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**SUMMARIES
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\$525,000 Recovery – Nursing home negligence – Violation of regulations and Public Health Law relating to evaluation and treatment of nursing home resident – Decubitious ulcers – Death Action.11

\$525,000 RECOVERY – NURSING HOME NEGLIGENCE – VIOLATION OF REGULATIONS AND PUBLIC HEALTH LAW RELATING TO EVALUATION AND TREATMENT OF NURSING HOME RESIDENT – DECUBITIOUS ULCERS – DEATH ACTION.

Orange County

The plaintiff contended that the 87-year-old patient was admitted to the defendant nursing home with a history of mild dementia, congestive heart failure, depression and hypothyroidism, but in good nutritional condition and with totally intact skin. The plaintiff contended that the defendant nursing home failed to properly evaluate the patient for the risk of decubitus ulcers and negligently failed to implement procedures to avoid the formation of such ulcers and provide treatment once they formed. The plaintiff further contended approximately three months after the patient was admitted to the facility, she died from sepsis secondary to decubitus ulcers. The plaintiff maintained that the facility violated PHL §2801-d in that it violated PHL §2803-c and numerous New York State and Federal regulations in addition to committing gross negligence and medical malpractice and such violations give rise to liability.

The evidence reflected that upon admission to the nursing home, the patient was assessed by the defendant's nurses as being at "moderate" risk for decubitus ulcer development when she scored "high" risk because of incontinence and immobility. The plaintiff contended that the care plan for dealing with the risk of decubitus ulcers was incomplete in that it failed to identify risk factors and it failed to identify goals. The plaintiff maintained that nurses soon noted that the patient had a poor appetite and they did nothing about it. The resident spoke Italian and no staff did so. The plaintiff also contended that although both the family and health care proxy regularly visited, the staff did not discuss food preferences nor inform the family of her poor appetite. The plaintiff contended that proper maintenance of nutrition is essential to prevent the skin from becoming brittle and more susceptible to decubitus ulcers.

The plaintiff established that after an initial assessment that is conducted when the patient is first admitted, the defendant must complete a Minimum Data Set (MDS) form from days 14 to 21 enabling the staff to conduct a thorough assessment once they have had the opportunity to observe the patient for a period of time. The plaintiff contended that although the first comprehensive MDS assessment should have triggered a resident assessment protocol (RAP) for pressure ulcers, the defendant failed to conduct such an assessment. In her deposition, the plaintiff maintained that the charge nurse admitted that the facility had no RAPs for pressure ulcers. The plaintiff contended, therefore, that pertinent interventions for incontinence and immobility, the necessity of addressing the issues of toileting and skin care in order to prevent skin breakdown, were not included in the care plan. The plaintiff maintained that no clear direction

was provided for the certified nursing assistants (CNAs) regarding toileting and types of incontinence care. The plaintiff further maintained that there were no directives regarding heel pads, wheelchair cushions or turning and positioning on the CNA's records.

The plaintiff further contended that although the patient's appetite was still noted as poor, no action was taken to address the issue. The defendant denied that the plaintiff's claims should be accepted. The defendant pointed to handwritten orders by a charge nurse, on admission, for ulcer preventative care, such as turning and positioning, the use of an air mattress and the use of heel pads. The nurse testified that the order with the handwritten additions was faxed to the pharmacy. The plaintiff presented evidence from the pharmacy of the orders without the handwritten entries. The plaintiff contended that the implication of false charting was reinforced by the plaintiff's expert who identified that there were no turn and position records in the chart and that the heel pads and air mattress were ordered by doctors much later.

At deposition, the defendant's witness stated there were, in fact, turn and positioning records kept, but that they must have been misfiled in someone else's chart.

The plaintiff contended that the patient's nutrition and hydration levels were diminishing and no one acted. Within weeks, the ulcers began. The plaintiff maintained that after the ulcers began to develop, there were serious delays, deficiencies, and many failures in documenting, assessing, monitoring, tracking, and treating the pressure ulcers by both the nursing staff and the physicians at the nursing home. The first documentation of the ulcers indicated that the resident had "another" open area. At deposition, the defendant responded that there was no pressure ulcer prevention protocol in the facility at that time. The plaintiff established that the care plan for pressure ulcers was not updated and that there were no treatment orders or actual treatment for another ten days. The plaintiff contended that when the nursing home finally began treating the ulcers, the treatment was improper and/or incomplete in that no wound cultures were taken and no medicines, including antibiotics were ordered, to treat an obvious infection. There was now degradation to the sacrum to a stage IV pressure ulcer with infection.

The nursing home doctor testified that he did not examine the ulcers under the dressing as the nurse failed to tell him the ulcers were infected. The plaintiff contended that the progress notes then indicated that her motivation had decreased secondary to decubitus on buttocks and pain from being in bed for the past week. The following day, a physician attended and addressed her edema, but never mentioned her severe pressure ulcers. The resident's lab results revealed that her albumin level was now at 2.1. However,

the physician reviewing the lab results did not address the lower albumen level. The pressure ulcers were still not being tracked to determine if the treatment was effective.

The resident had a significant weight loss of eight pounds in one month. The plaintiff maintained that although the records noted that protein supplements were contraindicated, the nursing home made no determination regarding what protein the patient was getting from her meals. The plaintiff contended that in view of such a significant and unintended weight loss, the nursing home was required to properly address the weight loss, and failed to do so. The plaintiff maintained that the staff "watched the patient starve" and suffer malnutrition and did not perform an assessment. The plaintiff further contended that although a podiatry evaluation was performed that indicated a stage IV ulceration of the left medial heel and the instructions indicated "dispense heel protectors to patient's left heel," the heel ulcer had not received pads as supposedly ordered earlier.

The plaintiff also maintained that the defendant never told the family that the ulcers had developed, nor were they told that the ulcers had become infected and that whatever opportunity the family had to intercede to secure medical help was not possible due to the lack of disclosure by the facility. The facility had no policies or procedures and the staff was not trained to inform the family. The plaintiff contended that a significant change MDS assessment was required to have been done due to the development of stage IV pressure ulcers and a significant weight loss and that the defendant failed to perform the new assessment and failed to properly maintain nutrition and hydration status.

The plaintiff contended that on December 30, 2002, it was noted that the patient had two stage IV pressure ulcers on her buttocks, a stage IV pressure ulcer on her right upper thigh, and a stage IV left heel pressure ulcer. All of the pressure ulcers were badly infected. The resident was malnourished and dehydrated. She had an unresponsive episode and was transferred to the hospital where the admitting doctor noted large and infected ulcers. At the hospital, plaintiff received intravenous antibiotics for the numerous infections caused by the pressure ulcers, percocet and a morphine drip in an attempt to relieve her of the pain. The patient succumbed and passed away on January 11, 2003. The cause of

death was sepsis secondary to multiple decubitus ulcers. The case settled prior to trial and after numerous depositions for \$525,000. As part of the settlement, the facility agreed to revise its policies and now requires staff to inform the family when there is any significant change in condition or where an ulcer develops, and the hire and use of translators to enhance communication with residents.

REFERENCE

Patane vs. St. Teresa's Nursing Home, Inc. Index no.154/05; Judge Lewis J.Lubell, 5-06.

Attorney for plaintiff: Robert A. Hyman of Pleasantville, N.Y.

COMMENTARY:

The plaintiff would have maintained that defendant violated sections of the Public Health Law and applicable regulations requiring prompt assessments of the patient. The plaintiff would also have maintained that the defendant failed to follow regulations concerning the provision of adequate hydration and nutrition of the patient, contributing to the development and lack of resolution of the decubitus ulcers. The violation of ulcer regulation would give rise to liability on the part of the nursing home.

It is felt that if the case had been tried, the evidence of the continuing failure to either prevent or respond to the ulcers and that the family was never advised that the ulcers had formed and had become infected and that the family was unable to intercede or provide alternative medical care, could have easily prompted a reaction of outrage on the part of the jury that would have been reflected in a very large damages award. Moreover, this reaction would probably have been heightened by finding upon the patient's transfer to the hospital with two large buttocks ulcers, "both open and draining foul-smelling discharge."

Finally, it should be noted, that as part of the settlement, the facility agreed to revise its policies and now requires staff to inform the family when there is any significant change in condition or where an ulcer develops. □