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Dysphagia, Choking, Death: Civil Monetary Penalty Upheld Against Nursing Facility.

The sixty year-old nursing home resident suffered from schizophrenia and dysphagia.

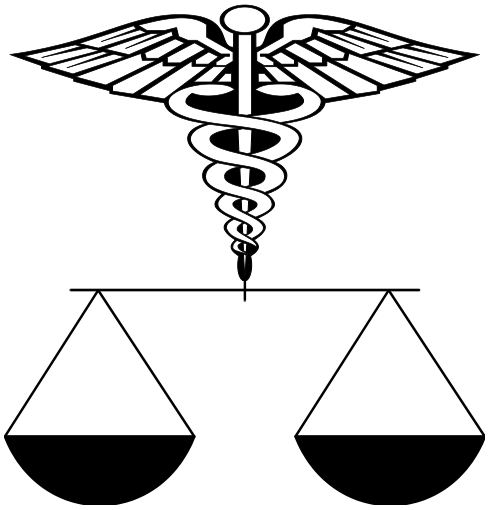
Her dysphagia was so severe that she could not safely consume any food or liquids due to the risk she could aspirate, that is, inhale foreign matter into her trachea and lungs, resulting in suffocation.

A percutaneous endoscopic gastrostomy (PEG) tube was inserted into her stomach through the wall of her abdomen. The PEG tube was to be the only permissible means for her to receive nutrition or hydration.

After insertion of the PEG tube she was returned to the nursing home with orders from the hospital that she was to be a strict npo patient. She was to receive nothing by mouth to eat or drink.

The resident was observed on at least eighteen occasions obtaining and ingesting food and liquids, according to the record in the US Court of Appeals for the Seventh Circuit. Presumably there were numerous other occasions which were not observed or recorded.

The resident was found dead on the floor of her bathroom. The first death certificate listed aspiration pneumonia as the cause of death. A physician changed it to schizophrenia and chronic obstructive lung disease after a lawsuit was filed by the family.



Federal regulations require a nursing facility to ensure that -
The resident environment remains as free of accident hazards as possible; and
Each resident receives adequate supervision and assistance to prevent accidents.
The PEG tube itself and the hospital discharge orders signaled a serious risk if the resident consumed food or drink.
UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
May 6, 2010

Staff had repeatedly instructed and reminded the resident she was not to take food or drink from other residents' meal trays. However, according to the Court, education, admonishment, correction and redirection are often not effective safety measures with a patient with cognitive or behavioral deficits like those suffered by this patient.

The resident needed very close supervision when outside her room during other residents' meal times.

The patient's roommate was also giving food to her. The patient should, at least, have had a roommate who did not eat her own meals in their room, or, better but more expensive, could have been placed in a room by herself.

The water faucet in the room was a known safety hazard. The patient was seen drinking from it. It should have been locked so that only staff could access the sink to perform ADL's but the patient herself could not turn the water on, the Court said.

Unlike a civil lawsuit for damages, imposition of a civil monetary penalty for violation of Federal standards does not require proof the violation was the actual cause of death, only that it presented a serious risk of harm. **Fal-Meridian, Inc. v. US Dept. of Health and Human Services, __ F.3d __, 2010 WL 1791366 (7th Cir., May 6, 2010).**

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