22.

Resident: Germaine M.
State: Rhode Island
Type of Facility: Nursing Home
Residency: 9/14/00 – 2/29/04

THE BEFORE PICTURE

An introduction to Germaine M.

- Age: 87
- Life's occupation: Factory worker
- 2 children, 4 grandchildren, 2 great grandchildren
- Hosted square dance parties at her house

Facility assessment of Germaine M. upon admission:

- At risk for malnutrition
- Needed monitoring of food and fluids to ensure adequate intake
- Independent in eating, toileting, bathing, dressing/grooming, and transferring★
- Able to walk with a cane

A PROFILE IN NEGLECT

How Germaine M. was neglected:

- In late 2002, two years after Mrs. M. entered the nursing home, she fractured her left hip and subsequently experienced infection of her hip replacement. She became less mobile, which placed her at risk of pressure sores★.
- Mrs. M. developed a Stage I★ pressure sore on her left buttock in August 2003.
- In December 2003, Rhode Island Department of Health surveyors observed that this sore had deteriorated to a Stage II★ pressure sore and discovered two new Stage II★ pressure sores — one on Mrs. M.'s coccyx★ and one on her left lower buttock. The facility had been unaware of both of these new pressure sores.
- Nursing staff failed to follow doctor's orders for pressure relief of Mrs. M.'s heels and for a pillow to be placed under Mrs. M's legs.
- Mrs. M. was left lying in urine and stool without dressings in place on multiple occasions, which probably caused or contributed to an infection of the sores. On one occasion, nursing staff told the surveyors that they had been out of dressings for at least 3 days.
- By February 13, 2004, Mrs. M.'s left buttock pressure sore had worsened to a Stage IV★ sore. State surveyors documented that dressings for Mrs. M.'s pressure sores were not changed or were improperly changed. One of the state surveyors later described Mrs. M.'s pressure sore, saying, "It's going through layers of skin. It's nine centimeters long, five wide, and three cen-

timeters deep. Deep, and it had a bloody discharge and large area of redness." The Department of Health determined that Mrs. M. was at immediate risk of serious injury or harm and ordered that she be moved to another unit that had less staff turnover.

- State surveyors found that nursing staff were not properly documenting Mrs. M.'s fluid intake and output and not providing her with the fluids she required.
- Based on a significant decline in Mrs. M.'s condition and care, the Rhode Island Department of Health ordered that she be moved to another facility on February 28, 2004.
- The facility where Mrs. M. had lived since September 2000 had a long history of poor pressure sore care. The Department of Health cited the nursing home for failure to prevent and treat pressure sores in December 2000; November 2001; October 2002; and yet again in November 2003.
- On June 6, 2004, the facility closed. A special report called for by the Rhode Island Governor states that the Department of Health (DOH) "should have taken more aggressive action to prevent further deterioration" of Mrs. M.'s condition after its survey on February 2, 2004. The report also notes that the "DOH should have moved more quickly to close admissions, to increase inspections, and based on the continued non-compliance, to close the facility."

The human cost of neglect:

- Stage IV pressure sore on buttocks
- Stage IV pressure sore on coccyx with tunneling* under the skin
- Pressure sore on heel
- Pain associated with pressure sore dressing changes

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**Yes**
- What was the amount of fine actually paid? .....**$0 as of 3/4/05 ($85,250 fine imposed)**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**Yes**
- Did the survey agency place the facility on state monitoring status? .....**Yes**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted? .....**Yes. There were 11 counts of neglect against the administrator.**
- Was action taken by the nursing home administrator licensing board?...**Yes. The license was revoked.**