ABEL URIBE/CHICAGO TRIBUNE

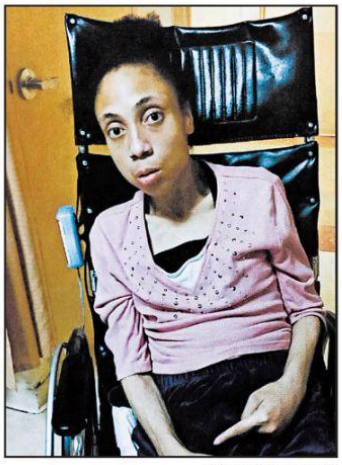
Mary Mims holds a photograph of her daughter, Letasha Mims, who died months after moving out of Wentworth Rehab.

City's worst nursing home: Bug bites, bruises, death

Government records provide bleak look at South Side facility

By Sam Roe
Chicago Tribune

FAMILY PHOTO



FAMILY PHOTO

Letasha, at left, around age 20, long before she lived at Wentworth. The photo at right was taken six months before she died at age 36.

For days, the Wentworth Rehab nursing home on the South Side ignored warnings that a resident was posing a fire danger by smoking while breathing with the aid of an oxygen tank. One patient, state inspection reports show, yelled at him to stop "before he blows everyone up."

Then on New Year's Day last year, the man was smoking in his room, and his bed and oxygen machine started on fire. Inspection reports cite security videotapes that showed a nursing aide racing to put the fire out as another nurse sat behind the nurse's station, sipping her drink.

The man, who was 79 years old and used a motorized wheelchair, wheeled himself into the hallway. His face was burned and he struggled for breath. But the nurse behind the station ignored him for several minutes, inspection reports state. She didn't immediately check his vital signs or help put out the fire, according to the reports.

A half-hour later, emergency medical officials pronounced him dead.

In a city with dozens of subpar nursing homes, Wentworth Rehab stands out as the worst, according to a Chicago Tribune review of evaluations by the federal government.

Inspectors have cited the home in recent years for chronic roach problems, poor food, untreated bedsores, and staff ignoring basic health and safety standards, resulting in broken bones and other harm.

You wouldn't know that by looking at Wentworth's website. The home page boasts that the facility receives a four-star

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Multiple suits have been filed against facility

ABEL URIBE/CHICAGO TRIBUNE

Mary Mims, with lawyer Stephan Blandin last month, sued Wentworth Rehab after her daughter's death. The suit against the facility was settled in January, but the lawsuit against a doctor in the case is pending.

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quality rating from the federal Centers for Medicare & Medicaid Services.

But in truth, the agency gives the home an overall rating of one out of five stars, the lowest possible score.

The agency has put Wentworth on its list of America's 83 most chronically poor nursing facilities — the only one on that list in Chicago. That designation has triggered more inspections and oversight, and the federal agency last month reported the home has shown significant improvement, even as it stayed on the list.

"We'll see," said Wendy Meltzer, executive director of Illinois Citizens for Better Care, a leading advocacy group for nursing home residents. "That home has had very serious problems with poor care for many, many years."

Wentworth is part of the Alden nursing home chain, a string of more than two dozen facilities in Illinois and southern Wisconsin that has had a spotty safety record, according to federal and state regulatory reports.

The chairman of the board of directors of Alden Management Services is Floyd Schlossberg; daughter Randi Schlossberg-Schullo is president of the firm, according to state records.

The Tribune requested interviews with Alden officials, including Schlossberg, but Alden spokeswoman Victoria Wolpoff said interviews would not be possible. She requested the newspaper put its questions in writing but then did not answer them.

Instead, she issued a written statement: "For over 30 years, Wentworth Rehabilitation and Health Care Center has provided long-term care services to the Englewood community. We have always been and remain committed to resident care and safety.

"The Centers for Medicare and Medicaid Services has rated Wentworth's quality of resident care with 4 out of 5 stars, which is an above average rating," the statement said. "Wentworth will continue to make resident care and services its first priority."

When asked to specify what the four-star rating referred to, Wolpoff did not respond.

The Centers for Medicare & Medicaid Services gives Wentworth an overall one-star rating but four out of five stars for a subset score called "Quality Measures." These are measures based on data that to a large degree are self-reported by the nursing homes, such as the percentage of residents in moderate to severe pain.

Meltzer said self-reported data cannot be trusted as there is a disincentive for nursing homes to report problems. She said it is highly misleading for Wentworth to claim a four-star rating.

"It's very sad because somebody might actually believe it," Meltzer said.

The federal agency did not directly comment when asked whether Wentworth had accurately described its rating.

But the agency emphasized that the centerpiece of the star rating system is the health inspection score, which is based on "comprehensive onsite inspections conducted by independent, objective inspectors." The agency gives Wentworth one star for inspections.

Meanwhile, numerous lawsuits have been filed against Wentworth in recent years, online court records show.

In a 2014 suit, Mary Mims alleges that her daughter, Letasha, who had mental disabilities, lived at Wentworth for about two years and suffered numerous injuries, including bedsores, bruises, bug bites and gangrenous feet. She also experienced poor hygienic and dental care; rodent feces in her linens; and improper nutrition that caused her to lose 60 pounds, the suit states.

"How all of this could be ignored by those caring for her is appalling," Mims said in a statement to the Tribune.

The poor care, her suit states, eventually caused or contributed to Letasha's death in August 2014, six months after she moved out of the facility. She was 36.

"This is hands down the worst case of medical neglect leading to abuse in a nursing home I have ever seen," said Mims' attorney, Stephan Blandin of the Romanucci & Blandin law firm.

According to court records, Wentworth denied the allegations, and the suit was settled in January; the suit against a doctor in the case is pending.

"The system which governs nursing homes and ultimately its patients is broken," Blandin said. "Until our state legislators are willing to budge on the rules and regulations that oversee the nursing home system as a whole and hold the doctors and owners of nursing homes accountable, nothing will change."

Although records show that several Alden facilities are rated five stars by the Centers for Medicare & Medicaid Services, others have had problems. In 2010, the Tribune exposed a pattern of death and neglect at Alden Village North, a North Side nursing facility for children with disabilities. Regulators announced plans to shut the home, but the facility remained open following a legal misstep by the state health department.

Wentworth is a four-story beige brick building on the eastern edge of Englewood, where there are numerous boarded-up houses and trash-strewn lots. The facility's lobby is clean but dated, and the front windows look out onto busy West 69th Street.

Meltzer said that Wentworth for many years has primarily served a low-income, African-American population. Because there are few good nursing homes on the South Side, she said, Wentworth doesn't have to compete on quality.

When the Tribune visited the home, the facility's administrator, Taylor Herron, referred all questions to Alden's spokeswoman.

A Tribune review of state inspection reports of Wentworth from 2010 to this past April reveals a pattern of poor care, repeat violations and few penalties.

In 2010, a 41-year-old resident died of intoxication of pain medication when the facility failed to follow hospital orders and gave him powerful narcotics, inspectors found. The state fined the home $20,000, and the penalty was eventually settled for $5,000.

In August 2017, staff failed to prevent a female resident from falling while being transported in a wheelchair, inspectors found. She suffered two leg fractures, and the federal government said it fined the home $11,100. The state fine was $2,200, which was reduced to $1,430 in settlement.

NANCY STONE/CHICAGO TRIBUNE 2010

Wentworth is part of the Alden nursing home chain, whose chairman of the board of directors is Floyd Schlossberg.

ABEL URIBE/CHICAGO TRIBUNE

The federal Centers of Medicare & Medicaid Services has given Wentworth an overall one-star rating, its lowest.

Inspectors also have repeatedly cited the facility for failing to provide basic services, such as suitable food. One resident told inspectors in 2014, "I only eat once a week when my daughter brings me food," according to a report.

> ***"That home has had very serious problems with poor care for many, many years."***
>
> *— Wendy Meltzer, of Illinois Citizens for Better Care*

In 2016, an inspector watched a dietary aide put "together a serving of unidentified food that is brown and of mashed potato consistency and placed on a plate" for a nursing assistant to bring to residents. When the inspector asked the aide what the food was, the worker responded, "country-fried steak."

Proper grooming has been a recurring problem. During a 2015 inspection, two residents "were observed in the activity room with long clawed nails with blackish caked substances underneath the nails," the report states.

In April 2017, inspectors observed a resident "awake in bed with dry lips, teeth with brownish sediments, and very thick saliva in his mouth."

In 2014, rodents were a problem; several residents said they saw rats. One patient showed a state inspector "a picture of a rat that jumped on his bed," records state.

The last three years, inspectors have cited the home for insects, including roaches. In 2015, an inspector saw a roach crawling on top of a toilet seat. "Resident notified nurse that she saw a bug in her drawer and on self this morning," an inspection report states.

The next year, a wound nurse reported seeing "roaches in hallways, resident rooms, all over," according to an inspection report.

And last spring, roaches were a problem in multiple locations. "We do have problems with roaches every now and then," a Wentworth maintenance director told an inspector. A housekeeping supervisor was more direct: "We have had issues with roaches for the last three years."

But perhaps the most alarming violation, as detailed in state inspection reports, involved the man who died in the fire.

He was admitted to Wentworth in October 2016, with diagnoses of major depressive disorder, cocaine use and lung disease, reports state. He was dependent on supplemental oxygen, typically delivered through lightweight tubes and nasal prongs.

Two months later, several Wentworth employees and a veterans' social worker met to discuss the man's care. The veterans' worker later told inspectors the man smoking while on oxygen was discussed as a behavior at his previous nursing homes but not as a current issue.

Health experts warn that smoking while using oxygen presents a serious fire risk because an oxygen-enriched environment can make nearby materials burn rapidly.

Even though Wentworth supervisors knew about the man's smoking history, they didn't take safety steps or warn staff, inspectors wrote.

On Christmas Eve, eight days before the fatal fire, a resident saw the man on the smoking patio with his oxygen on. She yelled at him, saying he was putting everyone in danger, according to inspection reports.

The resident also reported seeing the man shortly thereafter smoking in the dining room and alerted the assistant director of nursing.

A registered nurse told inspectors that the day after Christmas, two aides informed her that the man was trying to smoke in the dining room. The nurse said she went to the dining area and took away the man's lighter and a small cigarette butt.

That same day, reports state, the facility made a "behavior note" regarding the man. It said "please monitor. He has tried on numerous occasions to smoke in the day room, he tries to go into other residents rooms."

The notes did not say what action, if any, was taken to stop the man from unsafe smoking.

Then, about 9:50 a.m. on New Year's Day, an aide heard the fire alarm go off and saw the man wheel himself out of his bedroom. When she ran to the man, she saw that his bed was on fire. She also noticed that the oxygen concentrator near the head of the bed was burned.

She pushed the man down the hall and grabbed a fire extinguisher. As the man gasped for air and as the corridor filled with smoke, the aide put the fire out, an inspection report states.

She continued to push the man down the hall but noticed that the fire had reignited. She stopped again to put the fire out.

"Once the fire was out, she proceeded down the hall again with (the man), but she noticed the fire had reignited again," an inspection report states. She put out the fire for a third time, this time permanently.

According to the report, videotape shows that after the fire alarm sounded, a nurse at the nursing station "was observed to take a sip of her drink, stand, walk over to the medication carts and place the medication carts behind the nursing station."

The nurse "was then observed sitting back down at the nurse's station to continue her drink. (She) was not observed leaving the nursing station to assist during the fire alarm."

A minute later, the aide and a social services worker brought the man up to the nursing station. The aide said the man was having difficulty breathing.

Video showed he was "slumped over the right side of the wheelchair, with no movement observed," records state. His hair, right ear and face were burned.

The nurse behind the station walked over to the man "and took a quick glance at (him) and walked away to stand behind the nursing station," an inspection report states.

A minute later, records state, the nurse walked back over to the man and placed the man's oxygen tubes on his face. The nurse was not observed taking vital signs for the next two minutes.

Five minutes after he first arrived at the nurse's station, the nurse applied an oxygen mask to his face.

Video also showed paramedics and a nurse's aide performing cardiopulmonary resuscitation. The nurse behind the station was not observed performing CPR. Paramedics reported the man died minutes later in the ambulance.

Two cigarette butts were found on the floor of the man's room and a lighter outside his room. Fire and public health authorities concluded he died from a fire caused by smoking while on oxygen.

State inspectors cited Wentworth for not preventing the man's unsafe smoking and not providing immediate emergency treatment after the fire broke out. The state fined the home $50,000 — one of the largest fines against an Illinois nursing facility in recent years — but eventually reduced it to $12,500.

According to records and interviews, the federal government fined Wentworth $181,689 but approved the facility's financial hardship request and lowered the amount to $100,383.

As in past cases, Wentworth vowed to do better, telling regulators it was revising policies to ensure that residents who smoke are supervised.

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