



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**



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 | • Did the survey agency place the facility on state monitoring status?..... | No |
| • What was the amount of fine actually paid? | \$10,000
(reduced from \$75,000) | • Was the facility’s license placed on probationary status or revoked for this neglect?..... | No |
| • Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? | No | • Was this neglect criminally prosecuted? | No |



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



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.



Resident: Margaret D.
State: West Virginia
Type of Facility: Assisted Living
Residency: 8/24/98 – 9/30/99

THE BEFORE PICTURE

An introduction to Margaret D.

- Age: 78
- Life's occupation: Homemaker
- 2 children
- Enjoyed sewing

Facility assessment of Margaret D. upon admission:

- Alzheimer's Disease
- Had had a stroke

A PROFILE IN NEGLECT

How Margaret D. was neglected:

- Because of her Alzheimer's Disease and increased wandering away from home, Mrs. D.'s family felt that they could no longer care for her safely at home and admitted her to the facility on August 24, 1998. Mrs. D.'s family discussed her wandering with facility staff, and they assured Mrs. D.'s family that they were equipped to care for her and keep her safe.
- Subsequent to her admission, Mrs. D.'s cognitive and physical abilities deteriorated. Mrs. D.'s wandering and elopement* behaviors and frequent falls put her at high risk.
- From the time of her admission until the time of her death, Mrs. D. left the facility without notice by facility staff on 15 occasions. On one occasion, Mrs. D. was shocked by an electric fence while wandering from the facility.
- During her stay at the facility, Mrs. D. also experienced more than 22 falls. Several of the falls resulted in injury, including skin tears, bruises, scratches, and displacement of teeth.
- Despite these ongoing risks to her safety, the facility failed to effectively implement care and treatment plans to address Mrs. D.'s behaviors and conditions, such as bed or chair sensors, a Wanderguard bracelet, involvement in planned group activities, or relocation to a room where visual supervision was readily available.
- The facility also failed to determine that it could not effectively care for Mrs. D. and seek alternative placement to a facility with a contained living unit for residents for whom elopement is a risk.
- Unsupervised by staff, Mrs. D. wandered from the facility again on September 30, 1999. At 6:45 p.m., she was found outside of the facility on the roadway, unresponsive, and with head injuries. She died of her injuries a few hours later at the hospital.

The human cost of neglect:

- Multiple injuries from falls
- 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?**Not applicable**

- 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**