8.

Resident: Albert S.
State: California
Type of Facility: Nursing Home
Residency: 8/27/02 – 1/25/03

THE BEFORE PICTURE

An introduction to Albert S.

- Age: 79
- Life's occupation: Structural engineer
- Four children, two grandchildren
- Decorated veteran of WWII
- Married for 55 years

Facility assessment of Albert S. upon admission:

- Broken hip
- Transverse myelitis★
- Totally dependent on staff for help with dressing/grooming, walking, bathing, and transferring★

A PROFILE IN NEGLECT

How Albert S. was neglected:

- Although Mr. S. was able to feed himself when he was admitted to the facility in August 2002, nursing staff noted in their admission assessment that he had nutritional problems, leaving 25% to 75% of his food uneaten at meals. Nursing staff therefore initiated a care plan to address weight loss and dehydration.
- Nursing staff failed to implement this care plan, resulting in weight loss and severe dehydration.
- Sometime between January 16 and 20, 2003, Mr. S. aspirated★ food into his lungs while he was eating.
- Between January 20 and 25, Mr. S. became "difficult to arouse," developed a temperature of 101 degrees, had a significant deterioration in blood pressure, developed slurred speech, and, finally, developed a cough with "greenish yellow secretions," a high fever and cloudy urine.
- This problem was left untreated by facility staff for five days despite the onset of this succession of alarming symptoms.
- Staff failed to notify Mr. S.'s physician of his change in level of consciousness and other symptoms and did not take his vital signs. The physician said, "I would have sent him out to the hospital for any change in his level of consciousness….I had no idea this was going on."
- On January 25, 2003, nurses noted that Mr. S. was very pale, had twitching arms and milky urine that contained blood, and was unable to respond verbally.

- Even after these findings, facility staff took no action to help Mr. S. until his daughter repeatedly requested that they send him to the hospital.
- Upon his admission to the hospital on January 25, Mr. S. was found to be suffering from aspiration pneumonia*, profoundly dehydrated, and severely malnourished. Mr. S. died of aspiration pneumonia and renal* failure due to dehydration on January 28.
- In the preceding two years, the facility had been cited seven times for similar violations such as failure to identify resident care needs, failure to implement a care plan, and failure to notify physicians of a change in medical condition.
- The Department of Health Services determined that the nursing staff's failure to assess Mr. S., update his care plan, and notify the physician of changes were a "direct proximate cause" of his death.

The human cost of neglect:

- Aspiration pneumonia*
- Renal failure* due to severe dehydration
- Death

The financial cost of neglect:

- $59,264 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? ..... **$10,000 (reduced from $75,000)**
- 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**