

The Virgin Islands Consortium

Rampant Malpractice At JFL, CMS Report Finds

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The [scathing 112-page report](#) released by the Centers for Medicare and Medicaid Services (CMS) on the status of the Juan F. Luis Hospital (JFL), and the reason CMS decided to stop doing business with the hospital, paints a bleak picture for the future prospects of the facility. The report is properly detailed and shows the amount of work JFL has ahead before it can return to good standing. Among the most troubling, however, is the plethora of malpractice that is reported to have taken place over the years.

Below are just some of the examples of malpractice cases found in the CMS report, but there are much more which can be found in the [link above](#).

- On July 28, 2014, an elderly patient, Patient #4 was noted during rounds with staff to have a large hematoma of the center of the forehead. The patient alleged to have suffered an unwitnessed fall the evening before based upon statements from the patient. The physician assistant (PA) noted only no headache, no dizziness and no neurological findings and did not order close monitoring of neurologic status. No medical interventions were provided until the patient's condition deteriorated. The patient was transferred to the intensive care unit, was intubated and had less than a 2% chance of survival and would likely remain in a vegetative state according to physician documentation if the patient survived the ordeal.
- On June 17, 2014, Patient #3 presented to the emergency department and diagnosed with right pleural effusion. The x-ray showed "an almost complete opacification of the right hemothorax." Although the physical assessments, findings, and nurses notes were inconsistent with the imaging studies, the physician inserted a chest tube on the left side of the chest in spite of the patient telling the physician that the procedure was being done on the wrong side of the chest.
- On June 4, 2014, a newborn, Patient #9, was delivered by emergent vacuum delivery due to signs of fetal distress. The baby sustained a subgaleal bleed, a known potential complication of vacuum birth delivery. The newborn died within hours of birth.
- On April 27, 2014, Patient # 25 presented to the emergency department at 1:34 p.m., with complaints of insidious onset of left chest pain and epigastric pain while lying down. The patient was discharged at 8:10 p.m., April 27, 2014. The patient was brought back to the hospital by ambulance, in full code 72-hours later, April 29, 2014, at 10:51 a.m and expired.

At a press conference last Friday, before the *VI Consortium* gained access to the CMS report, JFL Interim CEO Dr. Kendall Griffith said he does not believe the hospital should have lost its certification and seemed to imply surprise when he said he learned of CMS's decision to end its relationship with the hospital. He pointed out he was misled by CMS representatives on the scope of the organization's audit.