**MARYLAND**
**Department of Health and Mental Hygiene**
**Office of Health Care Quality**
Spring Grove Center • Bland Bryant Bldg. • 55 Wade Avenue • Catonsville, MD 21228 • 410-402-8015

# COMPLAINT REPORT FORM

Complete this form if you have concerns about the health care or treatment that you or a family member received or did not receive. Answer all questions. Give complete details. Use additional sheet, if necessary. You may use this form as a guide when making a complaint by telephone. We will investigate your concerns based on the information that you provide.

You may file an anonymous complaint

## Complete the following questions.

**I. Name of patient/resident/client involved in the incident:** Israel Neustadter

**Sex:** [x] Male [] Female **Age:** 91 **Social Security Number (if known):** 053-24-7926-A

**II. Health care facility, residence, or community treatment program involved in the incident:**

**Name:** Holy Cross Hospital

**Address:** 1500 Forest Glen Road, Silver Spring, Maryland 20910

**Check the type of facility or program:** [] Nursing home [] Adult medical day care [] Assisted living [x] Hospital [] Home health agency [] Residential treatment center [] Community mental health program [] Hospice [] Dialysis Center [] HMO [] Ambulatory surgery center [] Residential services agency [] Birthing center [] Medical laboratory [] Community drug treatment program [] Developmental disabilities provider [] Other. Please specify _____

**III. Witnesses to the incident:**

| **Name** | **Contact information, if known** (include telephone number) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**IV. Person filing complaint or reporting incident (optional).** Note: If you would like a deficiency report that may result from our investigation, please complete this section.

**Name:** Alexander H. Neustadter **Relationship:** Son

**Address:** 1111 University Blvd West, Silver Spring, Maryland 20902

**Telephone:** h: 301-649-1319 w: 202-260-2454

**May we reveal your identity during the investigation of your complaint?** [x] Yes [] No

**V. Briefly describe the incident or your concerns (use additional paper if necessary):**
Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate. **Note:** If this is an anonymous report, be complete since we will not be able to contact you to obtain missing information.

*(Referenced medical records)*

**Unauthorized DNR Notations:** The very first Physicians Order Form lists my father as DNR, something that was not even discussed with me until the following day. He was never DNR at any time during his hospitalization, and although this was corrected in the records, it returns.[11,12,15,19] On March 16, 2003, an unauthorized DNR form was written by Dr. Ball, which in any case would have expired upon my father's transfer out of the ICU.[43,140,141] DNR was never requested or desired by my father or me, his surrogate. Given that the level of care tends to decrease in patients designated as DNR, I can't help but wonder if this was not the fatal mistake. Holy Cross Hospital had no safeguards in place to prevent an authorized DNR form from being written, or for noting an expired or defective form.

**Major Antibiotic Dosing and Nutritional Delivery Discrepancies:** The second Physicians Order Form cut my father's dosage of levaquin from the standard 500mg down to 250mg, but the nurses' Kardex and notations on the side of the physicians' progress notes made by the residents, continued to indicate a dosage of 500mg of levaquin. Which is correct? There were no antibiotics at all ordered for the period of March 17-20, yet the Kardex indicates they were administered. Given the many such mistakes reputed to occur in hospitals and given the importance of antibiotics in treating pneumonia, I asked the hospital to obtain the pharmacy record of distributed medication so that we could know definitively what dose was actually dispensed by the pharmacist. The hospital refused my request.[107]

Throughout the hospitalization, the doctors tolerated a white count hovering in the 20k range, ignoring the risks of bacterial resistance and never seeking an infectious disease consult. It was only a matter of time before the infection broke out again. The hospital had no mechanisms in place to catch the obvious dosing errors, or to flag such basic oversights as tolerating a continuingly high white count.

March 14, 2003: Dr. Koch, and later in the day Dr. Nawaz, failed to order needed nutritional support. Dr. Nawaz forgot to order it on March 15th again. Dr. Ball ordered the nutrition later on March 15, but mistakenly ordered central instead of peripheral nutrition, delaying it by yet an additional 24 hours.[32,33,35,36] My father's prealbumin level sank to 3.8 mg/dl, indicative of starvation. Holy cross had no safeguards in place to correct such preventable errors, or to quickly deliver the nutrition once the errors were discovered.

**March 25, 2003:** When my father suddenly developed respiratory distress, Dr. Kariya, a hospital pulmonologist, failed to offer or to provide life-sustaining treatment (intubation). He failed to discuss treatment options with me at all; he just walked away.[63]

Medical records show that prior to this my father was receiving the most aggressive treatment and the plan was to continue on that course. It also shows that Dr. Kariya knew that I, the surrogate, desired the most aggressive treatment for my father.[58,61,63]

Holy Cross Hospital allowed a patient in a life-threatening situation to remain that way with no intervention and no documentation to confirm that further treatment was not desired.

**March 26, 2003:** When I suspected treatment was being withheld I demanded it of Dr. Shamim, who was covering for Dr. Nawaz, and of Dr. Weiner, a hospital pulmonologist who practices with Dr. Kariya. Dr. Weiner refused my demand, telling me it could not be done. When I protested that my father was awake and improving until just yesterday, Dr. Weiner told me that my father was "dead the day he got here" and left the room together with Dr. Shamim.

Dr. Weiner failed to document this pivotal visit to my father's room. Dr. Shamim falsified his notations* in the progress notes and physicians orders to indicate that he was alone and that Dr. Kariya was called.[65,66]

* Dr. Weiner's undocumented presence (and abandonment of my father) confirmed in trial testimony. OHCQ refuses to investigate this crux of my complaint, calling it a "single episode..."

Holy Cross Hospital failed to prevent this from happening, and refuses to conduct a serious investigation that takes into account the discrepancies in the record. The discharge summary states that when my father decompensated, doctors Kariya and Shamim had a long conversation with me because my father needed to be intubated and that I decided against it.

On November 30, 2005, Dr. Kariya acknowledged during a meeting at which hospital management was present that such a conversation never took place. He stated for all in the room to hear that intubation was not an option, and that he was no more obligated to discuss it with me than if I would have asked that a craniotomy be done on my father. I submitted a record correction request pursuant to Maryland and HIPAA regulations but Holy Cross has failed to comply.

**March 27, 2003:** At the very end, although the records show my father to have been full-code and not suffering from any underlying fatal disease, he was allowed to die of respiratory distress in the most horrific of circumstances, when standard treatment was readily available and appropriate – and when the records indicate that we desired such treatment.

The head nurse in charge of the ICU actually writes in a letter to me that "nursing probably knew that additional life-support measures were not planned." [118,119] Do the words *probably knew* have any rightful place in a life-or-death situation? Aren't there procedures and safeguards to prevent any doubt in such matters?

I asked Holy Cross to determine when my father transitioned from a full-code, aggressively treated patient, to an actively dying one for whom no further treatment was planned.[120] I have not received a reply.

**VI. Have you reported this incident or concern to the person in charge of the facility, residence or program?** [x] Yes [] No

Address written complaints to the appropriate licensing unit (listed below) and mail to:

Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228

Or submit your complaint to the appropriate OHCQ licensing unit phone:

Nursing homes- (410) 402-8201 Toll-free 877-402-8219
Hospitals- (410) 402-8000 Toll-free 877-402-8218
Health maintenance organizations- (410) 402-8000 Toll-free 877-402-8218
Developmental disabilities programs- (410) 402-8050 Toll-free 877-402-8220
Assisted living homes- (410) 402-8217 Toll-free 877-402-8221
Clinical laboratories- (410) 402-8025 Toll-free 877-402-8202
Home health agencies, hospice programs, residential service agencies, kidney dialysis centers- (410) 402-8040 Toll-free 800-492-6005
Adult day care- (410) 402-8201 Toll-free 877-402-8219
Substance abuse treatment programs- (410) 402-8050 Toll-free 877-402-8220
Mental health treatment programs- (410) 402-8060 Toll-free 877-402-8220