Statement of Joy Nathan Stern before the District of Columbia Council Committee on Health 2014 Performance Oversight and Budget Hearing, March 7, 2014

When my mother died just days after the last in a series of critical interruptions in the 24-7 oxygen therapy she required at the Methodist Home, I filed a complaint with the D.C. Department of Health. That is how I discovered the serious shortcomings of the Department. Resorting to a Freedom of Information Act request, I obtained documents showing that the investigation into my complaint included an outrageous number of mistakes, omissions, incorrect dates, misquotes, distortions, missing interviews and overall inaccuracies. **These are failures of will, resources and effective leadership – all of which the D.C. Council has the power to correct.**

My complaint was essentially dismissed on the basis that there were no written records at the nursing home substantiating the incidents I reported. No substantiation! That is because *not a single incident* in which my mother suffered from disruptions in her oxygen supply was ever documented in the all- important daily nurse's notes -- the notes which the physician and other caregivers relied on to keep abreast of my mother's condition.

In the weeks prior to my mother's death *no nurse's notes were entered for 26 days.* With the support of the long-term care

ombudsman Lynn Person and attorney Mary Ann Parker, I attempted to convince the Department of Health to address the issue of the "gap" in the notes -- and to enact specific record-keeping requirements. This never happened.

The ombudsman's office submitted an excellent proposal to add language to the District's health regulations concerning the administering of oxygen. The proposal would require nursing supervisors to check *at regular intervals* that residents are actually getting the oxygen they so vitally need and which the doctor has ordered. The Department of Health rebuffed our effort.

Unfortunately, as recently as last July -- two years after my mother's death – the Centers for Medicare and Medicaid Services, in a full survey of the Methodist Home, cited the facility for deficiencies in respiratory care "with potential for more than minimal harm."

Through another Freedom of information Act request I received a copy of that survey which noted, among other things, that there would be no provider's plan of correction for one of the residents affected by the respiratory deficiency *because that resident had expired.*

Right after my mother died, I met with Mary Savoy, the Director of Nursing at the Methodist Home, and Sandy Douglass, the Administrator, to once again emphasize the gravity of the

situation. Ms. Savoy took some notes and asked me “what do you want”? Ms. Douglass said, “I’m a CEO, not a clinician. What do you want”?

This is what I want:

First, please direct the Department to enact requirements for **complete and accurate documentation** (rather than accept the absence of documentation as an excuse for doing nothing about substandard and life-threatening care).

Second, **impose specific regulations for oxygen therapy** – most importantly, mandating the adoption of protocols requiring supervisors to confirm, *at regular* intervals, that residents in need of continuous oxygen have not been left without it by accident or negligence (as happened, in my mother’s case, so many times).

And last, that when complaints are made, the Department should understand that the complaints are an ***opportunity*** to see if a real problem exists, and propose reasonable solutions, rather than fall back on the easy response that since the facility made no record of the alleged negligence, there is no basis for taking action.

Thank you.