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10 YEARS. 13 DEATHS.

TRIBUNE WATCHDOG DEADLY NEGLECT

A Chicago care facility's safety record is the worst in Illinois, yet state officials have done little about it

A home for children with severe disabilities has repeatedly failed to take basic steps to care for its residents, putting lives in jeopardy and racking up a troubling record of violations and fatalities, a Tribune investigation has found. In all, 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations for neglect or for failure to adequately investigate.

Instead of cracking down, regulators and lawmakers have allowed problems to worsen.

While the state has levied $250,000 in fines against the home in the last decade, the facility has never paid the full amount of any penalty. Illinois' rules are so weak, inconsistent and reliant on industry self-reporting that the state cannot gauge the true scope of problems at the Chicago facility, now called Alden Village North.

READ THE STORY BY DARNELL AND JARED S. HOPKINS ON PAGE 18

Read more about the 13 deaths on PAGE 18

Normenee Robinson, 72, now a recruiter for the Peace Corps, served in India's Punjab state in the early 1960s. "There was a challenge in understanding how to work with another culture," he says. "That excited me." CHRIS WALKER/TRIBUNE PHOTOS

World opened up for Peace Corps vets

50 years after Kennedy's proposal, earliest volunteers cherish memories, experiences

By John Kelliman
Tribune reporter

It was well after midnight at the University of Michigan when presidential candidate John F. Kennedy gave a short speech that would, in thousands of small ways, reshape the world.

"How many of you who are going to be doctors are willing to spend your days in Ghana?" he asked a crowd of students 50 years ago this week. "Technicians or engineers, how many of you are willing to work in the Foreign Service and spend your lives traveling around the world?

"Do your willingness to do that, not merely to serve one year or two years in the service, but be willing to devote a large part of your life to this country, I think will depend whether or not whether a free society can compete."

That was born the idea of the Peace Corps, and when Kennedy took office the next year, he swiftly made it a reality. He called for volunteers to spend two years improving the health, education and economic prospects of some of the poorest people on earth — and, not coincidentally in those Cold War years, to

Please turn to Page 12

Barbara James, 71, served in Pakistan. Now in retirement, she has returned several times to conduct teacher training workshops.

TRIBUNE EDITORIAL

Tribune endorses Brady

Gov. Pat Quinn has had two years to pull this state out of its dreadful decline, to defang corruption and cleat, to finally say no to careless spending and borrowing. That's two years squandered. Quinn has proved to voters he is a nice man who cannot do the job. Illinois can't afford to waste more time. The Tribune believes state Sen. Bill Brady is up to the job now, that he will confront the power elite and get Illinois back on track.

FULL EDITORIAL ON PAGE 24

NEWS FOCUS

Spotlight on No. 2

The primary election shed light on the importance of the second spot on the ticket: lieutenant governor. PAGE 4

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Complete forecast on PAGE 28

TRIBUNE WATCHDOG DEADLY NEGLECT

10 years. 13 deaths

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PAGE 1 PROMO
SUNDAY, OCT. 10, 2010

A home for children with severe disabilities has repeatedly failed to take basic steps to care for its residents, putting lives in jeopardy and racking up a troubling record of violations and fatalities, a Tribune investigation has found. In all, 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations for neglect or for failure to adequately investigate.

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A care center's troubled history

Government records show a pattern of substandard care — sometimes with deadly consequences — at Alden Village North and its predecessors. The Tribune found that 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations. In five deaths, the failing was cited for neglect; in the other eight, the home was cited for failing to thoroughly investigate the deaths to rule out neglect.

KEY
N Facility cited for neglect
I Facility cited for failure to investigate fully to rule out neglect

2000

N June 9: Brian Marrero, 2, dies after his breathing tube becomes dislodged. The facility is cited for neglect and fined $10,000. Four children, including Brian, had previously experienced close calls after pulling out their tubes in 2000.

FAMILY PHOTO

Crenly Marrero, shown holding his son Brian in a hospital room, said he remains upset that Brian died from the same behavior that led the family to place him in a care facility: playing with his breathing tube.

2003

June: The facility changes owners and switches names from the Pediatric Rehabilitation Institute to the Mosaic Living Center.

2004

I July 19: Kyle Pryor, 24, dies after going into respiratory and cardiac arrest. "I miss his h[illegible]," said his mother, La Vern. "Even though he was g[illegible] he never really grew up. That was my baby."

N Aug. 27: A 4-year-old boy dies after going into respiratory and cardiac arrest; no alarms on his oxygen m[illegible]

N Sept. 17: A 4-year-old girl dies under simil[illegible] facility is cited for neglect and fined $50,000 after investigators discover numerous alarms are not set properly or are inaudible.

I Nov. 15: Demetri Franklin, 10 months, dies of pulmonary hemorrhage. "It was shocking because he was on his way home. He was doing better," said his mother, Ashley Seawood.

2005

October: The facility is cited after a school repeatedly complains *(example below)* that some children from the facility have soiled clothes, extreme body odor and filthy wheelchairs.

> The children are coming in with no extra clothing in case they soil their clothes. They often come in with badly soiled diapers, and body odor. [redacted] bad body odor so severe, that we studied her. We asked Mosaic to wash [redacted] hair so that we could have her hair look presentable for the holidays, and it took almost a week for a reply.

Excerpt from a Dec. 16, 2004, fax from a Chappell Elementary School teacher to the facility. Children's names are redacted.

2007

I Dec. 11: Ke'Shaun Emanuel Miller-Harris, 6, dies after a respiratory therapist finds his blood-oxygen levels had dropped. He depended on a ventilator to breathe and had multiple other disabilities.

2008

Jan. 3: The facility changes ownership and its n[illegible] Village North.

I Feb. 19: Christina Polley, 25, dies of pne[illegible] She had been living at the facility since 19 walk in the room and she'd always smile," said her mother, Loretta Wave.

I March 18: Gerald Crosby, 2, dies. His mother, Tamika Adams, said the care he received at Alden was poor. "I often think to myself, were they the reason that my son passed away?" she said.

I March 21: Gabriel Melgar, 1, dies after being m[illegible] ral "unresponsive and blue" in his stroller. He had Down syndrome and profound mental disabili[illegible]

I old man whom records identify as Justin [illegible] entitled alarm sounded. The state found no evidence that Alden had reviewed whether proper supervision was

I April 16: A 16-year-old girl with profound mental disabilities and cerebral palsy dies after a hospitalization of more than a month.

November: The facility is hit with more than two dozen violations in a 110-page inspection report, one of the longest involving Illinois nursing facilities in recent years.

2009

N Jan. 20: Derrick Black, 12, dies after he is left unattended because his night nurse left work early and his day nurse showed up late. The facility is cited for neglect and fined $25,000.

N May 21: Jeremiah Clark, 9, dies of shock, infection and bowel obstruction. His school had sent him home two days in a row because he was ill, but Alden did not call his doctor until the third day. The facility is cited for neglect and fined $25,000.

SOURCES: State, court and other government records; Tribune

JENGI, R. ERIKSON, SAM ROE AI

13 DEATHS ON THEIR WATCH

Failures of care have repeatedly jeopardized the lives of fragile children at a Chicago nursing facility

By Sam Roe and Jared S. Hopkins
TRIBUNE REPORTERS

A 4-year-old boy with severe developmental disabilities died in his nursing facility when he had difficulty breathing and no one heard the alarm on his monitor. Three weeks later, a 4-year-old girl died at the home in an almost identical way.

When state regulators investigated, records show, they found that numerous alarms at the Chicago facility had not been set correctly or the volume had been turned down so low that the sound could not be heard.

Such failures of care have repeatedly jeopardized the lives of children at the facility now known as Alden Village North, a Tribune investigation has found. Records show the problems have persisted for a decade, through various owners, sometimes with deadly consequences.

Illnesses have been ignored, life-support alarms have gone unmonitored and residents with complex medical problems have been left unattended. Even basic hygiene, such as bathing children and changing diapers, has been neglected.

Instead of cracking down, regulators and lawmakers have allowed problems to worsen.

Fines have been dropped or reduced, and deaths at the facility haven't been fully investigated. Illinois' rules are so weak, in consistent and reliant on industry self-reporting that the state cannot gauge the true scope of problems at Alden and the 360 other facilities caring for people with developmental disabilities.

And earlier this year, when state lawmakers had a rare chance to boost oversight of those homes, they did not.

Deaths of children living at Alden have occurred with alarming regularity. Last year, records show, 13-year-old Derrick Black died when he was left unmonitored because his night nurse left work early and his day nurse showed up late. In 2008, five children and young adults died within three months of each other, yet the facility did not thoroughly investigate any of the deaths.

In all, 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations for neglect or for failure to investigate adequately in order to rule out neglect, the Tribune found.

The newspaper's investigation was based on state and court records as well as interviews with former employees and parents of Alden children. Although state records typically do not disclose identities of children who have died at nursing facilities, the Tribune tracked down names by cross-checking public inspection reports with other government documents.

Five parents of children who died at the facility said they did not know until they were informed by the newspaper that regulators had cited the home in the deaths. "Wow. I had no idea," said Esmeralda Alvarado, whose 5-year-old son, Gabriel Melgar, died in 2008.

Although the Illinois Department of Public Health has levied $100,000 in fines against the home in the past decade, the facility has paid only $21,450 of that total. The penalty records show. Instead, it has negotiated reduced fines, is currently challenging others and, in one case, simply never paid.

Since 2000 the facility has paid just $21,450 in fines.

In the case of the two 4-year-olds who died in 2004 when no one heard their alarms, the state fined the home $10,000 but never collected because the facility changed owners. The state usually denies a license to new owners until an outstanding fine is paid, but a state employee erred and allowed Alden to take over without paying, said Melaney Arnold, spokeswoman for the Illinois Department of Public Health.

Arnold said the state had hoped that Alden would improve care at the facility. New owners, she said, often straighten out troubled homes.

"In this case," she said, "it didn't happen."

The state has found 10 serious violations at Alden since 2000, far more than at any other Illinois facility that cares primarily for children with developmental disabilities, records show.

The vast majority of residents at Alden Village North, a for-profit facility at 7464 N. Sheridan Road, have severe or profound cognitive disabilities. Some cannot walk, talk or call for help. Many are in wheelchairs and diapers. Some breathe and eat through tubes. More than half have epilepsy or cerebral palsy. Several have impaired vision.

Their parents, in some cases, are extremely indigent and seldom visit or advocate on their children's behalf. In trying to keep track of residents who have been wheelchaired, the Tribune found that four of them were in jail or prison.

According to state records, Alden's operator is Floyd A. Schlossberg, president of Chicago-based Alden Management Services. His firm runs more than 20 nursing facilities in Illinois, primarily providing care for the elderly. His firm took over the home in January 2008, after which seven of the 13 deaths identified by the Tribune occurred.

Schlossberg's firm did not respond to repeated requests for interviews or answer written questions submitted by the newspaper.

In a brief statement, his company wrote: "We cannot comment on those matters due to pending litigation. However, we want our residents and their families to know we strive to provide quality care and services to the children and young adults in our care."

While the Illinois Department of Public Health says it has "grave concerns" about the facility and will close it if violations persist, ineffective state laws and regulatory policies almost guarantee that problems will be missed.

For example, when a child dies at Alden or a similar facility, the death does not automatically trigger an investigation, either by the home or by regulators. The state investigates deaths only if the facility reports it to officials, the public submits a tip or a regulator discovers an unexplained death during a routine inspection.

If a schoolteacher had not complained to regulators last year about the death of Jeremiah Clark, a 9-year-old Alden resident who had suffered for two days with a bowel obstruction, his death would likely have gone unprobed, and the facility might not have been penalized.

Except for a handful of state-operated homes, facilities are not even required to notify regulators about every resident's death. And private facilities don't have to conduct their own investigation of a child's death unless administrators at the home deem it unusual or unexpected.

"These facilities really have no incentive to report all deaths to the Department of Public Health," Arnold said.

Lawmakers loosened the reporting rules even further last year. Instead of notifying regulators every time a resident is sent to a hospital, homes must report only those cases caused by accidents or unusual incidents — a judgment the facility gets to make.

And when the legislature passed sweeping nursing home reform earlier this year, boosting minimum staffing levels, stepping up criminal background checks on new residents and tightening rules on psychotropic medications, lawmakers quietly exempted Alden and other facilities caring for the developmentally disabled — about a quarter of the 1,232 facilities providing long-term care in Illinois.

"I thought they should have been included, but we had to compromise," recalled Wendy Mellner, a leading advocate for nursing home residents who was instrumental in crafting the legislation.

She said that if homes for the developmentally disabled had been included, owners of the facilities would have fought the measure, jeopardizing the entire reform package. More important, she said, no one was demanding that those residents be covered.

"There weren't people lobbying on their behalf," she said. "It's really sad."

Alarms unanswered

Children with multiple disabilities often wear protective medical devices such as pulse oximeters, which are typically clipped onto a finger to measure heart rate and blood-oxygen levels. They can help save young adults in our care."

Others have apnea monitors, which measure heart and respiratory rates.

If the devices detect a problem — a child's pulse rate suddenly drops, for instance — an alarm is supposed to sound and nurses are supposed to respond.

But that doesn't always happen.

Take the case of the two 4-year-olds who died in the summer of 2004 at Mosaic Living Center, the facility now known as Alden Village North.

At 3:30 a.m. a nurse checked on the boy and found he was fine, with a respiratory registering his oxygen saturation at 100 percent. But 45 minutes later, records show, a nursing assistant saw that the oxygen reading had dropped to 88 percent. She aborted a respiratory therapy and nurse, who found the boy not breathing. No alarm had sounded, the tube was tilted, had heard alarms from the monitor. The therapist and nurse tried to save the boy, but he died at 7:29 a.m.

Three weeks later, state records show, a 4-year-old girl died when her breathing tube developed a kink and no one heard the alarms.

La Vern Pryor said she did not know the state had cited a care facility in the 2004 death of her 24-year-old son, Kyle, until the Tribune told her.

TERRENCE ANTONIO JAMES/TRIBUNE PHOTO

"I felt like I was living in a prison."

— Liz Robinson, left, who lived at Alden Village North until July. Robinson, shown with her case manager, Carla Fox-Hawthorne, said outings were rare at the facility.

KERI WIGINTON/TRIBUNE PHOTO

Residents' basic needs unmet

Complaints pile up over lack of outings, kids going to school in tattered clothes and residents' possessions disappearing

By Jared S. Hopkins and Sam Roe
TRIBUNE REPORTERS

Because of their disabilities and medically fragile state, children and young adults living at the Alden Village North nursing facility require consistent and specialized care.

But sometimes they don't even get the basics.

Documents and interviews show that, since 2000, Chicago public school teachers have repeatedly complained about the facility sending children to school in tattered, ill-fitting clothing, badly soiled diapers and wheelchairs reeking of urine. Regulators have cited the home numerous times for not providing activities or outings. Some residents' clothes, shoes and toys bought for their children disappeared.

In 2004 and 2005, records show, Chappell Elementary teacher Diane Sorokas fired off numerous faxes to the facility, then known as Mosaic Living Center. In one, she complained that a 9-year-old girl "had body odor so severe, that we washed her." Another time she took a photo of an 11-year-old boy wearing a thin jacket on a frigid day and sent it to the facility. "The jacket is very light and at least 3 sizes too small," she wrote. "He couldn't move his head or shoulders because the jacket was immobilizing him."

In an interview, Sorokas said staffers at the home would make excuses, such as saying the children must be soiling their diapers on the way to school. So Sorokas marked one boy's diaper with a small "x" before sending the child back to the facility.

The next day, she said, the boy returned to school wearing the same soiled diaper with the "x."

Regulators cited the home in 2005 for those hygiene issues, but Sorokas said problems persisted. "It was enough to make you want to cry every day," she said.

Bruce Allman, Chappell principal from 1998 to 2007, said no other facility caused his school so much trouble — a sentiment echoed today by Shannon Moffitt, a special education teacher at Gale Elementary.

Alden Village North officials did not respond to requests for comment.

Several mothers told the Tribune they would often bathe their son or daughter on visits because the child was so filthy. "If I didn't visit her every day she wouldn't get clean," said Loretta Wear, whose 25-year-old daughter, Christina Polley, died in 2008. She said the facility smelled so bad that one of her sons refused to visit.

Tamika Adams, whose 2-year-old son, Gerald Crosby, died in 2008 at the facility, said her son's diaper often went unchanged and caused severe rashes.

Liz Robinson, 27, who had lived at the facility since 2000 before leaving in July, said in an interview that outings, such as trips to the park, were rare, and the residents, although confined outside the home, "felt like I was living in a prison," said Robinson, who has cerebral palsy and is her own guardian.

Records show the state has cited the for-profit facility eight times since 2001 for not providing enough outings or activities for some residents, with five citations coming since 2008, when Floyd Schlossberg of the Alden nursing chain became operator.

In 2008 and last year, Alden Village North employees told investigators they had trouble offering more outings because they were short-staffed. They also said they no longer had their own vans and had to share one with two other nursing homes within their company.

La Vern Pryor, a social worker, said she bought her son Kyle brand-name pants, coats and shirts and sewed his name on some of them, but most vanished. She suspected they were stolen by staff.

When her son died in 2004 at age 24, regulators cited the facility for not thoroughly investigating his death — a fact his mother didn't know until the Tribune told her. After he died, the home asked her whether she wanted his remaining possessions.

"I'm thinking, 'You gave me it,'" she recalled. "They stole most of it anyway."

Moreover, investigators found, the pulse oximeters used on other residents were inaudible and the 20 apnea devices in the facility were not set correctly. The respiratory therapy director told investigators no one at the home knew the proper settings.

The problem was so pervasive that an inspector investigating the deaths of the 4-year-olds witnessed a close call involving another child.

A respiratory therapist ran into the hallway yelling "code blue" after a 5-month-old boy had disconnected his breathing tube and was turning pale, records show. The boy survived, but the inspector noticed that alarms could not be heard in the hallway. When the inspector asked why, the therapist said he thought they were broken.

A similar issue plagued the facility in 2000, when several children were accidentally pulling out their tracheotomy breathing tubes.

The facility had to call 911 on two occasions when a baby girl dislodged her tube and was found unconscious, state inspection records show. A 4-year-old boy with cognitive disabilities pulled out his tube four times.

Then 2-year-old Brian Marrero, who was in the initial stages of having his trach tube medically removed, dislodged it several times. His family fed the Tribune he was in the facility only until he could breathe without the device.

But on the morning Brian's death was preventable, he said. "In retrospect, certainly."

Brian's family sued the facility, alleging neglect, including the lack of alarms. The suit was settled out of court for $100,000.

"I don't trust nobody now with my kids," said Crenly Marrero, Brian's father.

Over the years, the facility has vowed to improve its use of alarms and monitors, but its lax approach continued, records show.

In the deaths of three children from December 2007 to April 2008, the state cited the home for, among other violations, not investigating whether alarms had played a role — whether they had gone off, were immediately answered or were even working.

Staff shortages

Early last year, an Alden nurse walked into the room of 12-year-old Derrick Black and found him slumped in his wheelchair — unconscious, not breathing, eyes fixed. Paramedics pronounced him dead 12 minutes later.

Derrick had profound mental disabilities and breathed through a tracheotomy tube, according to state records. He couldn't walk or talk but was able to communicate through some sign and body language. The facility's administrator told state investigators that the boy had not been ill before he died and that nothing unusual had occurred that morning.

"Maybe it was just his time," she said.

But the investigators weren't so sure. They concluded that Derrick had been left unattended just before he died. In addition, records show, a nurse's aide made a series of crucial errors involving Derrick's feeding tube, one of which he attributed to the fact that no one was readily available to assist him.

Derrick's death underscores a chronic problem at the facility: lack of staffing.

For instance, when 1-year-old Gabriel Melgar died 19-year-old Justin Green died unexpectedly within six days of each other in March 2008, regulators cited Alden for, among other violations, not having enough staff to thoroughly investigate the deaths to rule out neglect.

Threatened with a cutoff of its Medicaid funding, Alden promised regulators it would investigate the two deaths within three days. But when the Tribune asked for the home's documents related to the deaths, state regulators said they had none.

Alden also vowed to address staffing issues, but several months later an 11-year-old boy bruised his chest when he crawled onto a cabinet and it fell on him. Records show an aide had left the boy unsupervised in order to assist two staffers caring for 12 residents.

Several former employees of the facility told the Tribune that workers were often overwhelmed. "They had to run from one client to another," said Roy Filsen, a case manager from 2004 to 2006. "They had to change a diaper. Or they had to feed someone. It was just run, run, run."

Filsen said he was fired from the facility in 2006, in part because he had complained about staffing levels. He is now a caseworker at Answer Center, a Chicago nonprofit agency that serves people with disabilities.

Samantha Cortez, a case manager in 2003 and 2004, said nursing aides often called in sick, and the facility rarely arranged for replacements. In such situations, Filsen said, "the only way to get through the day was take some shortcuts," such as putting children to bed early. "They are kind of put in their rooms and unintentionally abandoned," Filsen said.

The day Derrick died, Alden staff had left him unattended at a particularly vulnerable time.

At 6 a.m., he was being fed through a tube when a nurse's aide came in to bathe him in bed. The aide positioned the bed flat for the bath even though Derrick's medical orders required that he be upright during feedings, records state.

The aide also disconnected and reconnected the feeding tube to dress Derrick — a task that regulators said should have been done by a nurse, not an aide. The aide then lifted Derrick to his wheelchair, even though the boy's medical file indicated that, to avoid accidents, two people were required to move him. The aide told investigators he lifted Derrick himself because "no one else was around."

Once in his wheelchair, Derrick began coughing fluids from his mouth and breathing tube. The aide said he alerted the boy's night nurse, who told investigators she suctioned the secretions, though regulators said this was not documented in her nursing notes. The night nurse then left work early, records state. She told investigators that when she left, Derrick was in his wheelchair, alert, with his eyes open.

The boy's day nurse arrived late, leaving Derrick without an assigned nurse from 7:15 to 7:29 a.m., records show.

A minute later, at 7:30 a.m., another nurse found Derrick unresponsive, with an unusually large amount of secretions on the front of his shirt, according to the nurse's statement to investigators. Nurses and paramedics tried to revive the boy to no avail. According to the facility, Derrick had been receiving 24-hour one-to-one disabilities.

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Stephanie Black's 12-year-old son, Derrick, died last year after he was left unmonitored because his night nurse left work early and his day nurse showed up late, records show. JOSE M. OSORIO/TRIBUNE PHOTO

chicagotribune.com/neglect

Read Part 1, The Final Hours of Jeremiah Clark, and get details on the 13 children and young adults whose deaths at a care facility since 2000 led to state citations. Read key documents and watch videos of a former resident of the home and a mother whose son died there.

Contact us

If you have tips about problems at a similar facility, contact The Tribune at **sroe@tribune.com** or **jahopkins@tribune.com**

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TRIBUNE WATCHDOG DEADLY NEGLECT

13 deaths on their watch

Failures of care have repeatedly jeopardized the lives of fragile children at a Chicago nursing facility

By Sam Roe and Jared S. Hopkins
TRIBUNE REPORTERS
SUNDAY, OCT. 10, 2010

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Such failures of care have repeatedly jeopardized the lives of fragile children at the facility now known as Alden Village North, a Tribune investigation has found. Records show the problems have persisted for a decade, through various owners, sometimes with deadly consequences.

Illnesses have been ignored, life-support alarms have gone unanswered and residents with complex medical problems have been left unattended. Even basic hygiene, such as bathing children and changing diapers, has been neglected.

Instead of cracking down, regulators and lawmakers have allowed problems to worsen.

Fines have been dropped or reduced, and deaths at the facility haven't been fully investigated. Illinois' rules are so weak, inconsistent and reliant on industry self-reporting that the state cannot gauge the true scope of problems at Alden and the 300 other facilities caring for people with developmental disabilities.

And earlier this year, when state lawmakers had a rare chance to boost oversight of these homes, they did not.

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In all, 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations for neglect or for failure to investigate adequately in order to rule out neglect, the Tribune found.

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The vast majority of residents at Alden Village North, a for-profit facility at 7464 N. Sheridan Road, have severe or profound cognitive disabilities. Some cannot walk, talk or call for help. Many are in wheelchairs and diapers. Some breathe and eat through tubes. More than half have epilepsy or cerebral palsy. Several have impaired vision.

Their parents, in some cases, are extremely indigent and seldom visit or advocate on their children's behalf. In trying to reach the parents of the 13 children who died, the Tribune found that

La Vern Pryor said she did not know the state had cited a care facility in the 2004 death of her 24-year-old son, Kyle, until the Tribune told her.
TERRENCE ANTONIO JAMES/TRIBUNE PHOTO

four of them were in jail or prison.

According to state records, Alden's operator is Floyd A. Schlossberg, president of Chicago-based Alden Management Services. His firm runs more than 20 nursing facilities in Illinois, primarily providing care for the elderly. His firm took over the home in January 2008, after which seven of the 13 deaths identified by the Tribune occurred.

Schlossberg's firm did not respond to repeated requests for interviews or answer written questions submitted by the newspaper.

In a brief statement, his company wrote: "We cannot comment on these matters due to pending litigation. However, we want our residents and their families to know we strive to provide quality resident care for the children and young adults in our care."

While the Illinois Department of Public Health says it has "grave concerns" about the facility and will close it if violations persist, ineffective state laws and regulatory policies almost guarantee that problems will be missed.

For example, when a child dies at Alden or a similar facility, the death does not automatically trigger an investigation, either by the home or by regulators. The state investigates deaths only if the facility reports it to officials, the public submits a tip or a regulator discovers an unexplained death during a routine inspection.

If a schoolteacher had not complained to regulators last year about the death of Jeremiah Clark, a 9-year-old Alden resident who had suffered for two days with a bowel obstruction, his ordeal might not have come to light and the facility might not have been penalized.

Except for a handful of state-operated homes, facilities are not even required to notify regulators about every resident's death. And private facilities don't have to conduct their own investigation of a child's death unless administrators at the home deem it unusual or unexpected.

"These facilities really have no incentive to report all deaths to the Department of Public Health," Arnold said.

Lawmakers loosened the reporting rules even further last year. Instead of notifying regulators every time a resident is sent to a hospital, homes must report only those cases caused by accidents or unusual incidents — a judgment the facility gets to make.

And when the legislature passed sweeping nursing home reforms earlier this year, boosting minimum staffing levels, stepping up criminal background checks on new residents and tightening rules on psychotropic medications, lawmakers quietly exempted Alden and other facilities caring for the developmentally disabled — about a quarter of the 1,252 facilities providing long-term care in Illinois.

"I thought they should have been included, but we had to compromise," recalled Wendy Meltzer, a leading advocate for nursing home residents who was instrumental in crafting the legislation.

She said that if homes for the developmentally disabled had been included, owners of the facilities would have fought the measure, jeopardizing the entire reform package. More important, she said, no one was demanding that those residents be covered.

"There weren't people lobbying on their behalf," she said. "It's really sad."

Alarms unanswered

Children with multiple disabilities often wear protective medical devices such as pulse oximeters, which are typically clipped onto a finger to measure heart rate and oxygen saturation in the blood. Others have apnea monitors, which measure heart and respiratory rates.

If the devices detect a problem — a child's pulse rate suddenly drops, for instance — an alarm is supposed to sound and nurses are supposed to respond.

But that doesn't always happen.

Take the case of the two 4-year-olds who died in the summer of 2004 at Mosaic Living Center, the facility now known as Alden Village North.

At 5:30 a.m. a nurse checked on the boy and found he was fine, with a monitor registering his oxygen saturation at 100 percent. But 45 minutes later, records show, a nursing assistant saw that the oxygen reading had dropped to 88 percent. She alerted a respiratory therapist and nurse, who found the boy not breathing. No staffer, investigators later concluded, had heard alarms from the monitor. The therapist and nurse tried to save the boy, but he died at 7:29 a.m.

Three weeks later, state records show, a 4-year-old girl died when her breathing tube developed a kink and no one heard the alarms.

Moreover, investigators found, the pulse oximeters used on other residents were inaudible and the 20 apnea devices in the facility were not set correctly. The respiratory therapy director told investigators no one at the home knew the proper settings.

The problem was so pervasive that an inspector investigating the deaths of the 4-year-olds witnessed a close call involving another child.

A respiratory therapist ran into the hallway yelling "code blue" after a 5-year-old boy had dislodged his breathing tube and was turning pale, records show. The boy survived, but the inspector noticed that alarms could not be heard in the hallway. When the inspector asked why, the therapist said he thought they were broken.

A similar issue plagued the facility in 2000, when several children were accidentally pulling out their tracheotomy breathing tubes.

The facility had to call 911 on two occasions when a baby girl dislodged her tube and was found unconscious, state inspection records show. A 4-year-old boy with cognitive disabilities pulled out his tube four times.

Then 2-year-old Brian Marrero, who was in the initial stages of having his trach tube medically removed, dislodged it several times. His family told the Tribune he was in the facility only until he could breathe without the device.

One morning nurses found the boy unconscious, with his lips blue and his tube out. He was pronounced dead 35 minutes later. He had been in the facility just 29 days.

Brian's doctor, Audrius Plioplys, who also served as the facility's medical director from 1999 to 2003, told the Tribune that staffers had not informed him the boy was pulling out his trach tube. When asked whether Brian's death was preventable, he said: "In retrospect, certainly."

Brian's family sued the facility, alleging neglect, including the lack of alarms. The suit was settled out of court for $300,000.

"I don't trust nobody now with my kids," said Crenly Marrero, Brian's father.

Over the years, the facility has vowed to improve its use of alarms and monitors, but its lax approach continued, records show.

In the deaths of three children from December 2007 to April 2008, the state cited the home for, among other violations, not investigating whether alarms had played a role — whether they had gone off, were immediately answered or were even working.

Staff shortages

Early last year, an Alden nurse walked into the room of 12-year-old Derrick Black and found him slumped in his wheelchair — unconscious, not breathing, eyes fixed. Paramedics pronounced him dead 12 minutes later.

Derrick had profound mental disabilities and breathed through a tracheotomy tube, according to state records. He couldn't walk or talk but was able to communicate through some sign and body language. The facility's administrator told state investigators that the boy had not been ill before he died and that nothing unusual had occurred that morning.

"Maybe it was just his time," she said.

But the investigators weren't so sure. They concluded that Derrick had been left unattended just before he died. In ad-

Stephanie Black's 12-year-old son, Derrick, died last year after he was left unmonitored because his night nurse left work early and his day nurse showed up late, records show.
JOSE M. OSORIO/TRIBUNE PHOTO

dition, records show, a nurse's aide made a series of crucial errors involving Derrick's feeding tube, one of which he attributed to the fact that no one was readily available to assist him.

Derrick's death underscores a chronic problem at the facility: lack of staffing.

For instance, when 1-year-old Gabriel Melgar and 19-year-old Justin Green died unexpectedly within six days of each other in March 2008, regulators cited Alden for, among other violations, not having enough staff to thoroughly investigate the deaths to rule out neglect.

Threatened with a cutoff of its Medicaid funding, Alden promised regulators it would investigate the two deaths within three days. But when the Tribune asked the state for documents related to the follow-up inquiry, regulators said they had none.

Alden also vowed to address staffing issues, but several months later an 11-year-old boy bruised his chest when he crawled onto a cabinet and it fell on him. Records show an aide had left the boy unsupervised in order to assist two staffers caring for 32 residents.

Several former employees of the facility told the Tribune that workers were often overwhelmed. "They had to run from one client to another," said Roy Filson, a case manager from 2004 to 2006. "They had to change a diaper. Or they had to feed someone. It was just run, run, run."

Filson said he was fired from the facility in 2006, in part because he had complained about staffing levels. He is now a caseworker at Anixter Center, a Chicago nonprofit organization serving people with disabilities.

Samantha Cortez, a case manager in 2003 and 2004, said nursing aides often called in sick, and the facility rarely arranged for replacements. In such situations, Filson said, "the only way to get through the day was take some shortcuts," such as putting children to bed early. "They are kind of put in their rooms and unintentionally abandoned," Filson said.

The day Derrick died, Alden staff had left him unattended at a particularly vulnerable time.

At 6 a.m., he was being fed through a tube when a nurse's aide came in to bathe him in bed. The aide positioned the bed flat for the bath even though Derrick's medical orders required that he be upright during feedings, records state.

The aide also disconnected and reconnected the feeding tube to dress Derrick — a task that regulators said should have been done by a nurse, not an aide. The aide then lifted Derrick to his wheelchair, even though the boy's medical file indicated that, to avoid accidents, two people were required to move him. The aide told investigators he lifted Derrick himself because "no one else was around."

Once in his wheelchair, Derrick started coughing fluids from his mouth and breathing tube. The aide said he alerted the boy's night nurse, who told investigators she suctioned the secretions, though regulators said this was not documented in her nursing notes. The night nurse then left work early, records state. She told investigators that when she left, Derrick was in his wheelchair, alert, with his eyes open.

The boy's day nurse arrived late, leaving Derrick without an assigned nurse from 7:15 to 7:29 a.m., records show.

A minute later, at 7:30 a.m., another nurse found Derrick unresponsive, with an unusually large amount of secretions on the front of his shirt, according to the nurse's statement to investigators. Nurses and paramedics tried to revive the boy to no avail. According to the facility, Derrick's death certificate said he died from "pulmonary, respiratory arrest."

The state cited Alden for neglect and levied a $25,000 fine, which the facility is contesting. A hearing is set for January.

Derrick's mother, Stephanie Black, filed a wrongful-death suit against Alden in August. She and her boyfriend, Carlton Stinson, said they did not know until they were told by the Tribune that other children had died at the facility in cases involving neglect.

"See, honey?" Stinson said to her. "We're not the only ones."

"I felt like I was living in a prison."

— Liz Robinson, left, who lived at Alden Village North until July. Robinson, shown with her case manager, Carla Fox-Hawthorne, said outings were rare at the facility. **KERI WIGINTON/TRIBUNE PHOTO**

Chicago Tribune
Deadly Neglect

Residents' basic needs unmet

Complaints pile up over lack of outings, kids going to school in tattered clothes and residents' possessions disappearing

By Jared S. Hopkins and Sam Roe
TRIBUNE REPORTERS
SUNDAY, OCT. 10, 2010

Because of their disabilities and medically fragile state, children and young adults living at the Alden Village North nursing facility require consistent and specialized care.

But sometimes they don't even get the basics.

Documents and interviews show that, since 2000, Chicago public school teachers have repeatedly complained about the facility sending children to school in tattered, ill-fitting clothing, badly soiled diapers and wheelchairs reeking of urine. Regulators have cited the home numerous times for not providing activities or outings. Some parents say toys and clothes they bought for their children disappeared.

In 2004 and 2005, records show, Chappell Elementary teacher Diane Sorokas fired off numerous faxes to the facility, then known as Mosaic Living Center. In one, she complained that a 9-year-old girl "had body odor so severe, that we washed her." Another time she took a photo of an 11-year-old boy wearing a thin jacket on a frigid day and sent it to the facility. "The jacket is very light and at least 3 sizes too small," she wrote. "He couldn't move his head or shoulders because the jacket was immobilizing him."

In an interview, Sorokas said staffers at the home would make excuses, such as saying the children must be soiling their diapers on the way to school. So Sorokas marked one boy's diaper with a small "x" before sending the child back to the facility.

The next day, she said, the boy returned to school wearing the same diaper, thoroughly soiled.

Regulators cited the home in 2005 for these hygiene issues, but Sorokas said problems persisted. "It was enough to make you want to cry every day," she said.

Bruce Allman, Chappell principal from 1999 to 2007, said no other facility caused his school as much trouble — a sentiment echoed today by Shannon Moffitt, a special education teacher at Gale Elementary.

Alden Village North officials did not respond to requests for comment.

Several mothers told the Tribune they would often bathe their son or daughter on visits because the child was so filthy. "If I didn't visit her every day she wouldn't get clean," said Loretta Waue, whose 25-year-old daughter, Christina Polley, died in 2008. She said the facility smelled so bad that one of her sons refused to visit.

Tamika Adams, whose 2-year-old son, Gerald Crosby, died in 2008 at the facility, said her son's diaper often went unchanged and caused severe rashes.

Liz Robinson, 27, who had lived at the facility since 2006 before leaving in July, said in an interview that outings, such as trips to the park, were rare, and that residents were seldom allowed outside the building. "I felt like I was living in a prison," said Robinson, who has cerebral palsy and is her own guardian.

Records show the state has cited the for-profit facility eight times since 2001 for not providing enough outings or activities for some residents, with five citations coming since 2008, when Floyd Schlossberg of the Alden nursing chain became operator.

In 2008 and last year, Alden Village North employees told investigators they had trouble offering more outings because they were short-staffed. They also said they no longer had their own van and had to share one with two other nursing homes within their company.

La Vern Pryor, a social worker, said she bought her son Kyle brand-name pants, coats and shirts and sewed his name on some of them, but most vanished. She suspected they were stolen by staff.

When her son died in 2004 at age 24, regulators cited the facility for not thoroughly investigating his death — a fact his mother didn't know until the Tribune told her. After he died, the home asked her whether she wanted his remaining possessions.

"I told them they could have it," she recalled. "They stole most of it anyway."

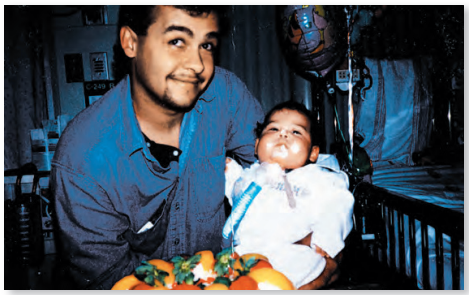
A care center's troubled history

Government records show a pattern of substandard care — sometimes with deadly consequences — at Alden Village North and its predecessors. The Tribune found that 13 children and young adults have died at the facility since 2000 in cases that resulted in state citations. In five deaths, the facility was cited for neglect; in the other eight, the home was cited for failing to thoroughly investigate the deaths to rule out neglect.

KEY (N) - Facility cited for neglect
(I) - Facility cited for failure to investigate fully to rule out neglect

2000

June 9: Brian Marrero, 2, dies after his breathing tube becomes dislodged. The facility is cited for neglect and fined $10,000. Four children, including Brian, had previously experienced close calls after pulling out their tubes in 2000. (N)



FAMILY PHOTO

Crenly Marrero, shown holding his son Brian in a hospital room, said he remains upset that Brian died from the same behavior that led the family to place him in a care facility: playing with his breathing tube.

2003

June: The facility changes owners and switches names from the Pediatric Rehabilitation Institute to the Mosaic Living Center.

2004

July 19: Kyle Pryor, 24, dies after going into respiratory and cardiac arrest. "I miss his hugs," said his mother, La Vern. "Even though he was grown he never really grew up. That was my baby." (I)

Aug. 27: A 4-year-old boy dies after going into respiratory and cardiac arrest; no alarms on his oxygen monitor were heard. (N)

Sept. 17: A 4-year-old girl dies under similar circumstances. The facility is cited for neglect and fined $50,000 after investigators discover numerous alarms are not set properly or are inaudible. (N)

Nov. 15: Demetri Franklin, 10 months, dies of pulmonary hemorrhage. "It was shocking because he was on his way home. He was doing better," said his mother, Ashley Seawood. (I)

2005

October: The facility is cited after a school repeatedly complains *(example below)* that some children from the facility have soiled clothes, extreme body odor and filthy wheelchairs.

The children are coming in with no extra clothing in case they soil their clothes. They often come in with badly soiled diapers, and body odor. [redacted] had body odor so severe, that we washed her. We asked Mosaic to wash [redacted]'s hair so that we could have her hair look presentable for the holidays, and it took almost a week for a reply.

Excerpt from a Dec. 16, 2004, fax from a Chappell Elementary School teacher to the facility. Children's names are redacted.

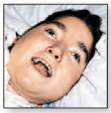
2007

Dec. 11: Ke'Shaun Emanual Miller-Harris, 6, dies after a respiratory therapist finds his blood-oxygen levels had dropped. He depended on a ventilator to breathe and had multiple other disabilities. (I)

2008

Jan. 3: The facility changes ownership and its name becomes Alden Village North.

Feb. 10: Christina Polley, 25, dies of pneumoni[redacted]. She had been living at the facility since 1999. "I'd walk in the room and she'd always smile," said her mother, Loretta Waue. (I)



March 18: Gerald Crosby, 2, dies. His mother, Tamika Adams, said the care he received at Alden was poor. "I often think to myself, were they the reason that my son passed away?" she said. (I)

March 21: Gabriel Melgar, 1, dies after being found "unresponsive and blue" in his stroller. He had Down syndrome and profound mental disabilities. (I)

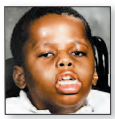
March 26: A 19-year-old man whom records identify as Justin Green dies after his ventilator alarm sounded. The state found no evidence that Alden had reviewed whether proper supervision was provided. (I)

April 16: A 16-year-old girl with profound mental disabilities and cerebral palsy dies after a hospitalization of more than a month. (I)

November: The facility is hit with more than two dozen violations in a 110-page inspection report, one of the longest involving Illinois nursing facilities in recent years.

2009

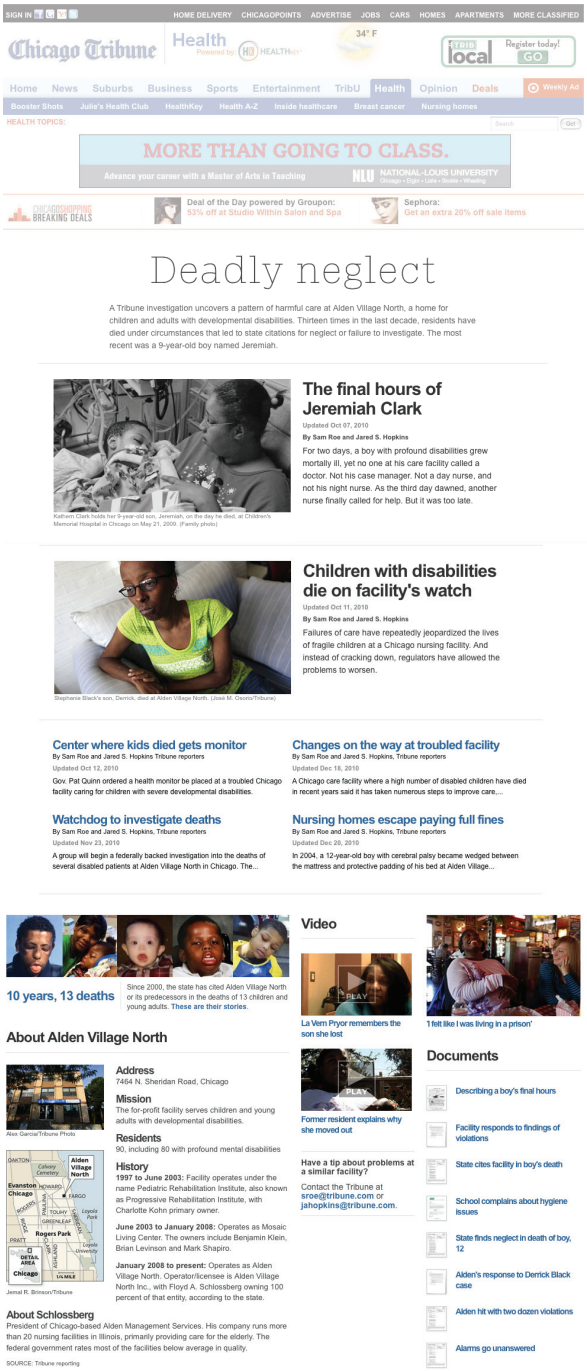
Jan. 20: Derrick Black, 12, dies after he is left unattended because his night nurse left work early and his day nurse showed up late. The facility is cited for neglect and fined $25,000. (N)



May 21: Jeremiah Clark, 9, dies of shock, infection and bowel obstruction. His school had sent him home two days in a row because he was ill, but Alden did not call his doctor until the third day. The facility is cited for neglect and fined $35,000. (N)

SOURCES: State, court and other government records; Tribune reporting

JEMAL R. BRINSON, SAM ROE AND JARED S. HOPKINS/TRIBUNE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Deadly neglect
A Tribune investigation uncovers a pattern of harmful care at Alden Village North, a home for children and adults with developmental disabilities. Thirteen times in the last decade, residents have died under circumstances that led to state citations for neglect or failure to investigate. The most recent was a 9-year-old boy named Jeremiah.
Kathern Clark holds her 9-year-old son, Jeremiah, on the day he died, at Children's Memorial Hospital in Chicago on May 21, 2009. (Family photo)
The final hours of Jeremiah Clark
Updated Oct 07, 2010
By Sam Roe and Jared S. Hopkins
For two days, a boy with profound disabilities grew mortally ill, yet no one at his care facility called a doctor. Not his case manager. Not a day nurse, and not his night nurse. As the third day dawned, another nurse finally called for help. But it was too late.
Stephanie Black's son, Derrick, died at Alden Village North. (José M. Osorio/Tribune)
Children with disabilities die on facility's watch
Updated Oct 11, 2010
By Sam Roe and Jared S. Hopkins
Failures of care have repeatedly jeopardized the lives of fragile children at a Chicago nursing facility. And instead of cracking down, regulators have allowed the problems to worsen.
Center where kids died gets monitor
By Sam Roe and Jared S. Hopkins Tribune reporters
Updated Oct 12, 2010
Gov. Pat Quinn ordered a health monitor be placed at a troubled Chicago facility caring for children with severe developmental disabilities.
Changes on the way at troubled facility
By Sam Roe and Jared S. Hopkins, Tribune reporters
Updated Dec 18, 2010
A Chicago care facility where a high number of disabled children have died in recent years said it has taken numerous steps to improve care,...
Watchdog to investigate deaths
By Sam Roe and Jared S. Hopkins, Tribune reporters
Updated Nov 23, 2010
A group will begin a federally backed investigation into the deaths of several disabled patients at Alden Village North in Chicago. The...
Nursing homes escape paying full fines
By Sam Roe and Jared S. Hopkins, Tribune reporters
Updated Dec 20, 2010
In 2004, a 12-year-old boy with cerebral palsy became wedged between the mattress and protective padding of his bed at Alden Village...
10 years, 13 deaths
Since 2000, the state has cited Alden Village North or its predecessors in the deaths of 13 children and young adults. These are their stories.
About Alden Village North
Alex Garcia/Tribune Photo
Address
7464 N. Sheridan Road, Chicago
Mission
The for-profit facility serves children and young adults with developmental disabilities.
Residents
90, including 80 with profound mental disabilities
History
1997 to June 2003: Facility operates under the name Pediatric Rehabilitation Institute, also known as Progressive Rehabilitation Institute, with Charlotte Kohn primary owner.
June 2003 to January 2008: Operates as Mosaic Living Center. The owners include Benjamin Klein, Brian Levinson and Mark Shapiro.
January 2008 to present: Operates as Alden Village North. Operator/licensee is Alden Village North Inc., with Floyd A. Schlossberg owning 100 percent of that entity, according to the state.
Alden Village North
Evanston
Chicago
Rogers Park
Loyola Park
Loyola University
DETAIL AREA
Chicago
1/4 MILE
Jemal R. Brinson/Tribune
About Schlossberg
President of Chicago-based Alden Management Services. His company runs more than 20 nursing facilities in Illinois, primarily providing care for the elderly. The federal government rates most of the facilities below average in quality.
SOURCE: Tribune reporting
Video
PLAY
La Vern Pryor remembers the son she lost
PLAY
Former resident explains why she moved out
Have a tip about problems at a similar facility?
Contact the Tribune at sroe@tribune.com or jahopkins@tribune.com.
I felt like I was living in a prison'
Documents
Describing a boy's final hours
Facility responds to findings of violations
State cites facility in boy's death
School complains about hygiene issues
State finds neglect in death of boy, 12
Alden's response to Derrick Black case
Alden hit with two dozen violations
Alarms go unanswered

10 years, 13 deaths

By Jared S. Hopkins and Sam Roe, Tribune reporters

Since 2000, at least 13 children and young adults living at Alden Village North or its predecessors at 7464 N. Sheridan Road have died in cases resulting in state violations, the Tribune found. Although state records typically do not disclose identities of children who have died at nursing facilities, the newspaper tracked down names by cross-checking public records with other government documents. Their stories:

Brian Marrero, shown with his father, Crenly, used a tracheotomy tube to breathe and was supposed to be monitored every two hours. But on the day he died — June 9, 2000 — he had not been checked for 3 1/2 hours, records show. (Family photo)

Brian Marrero, 2

Brian Marrero used a tracheotomy tube to breathe and was supposed to be monitored every two hours. But in the early morning hours of the day he died — June 9, 2000 — he had not been checked for 3 1/2 hours, records show.

After staff found that he was not breathing and his tracheotomy tube was out, paramedics were called at 5:15 a.m. Brian arrived at St. Francis Hospital in Evanston at 5:40 a.m. and was pronounced dead five minutes later, records show. The cause was asphyxiation and the dislodged tracheotomy tube. Prior to his death, he had pulled out the tube three times in 10 days, according to the state. The facility — then known as both the Pediatric Rehabilitation Institute and the Progressive Rehabilitation Institute — didn't fix the problem and did not notify his doctor or his attending nurse, records show.

The state cited the facility for neglect and fined it $10,000, part of which was paid when the penalty was combined with another fine. Brian's family filed a wrongful death lawsuit against the facility that was settled for $300,000.

Brian's father, Crenly Marrero, said the boy was born several months premature. At 6 months old, he had gained weight but needed a tracheotomy tube to breathe. Marrero said he remains upset that Brian died from the same behavior that led the family to place him in the facility: playing with the trach tube. "That makes no sense," he said. "I don't see how something like that could happen."

Brian's doctor, Audrius Plioplys, who was the facility's medical director from 1999 to 2003, told the Tribune he should have been notified of the boy's trach problems. When asked if Brian's death was preventable, he said, "In retrospect, certainly."

Kyle Pryor, 24

Kyle Pryor's health issues included profound mental disabilities and asthma. He died July 19, 2004, at Evanston's St. Francis Hospital, 32 minutes after going into respiratory and cardiac arrest. The state cited his care facility, by then called Mosaic Living Center, for not fully investigating the death. (Family photo)

Kyle Pryor's health issues included profound mental disabilities and asthma. His mother, La Vern Pryor, said she placed her son at the Pediatric Rehabilitation Institute in 2000 when he was 19. He had been living in a facility in Springfield, but his mother said she made the switch because he needed more specialized care for his gastrostomy tube. Kyle loved music, she said, and she bought him plastic musical toys that made loud sounds. "He could dance," she said. "He loved to dance."

But over time, Pryor grew concerned about her son's care. There weren't many outings or activities, clothes and toys went missing, and there wasn't enough staff, she said. On visits Pryor found her son dirty and wet, with food crumbs in his wheelchair. She took him into the shower to bathe him. "No one changed him, cleaned him — nothing. I grew tired, frustrated," she said. Pryor said she complained to staff regularly. "It was a constant battle."

Records show Kyle died July 19, 2004, at Evanston's St. Francis Hospital, 32 minutes after going into respiratory and cardiac arrest. The state cited the facility, by then called Mosaic Living Center, for not fully investigating the death and not resolving conflicting statements provided by the staff during its internal investigation.

Responding to the citations, Mosaic Living Center said it had reviewed its investigative techniques and that improvements would be made.

Pryor said she was unaware the facility had been cited for not thoroughly investigating her son's death until told by the Tribune. She said she still wants to know why her son died. "I miss his hugs. And he had a sense of humor. He was a real likable little kid — even though he was grown he never really grew up. That was my baby."

4-year-old boy and 4-year-old girl

In 2004 the state cited Mosaic Living Center for neglect, saying the facility had not properly monitored numerous residents, including two 4-year-olds who died within three weeks of each other, by failing to ensure that alarms meant to alert staff to health problems were audible or set correctly.

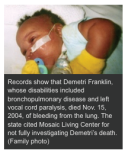
The 4-year-old boy was diagnosed with severe mental disabilities and breathed through a tracheotomy tube, records show. At 5:30 a.m. on Aug. 27, 2004, a nurse checked on him and found he was fine, with his monitor showing that the oxygen saturation in his bloodstream was a healthy 100 percent. But 45 minutes later, records show, a nursing assistant saw that the oxygen reading had dropped to 88 percent. She alerted a respiratory therapist and nurse, who found the boy not breathing. No staffer, investigators later concluded, had heard alarms from the monitor. The therapist and nurse tried to save the boy, but he died at 7:29 a.m.

The 4-year-old girl's disabilities included brain damage and seizure disorder, records show. She also had a tracheotomy tube. On Sept. 17, 2004, a nurse's aide went into the girl's room to take her temperature and saw blood coming from her mouth, records show. The aide alerted a respiratory therapist, who shook the girl, but she didn't open her eyes as she typically did. A "code blue" emergency was called, but she could not be revived. Records state she went into respiratory and cardiac arrest at 6:15 p.m. and died in a hospital at 7:11 p.m. Investigators concluded her trach tube had been dislodged, and staff didn't hear the alarms on her monitor.

In its investigation of the deaths the state also concluded that "by not conducting thorough investigations the facility failed to discover information that would lead to identifying problems with their apnea and oximeter alarms."

Responding to the violations, the facility said it immediately upgraded its alarm system and reviewed its investigation techniques.

The Tribune has been unable to reach the families of the two children.



Records show that Demetri Franklin, whose disabilities included bronchopulmonary disease and left vocal cord paralysis, died Nov. 15, 2004, of bleeding from the lung. The state cited Mosaic Living Center for not fully investigating Demetri's death. (Family photo)

Demetri Franklin, 10 months

Records show that Demetri Franklin, whose disabilities included bronchopulmonary disease and left vocal cord paralysis, died Nov. 15, 2004, from pulmonary hemorrhage, which is bleeding from the lung. The state cited Mosaic Living Center for not fully investigating Demetri's death, including the conflicting notes and statements made by the staff during an internal investigation.

A nurse's notes state that Demetri was seen "awake, responsive and smiling" in a crib at 11:30 a.m. on Nov. 14. But a respiratory therapist had earlier noted a change in Demetri's complexion. "The patient was changing color. I assessed the patient and he had a faint pulse," the therapist wrote at 11:13 a.m. At 11:46 a.m. a respiratory therapist was heard in Demetri's room yelling for help; the child was pale and not breathing. A "code blue" emergency was declared and he was transported to Children's Memorial Hospital, where he died the next day.

Demetri's mother, Ashley Seawood, said she never received an explanation from the facility's administrators for her son's death and still wants answers. "How did they not know he wasn't breathing?" she said.

In its response to the state, the facility said it had reviewed its investigation format and would "identify circumstances surrounding all incidents." It also said all similar incidents "will be investigated thoroughly,

10 years, 13 deaths

By Jared S. Hopkins and Sam Roe
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Since 2000, at least 13 children and young adults living at Alden Village North or its predecessors at 7464 N. Sheridan Road have died in cases resulting in state violations, the Tribune found. Although state records typically do not disclose identities of children who have died at nursing facilities, the newspaper tracked down names by cross-checking public records with other government documents. Their stories:

Brian Marrero, 2

Brian Marrero used a tracheotomy tube to breathe and was supposed to be monitored every two hours. But in the early morning hours of the day he died — June 9, 2000 — he had not been checked for 3 1/2 hours, records show.

After staff found that he was not breathing and his tracheotomy tube was out, paramedics were called at 5:15 a.m. Brian arrived at St. Francis Hospital in Evanston at 5:40 a.m. and was pronounced dead five minutes later, records show. The cause was asphyxiation and the dislodged tracheotomy tube. Prior to his death, he had pulled out the tube three times in 10 days, according to the state. The facility — then known as both the Pediatric Rehabilitation Institute and the Progressive Rehabilitation Institute — didn't fix the problem and did not notify his doctor or his attending nurse, records show.

The state cited the facility for neglect and fined it $10,000, part of which was paid when the penalty was combined with another fine. Brian's family filed a wrongful death lawsuit against the facility that was settled for $300,000.

Brian's father, Crenly Marrero, said the boy was born several months premature. At 6 months old, he had gained weight but needed a tracheotomy tube to breathe. Marrero said he remains upset that Brian died from the same behavior that led the family to place him in the facility: playing with the trach tube. "That makes no sense," he said. "I don't see how something like that could happen."

Brian's doctor, Audrius Plioplys, who was the facility's medical director from 1999 to 2003, told the Tribune he should have been notified of the boy's trach problems. When asked if Brian's death was preventable, he said, "In retrospect, certainly."

Kyle Pryor, 24

Kyle Pryor's health issues included profound mental disabilities and asthma. His mother, La Vern Pryor, said she placed her son at the Pediatric Rehabilitation Institute in 2000 when he was 19. He had been living in a facility in Springfield, but his mother said she made the switch because he needed more specialized care for his gastrostomy tube. Kyle loved music, she said, and she bought him plastic musical toys that made loud sounds. "He could dance," she said. "He loved to dance."

But over time, Pryor grew concerned about her son's care. There weren't many outings or activities, clothes and toys went missing, and there wasn't enough staff, she said. On visits Pryor found her son dirty and wet, with food crumbs in his wheelchair. She took him into the shower to bathe him. "No one changed him, cleaned him — nothing. I grew tired, frustrated," she said. Pryor said she complained to staff regularly. "It was a constant battle."

Records show Kyle died July 19, 2004, at Evanston's St. Francis Hospital, 32 minutes after going into respiratory and cardiac arrest. The state cited the facility, by then called Mosaic Living Center, for not fully investigating the death and not resolving conflicting statements provided by the staff during its internal investigation.

Responding to the citations, Mosaic Living Center said it had reviewed its investigative techniques and that improvements would be made.

Pryor said she was unaware the facility had been cited for not thoroughly investigating her son's death until told by the Tribune. She said she still wants to know why her son died. "I miss his hugs. And he had a sense of humor. He was a real likable little kid — even though he was grown he never really grew up. That was my baby."

4-year-old boy and 4-year-old girl

In 2004 the state cited Mosaic Living Center for neglect, saying the facility had not properly monitored numerous residents, including two 4-year-olds who died within three weeks of each other, by failing to ensure that alarms meant to alert staff to health problems were audible or set correctly.

The 4-year-old boy was diagnosed with severe mental disabilities and breathed through a tracheotomy tube, records show. At 5:30 a.m. on Aug. 27, 2004, a nurse checked on him and found he was fine, with his monitor showing that the oxygen saturation in his bloodstream was a healthy 100 percent. But 45 minutes later, records show, a nursing assistant saw that the oxygen reading had dropped to 88 percent. She alerted a respiratory therapist and nurse, who found the boy not breathing. No staffer, investigators later concluded, had heard alarms from the monitor. The therapist and nurse tried to save the boy, but he died at 7:29 a.m.

The 4-year-old girl's disabilities included brain damage and seizure disorder, records show. She also had a tracheotomy tube. On Sept. 17, 2004, a nurse's aide went into the girl's room to take her temperature and saw blood coming from her mouth, records show. The aide alerted a respiratory therapist, who shook the girl, but she didn't open her eyes as she typically did. A "code blue" emergency was called, but she could not be revived. Records state she went into respiratory

and cardiac arrest at 6:15 p.m. and died in a hospital at 7:11 p.m. Investigators concluded her trach tube had been dislodged, and staff didn't hear the alarms on her monitor.

In its investigation of the deaths the state also concluded that "by not conducting thorough investigations the facility failed to discover information that would lead to identifying problems with their apnea and oximeter alarms."

Responding to the violations, the facility said it immediately upgraded its alarm system and reviewed its investigation techniques.

The Tribune has been unable to reach the families of the two children.

Demetri Franklin, 10 months

Records show that Demetri Franklin, whose disabilities included bronchopulmonary disease and left vocal cord paralysis, died Nov. 15, 2004, from pulmonary hemorrhage, which is bleeding from the lung. The state cited Mosaic Living Center for not fully investigating Demetri's death, including the conflicting notes and statements made by the staff during an internal investigation.

A nurse's notes state that Demetri was seen "awake, responsive and smiling" in a crib at 11:30 a.m. on Nov. 14. But a respiratory therapist had earlier noted a change in Demetri's complexion. "The patient was changing color. I assessed the patient and he had a faint pulse," the therapist wrote at 11:13 a.m. At 11:46 a.m. a respiratory therapist was heard in Demetri's room yelling for help; the child was pale and not breathing. A "code blue" emergency was declared and he was transported to Children's Memorial Hospital, where he died the next day.

Demetri's mother, Ashley Seawood, said she never received an explanation from the facility's administrators for her son's death and still wants answers. "How did they not know he wasn't breathing?" she said.

In its response to the state, the facility said it had reviewed its investigation format and would "identify circumstances surrounding all incidents." It also said all similar incidents "will be investigated thoroughly to avoid future occurrences."

Seawood, a high school student in 2004, said she visited Demetri weekly and brought him toys. He would smile when he played with his favorite: a colored box that would light up and make noise. She said he had been living in the facility six months. "It was shocking because he was on his way home. He was doing better," said Seawood, now 23. "It's still hard."

Ke'shaun Emanual Miller-Harris, 6

In addition to his profound mental disabilities, Ke'shaun Emanual Miller-Harris had a seizure disorder and depended on a ventilator to breathe. His death was one of four for which the nursing facility was cited in June 2008 for not fully investigating "to rule out abuse and neglect."

At 2 a.m. on Dec. 11, 2007, a respiratory therapist notified a nurse that Ke'shaun's oxygen levels had dropped, records show. He was transported to St. Francis Hospital in Evanston. Hospital officials called Mosaic Living Center to say he died about 3 a.m. Records show the facility didn't investigate whether his monitor was working, whether the therapist was in the boy's room because the alarm rang or because he was doing routine rounds, what the boy's vital signs were at 2 a.m., or how long he received extra oxygen.

In its response to the state, the facility in 2008 wrote it was reviewing the child's medical records. It also said that in any future deaths, it would investigate the circumstances leading up to hospitalization and death, as well as the emergency response provided to the resident.

"I miss everything about him," said Manual Miller, the boy's father.

Christina Polley, 25

Christina Polley, whose disabilities included spastic cerebral palsy, profound mental disabilities and seizure disorder, died of pneumonia at Rainbow Hospice and Palliative Care in Park Ridge on Feb. 10, 2008, after spending more than two weeks in the hospital, records show. At 2:20 a.m. on Jan. 23, while living at Alden Village North, she developed breathing difficulties. At 3:30 a.m. staff called paramedics.

The state cited Alden for not investigating the circumstances leading to her hospitalization, including not determining who found her with breathing problems, whether the respiratory therapist was informed of the respiratory difficulties, whether Polley was treated and what happened in the hour before paramedics were contacted.

Christina's mother, Loretta Waue, learned of the violation from the Tribune. "I just thought, 'This is what happened.' She was in the hospital a lot," Waue said.

Responding to the violation, the facility told the state it was reviewing Polley's medical records. It also said that should there be future deaths, it would investigate the circumstances leading up to hospitalization and death, as well as the emergency response provided to the resident.

Waue, who said Christina entered the facility in 1999 at age 17 when it was called the Pediatric Rehabilitation Institute, misses her daughter's smile. "I'd walk in the room and she'd always smile," she said. "When she got to see other people she'd start to smile, but she'd really smile when she saw me."

Gerald Crosby, 2

Gerald Crosby's mother, Tamika Adams, said she thinks the care provided by Alden Village North contributed to his 2008 death. "They really did not ever care, they did not ever focus on those kids, and they did not focus on my son," she said.

The boy had profound mental disabilities and breathed with the aid of a tracheotomy tube and ventilator, records show. On visits, the mother said, she would see mildew on his neck from his tracheotomy tube and dried feces on his back that would cause sores.

On March 9, 2008, a respiratory therapist contacted staff members when he heard Gerald's alarm go off, records show. Gerald was found unresponsive, and the therapist performed bagging, or resuscitation. The boy died nine days later, on March 18, in Children's Memorial Hospital. The cause of death was cardiac arrest, records show.

The state said the facility did not thoroughly investigate his death "to rule out abuse and neglect." The state said the facility failed to investigate his condition, how long the alarm had sounded before the therapist heard it and whether any staff members had heard it before the therapist.

The facility told the state that it was reviewing Gerald's medical records, and that in the event of future deaths, it would investigate the circumstances leading up to hospitalization and death, as well as the emergency response provided to the resident.

Gerald's room was close to the nurse's station, so his mother doesn't understand what went wrong. "I often think to myself, were they the reason that my son passed away?" Adams said.

Gabriel Melgar, 1

Gabriel Melgar, who had Down syndrome and profound mental disabilities, died March 21, 2008, two weeks before his second birthday, records show.

His mother, Esmeralda Alvarado, said that on visits she would push him around the room in a little toy car and gently rock his bed as he slept. "I would just stay with him and play with him," she said.

On the day he died, Gabriel was fed by a certified nursing assistant at 6:30 a.m. and returned to his room in a stroller by 6:35. At 7:15, he was found "unresponsive and blue" in the stroller. CPR was initiated and he was transported to a hospital. He died from cardiac arrest at 8 a.m.

State investigators concluded that Gabriel's death was one of two "unexpected

deaths" in 2008 that the facility failed to thoroughly investigate "to ensure that appropriate medical and nursing care had been provided."

"This has the potential to affect all residents," they wrote.

Alden Village North's administrator told state investigators she didn't know the cause of Gabriel's death. She also said there was no written internal investigation but that she had spoken to staff and found no negligence. The state found no evidence that the facility reviewed whether proper supervision was provided. The facility was also cited for being understaffed and for not reporting Gabriel's death to the state health department.

Records show Alden promised the state agency it would reinvestigate the death. But there is no evidence that the state followed up on this vow. When the Tribune filed a Freedom of Information Act request with the state for documents on any follow-up inquiry, officials said they had none. Alden did not respond to requests by the newspaper for the documents.

Gabriel's mother said she never inquired about his death because she did not suspect any wrongdoing. But, she said, the state or facility should have informed her there was an investigation. "The only good thing is he can't get hurt anymore," Alvarado said. "He's my little angel. That's what I tell myself."

Justin Green, 19

Records show that on March 26, 2008, a respiratory therapist heard that a resident's ventilator pressure alarm was sounding. The resident was found unresponsive, CPR was performed, and he was sent to the emergency room. He died minutes later from what documents stated was a cardiopulmonary issue, or a condition related to the heart and lungs.

The Tribune was unable to reach the resident's family, but records identify him as Justin Green, 19. His diagnoses included profound mental disabilities and cerebral palsy, documents show.

State investigators concluded that Green's death was one of two "unexpected deaths" in 2008 that the facility failed to thoroughly investigate "to ensure that appropriate medical and nursing care had been provided."

Alden Village North's administrator told state investigators that she didn't know the cause of Green's death. She also said there was no written internal investigation but that she had spoken to staff and found no negligence. The state found no evidence that the facility reviewed the circumstances leading to Green's death, including whether his ventilator was working properly. The facility was also cited for being understaffed and for not reporting Green's death to the state health department.

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16-year-old girl

A 16-year-old girl who lived at Alden and whose disabilities included profound mental impairment and cerebral palsy died April 16, 2008, records show. The Tribune was unable to confirm her identity.

A nurse's notes show that at 3 a.m. March 10 she was having difficulty breathing. A respiratory therapist attended to her, and she was given Tylenol. A doctor, paged 49 minutes later, told staff to send her to a hospital, where she died more than a month later.

The state cited Alden for failing to investigate circumstances leading to her hospitalization, including what the girl's respiratory status was at 3 a.m., who saw her when she was last breathing normally, whether she was being electronically monitored and whether the monitor was working.

In its response to the state, the facility wrote it was reviewing the girl's medical records. It also said it would investigate the circumstances of any future death, as well as the emergency response provided.

Derrick Black, 12

Derrick Black had profound mental disabilities and couldn't walk or talk, but he was able to communicate through some sign and body language. He also had a history of respiratory problems and breathed through a tracheotomy tube.

On Jan. 20, 2009, an Alden nurse walked into his room and found him slumped in his wheelchair at 7:30 a.m. — unconscious, not breathing, eyes fixed. Paramedics pronounced him dead 12 minutes later. According to the facility, the death certificate listed the cause of death as "pulmonary, respiratory arrest."

The facility's administrator told state investigators that the boy had not been ill and nothing unusual had occurred that morning. "Maybe it was just his time," she said.

But investigators concluded that Derrick had been left unmonitored from 7:15 to 7:29 a.m. because his night nurse had left work early and his day nurse showed up late. In addition, a nurse's aide made a series of crucial errors involving his Derrick's feeding tube, such as positioning his bed flat even though medical orders required him to be upright during feedings.

The state cited Alden for neglect and fined it $25,000, which the facility is contesting. In August, Derrick's mother, Stephanie, filed a wrongful death suit against Alden. She and her boyfriend, Carlton Stinson, said they did not know other children had died at the facility in cases involving neglect until told by the Tribune.

"See, honey?" Stinson said to her. "We're not the only ones."

Jeremiah Clark, 9

Kathern Clark, of Harvey, cared for her son Jeremiah at home until he was 4, but in 2004 she reluctantly placed him in what was then called Mosaic Living Center. Diagnosed with profound cognitive disabilities, Jeremiah was fed through a gastrostomy tube, or G-tube, inserted directly into his stomach.

Clark said she visited him as much as possible, taking a two-hour bus trip to Chicago's North Side. Sometimes, she said, she would wheel him over to Lake Michigan, where she would show him the water and whisper: "Mommy loves you. It's going to be OK."

Jeremiah died May 21, 2009, of shock, infection and bowel obstruction. According to records and interviews, teachers at his school had sent Jeremiah home two days earlier after observing fluids leaking from the hole where his feeding tube entered his abdomen. The next day, he appeared at the school worse than before: pale, lethargic and moaning. Staff from Alden Village North retrieved him three hours later but did not call a doctor until the following morning, records show.

An emergency room doctor at Advocate Illinois Masonic Medical Center in Chicago sent him to Children's Memorial Hospital, where he died. His mother declined to pursue surgery, which a doctor said was a long shot and would be extremely hard on Jeremiah. "He's been through enough," she said.

The state cited Alden for several violations, including neglect. Regulators said Alden didn't recognize Jeremiah's illness, assess him before sending him to school or promptly notify a doctor of his condition. They fined Alden $35,000, which Alden is contesting. A wrongful death lawsuit filed by Jeremiah's mother is pending. "Simple, basic patient needs weren't met," said Craig L. Manchik, an attorney with Craig L. Manchik & Associates, P.C., who is representing Jeremiah's mother. "There should have been someone managing his G-tube on a daily basis."

Chicago Tribune

Deadly Neglect