Jane Doe v. Excellence Rehab Center

Case #: 123-456-789

SSN: 123-45-6789

Date of Birth: 1/1/1948

Date of Death: N/A

BIOGRAPHICAL INFORMATION

Ms. Mary Doe, an 83-year-old African-American [also listed as Caucasian on admission record] female, was to Excellence Rehab Center from 5/19/06 to 6/8/06. Insurance information: Primary payer-Humana, policy number 00000000. [JANE-DOE-00001] Ms. Doe was listed as AR representative and DPOA surrogate. [JANE-DOE-00001] Ms. Doe had Full Code status. [JANE-DOE-00127]

Ms. Doe's medical history was significant for left CVA [cerebrovascular accident], hypertension, GERD [gastrointestinal reflux disease], sick sinus syndrome with pacemaker, depression [JANE-DOE-00004], and dyslipidemia. [JANE-DOE-00010] Ms. Doe was allergic to Penicillin. [JANE-DOE-00004]

ALLEGATIONS

No allegation information is available.

FACILITY INFORMATION

Excellence Rehab Center, facility is located at 123 Sunshine Dr., My Town, VA, 11111; phone 000-000-0000. While a resident at Excellence Rehab Center, Ms. Doe's primary physician was Dr. Ultrapain, 1 Smith Rd, Welcomeville, VA 00000; phone 000-000-0000. [JANE-DOE-00001] Nancy Nurse, NP, also participated in Ms. Doe's care. [JANE-DOE-00006]

The names of staff members who provided care for Ms. Doe while she was a resident at Excellence Rehab Center can be obtained in a separate Provider of Care report. Key personnel included Dr. Ultrapain, Nancy Nurse, NP, Susan Skin, RN [JANE-DOE-00050], and Wanda Wound, RN. [JANE-DOE-00052]

MEDICAL RECORD ANALYSIS

Case Overview

5/9/06-5/19/06 St. Elsewhere Hospital [incomplete records]

Ms. Doe presented with acute mental status changes to St. Elsewhere Hospital. She was diagnosed with an acute left middle cerebral artery infarct, with profound bradycardia and underwent temporary pacemaker insertion. She underwent permanent pacemaker placement. [JANE-DOE-00211]

5/19/06-6/8/06 Excellence Rehab Center
Ms. Doe was admitted from St. Elsewhere Hospital for rehabilitation, PT, and OT. She was seen by Dr. Ultrapain on 5/19/06 for history and physical. Her nutrition/hydration status was poor. Primary diagnoses were hypertension, left CVA with right hemiplegia, sick sinus syndrome, and GERD. Secondary diagnoses were hyperlipidemia, atrial fibrillation, pacemaker, and depression. [JANE-DOE-00004] Orders included medications of Norvasc, Lipitor, Lisinopril, Lopressor, Protonix, Digoxin, Coumadin, and Tylenol. She was to be on a pureed diet with thin liquids and oxygen at 2 liters would be provided as needed. [JANE-DOE-00005] Upon admission her vital signs were BP 181/72, pulse 79, respirations 20, temperature 99.8, and oxygen saturation level was 95%. She was alert and oriented; speech was garbled. She was incontinent of bowel and bladder and dependent for assistance with all ADLs. Bruising was present on her left forearm and she had 1+ pitting edema of her lower right extremity. She weighed 169 pounds and was 5 feet 3 inches tall. [JANE-DOE-00082=00086] She was totally dependent for all ADLs. [JANE-DOE-00004]

Later on the day of admission, Ms. Doe cried when turned during a diaper change and the nurse performed a pain evaluation. The pain was rated as 7 out of 10 and orders were obtained for Tylenol # 3 as needed for pain. [JANE-DOE-00056=00058] On 5/20/06, Ms. Doe's oxygen saturation levels began to fluctuate to 85-88%; relief was obtained with oxygen administration. She remained in bed per her request. [JANE-DOE-00089] Care plans were initiated on 5/22/06, 5/23/06, and 5/25/06 to address all areas of concern including respiratory distress, risk for skin alteration, and risk for nutritional deficits. [JANE-DOE-00035=00048]

Initial admission MDS assessment was completed on 5/26/06. Cognitive patterns indicated that there were long-term and short-term memory problems and that Ms. Doe's cognitive skills for daily decision making were moderately impaired. She also had episodes of disorganized speech. Her communication was usually understood although she slurred or mumbled her words. She had limited range of motion in her arm, hand, leg, and foot on one side. She usually left 25% or more of her food [please refer to the Topic Chronology titled "Nutrition Information" for detailed information]. There were no skin alterations. [JANE-DOE-00017=00021]

PT evaluation was performed on 5/22/06. Ms. Doe demonstrated decreased strength, endurance, balance, and functional mobility, and required total assistance for all her needs. PT was initiated. [JANE-DOE-00062=00063] OT evaluation was also performed on 5/22/06. Ms. Doe was noted to have very limited verbal communication and very flaccid tone in her right upper extremity. OT was initiated. [JANE-DOE-00067=00068] Speech and language evaluation was performed on 5/23/06 which indicated that Ms. Doe had profound receptive-expressive aphasia with oral and verbal apraxia. Speech therapy was initiated. [JANE-DOE-00073=00074]

On 5/30/06, Ms. Doe was showing signs of improvement and she was able to verbalize some words on 5/31/06. [JANE-DOE-00090] MDS assessment completed on 6/1/06 indicated that Ms. Doe's condition had improved since her last assessment and discharge was expected within 30 days. [JANE-DOE-00021] RAPs triggered on 6/1/06 were for delirium, cognitive loss/dementia, communication, ADL rehabilitation/maintenance, urinary incontinence, falls, nutritional status, and pressure ulcers. [JANE-DOE-00025=00032]

On 6/5/06, the family complained that Ms. Doe had bedsores and body assessment revealed two stage II ulcers on the buttocks and a denuded area on the sacrum [please refer to the Topic Chronology titled "Skin Integrity" for details]. [JANE-DOE-00051=00053]

On 6/7/06, her vital signs as BP 153/63, pulse 66, respirations 18, and temperature 96. She was alert and oriented x 2. She was out of bed in a wheelchair after total AM care and dressing changes were done. Ms. Doe's daughter visited and pushed her around in a wheelchair. [JANE-DOE-00126] Ms. Doe was transferred to Even Better Rehab from Excellence Rehab Center on 6/8/06 per her daughter's request. [JANE-DOE-00090]

While a resident of Excellence Rehab Center from 5/19/06 to 6/8/06, the following medications were administered: Digitek, Lipitor, Lisinopril, Metoprolol Tartrate, Norvasc, Protonix, Tylenol, and Warfarin [incomplete list]. [JANE-DOE-00096=00098]

6/8/06-8/8/06 Even Better Rehab
Ms. Doe was admitted to Even Better Rehab on 6/8/06 from Excellence Rehab Center [she was transferred for closer proximity to her family]. [JANE-DOE-00191=00195] Speech therapy, PT, and OT were provided. [JANE-DOE-00167=00168; 00170=00171; 00175=00176] Psychiatric evaluation revealed vascular dementia with depression and Remeron was prescribed. [JANE-DOE-00117=00118] Ms. Doe was transferred to Diseasefree Hospital for administration of intravenous antibiotics, an infectious disease consult, and wound center evaluation. [JANE-DOE-00126]

8/8/06-8/16/06 Diseasefree Hospital [no records available]

8/16/06-unknown Happyland Healthcare Center [incomplete records]
Ms. Doe was admitted from Diseasefree Hospital for supportive care. She was evaluated at Diseasefree by the infectious disease and plastic surgery departments. Ms. Doe had a stage IV decubitus ulcer upon admission. [JANE-DOE-00353=00354] Peaceful Hospice services were initiated on 9/11/06. [JANE-DOE-00376=00377]

PERTINENT ISSUES

Skin Integrity, Nutrition Information, Staff Non-Compliance and Record Inconsistencies, Family Involvement

Detailed information related to these issues can be found in their respective Topic Chronologies.

Patient Non-Compliance

Instances of Ms. Doe's non-compliance are likely related to her impaired cognitive state.

FOR FURTHER INVESTIGATION

Pertinent records that are important to review include:
Missing ADL sheets and Medication Administration Records from 5/06 would be helpful in ascertaining the level of care.
Records from Ms. Doe's hospitalization prior to her admission to Excellence Rehab Center would provide information regarding her status at the time of admission.
Records from the cardiologist visits would be valuable in assessing her condition.
Records from Even Better Rehab would provide additional information regarding Ms. Doe's status at the time of her discharge from Excellence Rehab Center.
Records from Diseasefree Hospital would be valuable in ascertaining the condition of Ms. Doe at the time of transfer.

Other documents identified as missing can be found in the Topic Chronology titled "Missing Information."

CONCLUSION

Although there are no allegations, Ms. Doe developed pressure sores during her admission to Excellence Rehab Center. There was no documentation of pressure areas prior to the initial skin alteration reports of three pressure ulcers and preventative care was not adequately documented. The lack of adequate skin assessments represents a breach in the standard of care.