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Veterans home in Paramus pays $1.4M in resident's choking death

FILE PHOTO

Two patients at the New Jersey Veterans Memorial Home choked to death within weeks in 2012.

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The New Jersey Veterans Memorial Home in Paramus has agreed to pay $1.4 million to settle a lawsuit in the death of one of two patients who choked to death at the facility within two weeks.

Russell Larson was 85 when he choked on his breakfast after being left alone to eat in his room at the nursing home on June 10, 2012, according to court documents. His family claimed in their suit that the home failed to provide adequate nursing staff for the Navy veteran, who had a swallowing disorder and was supposed to be watched carefully whenever he ate.

Just two weeks later, another patient also choked to death, records show. A nurse found the patient choking in the day room around 12:45 p.m. and performed the Heimlich maneuver on the resident, who died soon after, according to a state report.

The home's administrators and director of nursing would later tell a state health inspector that they thought the resident died of heart failure – even though the patient's death certificate stated the cause of death was "acute airway obstruction with food," according to the inspector's report.

Accidental deaths in the nursing home must be reported to the state Department of Health, but that notification did not occur in either incident. The 336-bed state-operated nursing home was later cited for a "deficiency" for failing to properly report the death of the second patient, identified only as Resident No. 29.

The nursing home, operated by the New Jersey Department of Military and Veterans Affairs, is open to all honorably discharged veterans as well as retired National Guard members, spouses of eligible veterans as well as Gold Star parents — people whose children were killed in action while serving in the military.

"The department and the Paramus Veterans Memorial Home are deeply saddened by the loss of Mr. Russell Larson," said Kryn Westhoven, a spokesman for the state veterans affairs department, said in an emailed statement. The nursing home itself did not return calls seeking comment.

"The department strives for the highest quality of care and continuously seeks improvement to ensure residents' safety," Westhoven wrote. "The department acts with high moral principle, adheres to the highest professional standards and takes necessary steps to ensure our residents receive the top-notch care they deserve."

Separate from VA

The Paramus facility is one of three nursing homes operated by the state veterans affairs department. The federally run Veterans Health Administration has an extensive system of clinics and hospitals that have been the subject of congressional scrutiny and a criminal investigation into reports that employees conspired to hide evidence that veterans were subject to such long wait times for care that people died before getting to see a doctor.

The settlement with Larson's family in Mahwah was reached in March and recently became official. The state veterans department will pay $1.4 million to the family but did not admit liability in the settlement.

Before the case settled, the Larsons' attorney, Barry Sugarman, had gotten depositions from several workers and filed motions seeking staffing records and more details about the other choking death at the facility, which he argued in court papers would demonstrate a "pattern of misconduct."

The veterans department told The Record that there was no evidence of a pattern of choking incidents at the nursing home.

"Elderly residents periodically choke on items for various reasons," the statement said. "However, after reviewing incident report logs, there weren't any choking incidents resulting in significant injury or death."

Russell Larson, who served in the Navy from April 8, 1944, to January 20, 1948, lived at the home since August 2010.

The lawsuit accused the veterans home of "failing to provide sufficient nursing staff" to carry out Larson's care plan, which called for him to receive assistance at meals because of a swallowing disorder known as dysphagia, which made him susceptible to choking. He also suffered from dementia.

"For these reasons, he was completely dependent on [the nursing home] to monitor, supervise and provide him with assistance while eating and drinking to avoid the risk of injuries and death associated with choking, aspiration, asphyxiation and death," the lawsuit said.

The lawsuit claimed that a staff member brought Larson's breakfast to his room at 8 a.m. then left the room.

Twenty minutes later, a nurse who went to his room to give him medication found him "blue and cyanotic," the lawsuit said. The nurse performed the Heimlich maneuver and tried to clear the food from his airway. He died 10 minutes later.

Patricia Larson, Russell Larson's daughter and the executor of his estate, declined to comment, as did her attorney. Sugarman said his client did not want to discuss the settlement or the case because she "seeks closure on this whole incident."

Like that of Patient No. 29, the lawsuit also claimed that Larson's death had not been reported to the Department of Health.

In a statement, the veterans affairs department said Russell's death did not meet the criteria for the type of accidental death that must be reported.

Deficiency citation

While the home was issued a deficiency citation over the failure to report the second death, the state did not fine the nursing home and instead allowed the facility to resolve it by submitting an "acceptable plan of correction," said Dawn Thomas, a Health Department spokeswoman. State officials would not provide further details about either case.

The two deaths are not listed in inspection data included on a federal Centers for Medicare and Medicaid Services website, called Nursing Home Compare, which is billed as a way for consumers to help choose a facility for a loved one. Thomas said the citation issued to the nursing home for failing to report the second choking death was a "state deficiency, and thus would not appear on the federal CMS website." Consumers have to file an open records request to learn about state violations.

On the federal website, the Paramus home has an overall rating of four stars, meaning an "above average" rating. In the category of "health inspections," however, the ranking drops to three stars, or "average." Three inspections over the last three years found five or more deficiencies.

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