though she was admitted with a pressure sore on her buttocks.
- As a result, what was originally a Stage II pressure sore progressed to a massive Stage IV* pressure sore measuring 5 cm in diameter and 4.5 cm deep with tunneling* from the wound.
- The hospital physician who treated the pressure sore testified it was the worst pressure sore he had ever seen.
- Because of Mrs. J.'s weakness, her doctor ordered that her food be pureed; however, the facility failed to follow this order until the very end of her stay. As a result, Mrs. J. did not get the nutrition she needed to help her pressure sores heal.

- Although staff records indicated that Mrs. J. ate well at almost all meals, Mrs. J.'s son testified that this was not true based on his personal observations during lengthy, daily visits with her. He often found his mother's dinner tray cold and untouched, far from her reach. Because of general weakness, Mrs. J. needed help with eating. Mrs. J.'s son never saw staff assist her with eating.
- Despite repeated nurses' notes documenting that Mrs. J. moaned, grimaced, and cried out in pain, staff failed to address her pain. Records show that at the nursing home she was only given an occasional Tylenol for pain, and then nothing for three days (June 25 – June 28, 2001). Just before she was transferred to the hospital on July 1, 2001, she received a few Darvocet* pills. Upon her admission to the hospital, hospital staff found that Mrs. J.'s pain was so severe that she was given Demerol* injections.
- Nursing home staff also failed to adequately clean Mrs. J.'s urinary catheter*. Hospital records noted that the catheter was dirty when she entered the hospital on July 1, 2001.
- A nurse's note on July 1, 2001, when Mrs. J. was transferred to the hospital, indicates that the reason for the transfer was the insistence of Mrs. J.'s son: "Family concerned about the patient's 'condition,' temperature of 100 F ... and just not as responsive to son as before." Mrs. J.'s temperature upon admission to the hospital was 102.5 F, her heart rate was 130 per minute (adult normal = avg. 72 per minute), respirations were 30 per minute (normal for an adult at rest = 8–16 per minute), she was impacted, and diagnoses included sepsis and infected pressure sores.
- The hospital physician testified that this was the worst case of neglect he had ever seen in his practice.
- Mrs. J. died at the hospital on July 3, 2001, after undergoing debridement* of her pressure sore. Upon completion of the debridement, the sore measured 40 cm x 20 cm.
- The nursing home administrators testified that the systems of care at the nursing home were in "complete meltdown" and "massively broken" during the time Mrs. J. was a resident.

The human cost of neglect:

- Massive infected Stage IV sacral* pressure ulcer, requiring debridement and flap surgery*
- After debridement, Mrs. J. was left with a 40 cm x 20 cm gaping hole in her buttocks
- Untreated, severe pain

- Fecal impaction

- Death due to infection caused by pressure sores

The financial cost of neglect:

- \$27,869 (hospital expenses)

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**