

Misery: Inside a 1-star nursing home

By Sam Roe
TRIBUNE REPORTER

The inspectors knew there was trouble as soon as they entered the nursing home.

The lobby smelled of urine. In one room, they found a 97-year-old woman, lying in her own waste. She had severe bruises on her arm, foot and both legs that the staff could not immediately explain. Another resident had a bed sore larger than a golf ball and dripping blood.

This was life in one of Illinois' "one-star" nursing homes.

These health violations—and two dozen more—were documented last year on a single inspection of the Berwyn Rehabilitation Center, contributing to its dubious distinction as one of the area's worst nursing homes.

The federal government is now rating nurs-

TRIBUNE WATCHDOG

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ing facilities on a 1 to 5 star system. Although conditions at one-star homes are startling, what is perhaps more alarming is their prevalence: About a quarter of U.S. nursing homes, including 81 in the six-county Chicago area, received one star.

A government Web site began posting ratings on these homes in December. Nursing home operators and even some patient advocates have criticized the rankings as superficial and per-

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Anjanette Miller, director of nursing at the Berwyn Rehabilitation Center, said conditions at the facility have improved. **ANTONIO PEREZ/TRIBUNE**

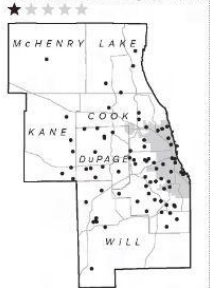
TRIBUNE WATCHDOG Troubled nursing homes

Where are Chicagoland's best, worst nursing homes?

The U.S. Department of Health and Human Services rates nursing homes nationwide using a star system based on such categories as health conditions and staffing levels. About one quarter of facilities, including 81 in the Chicago area, received the lowest rating of one star. One-star nursing homes are spread throughout the region but most five-star facilities are on the city's North Side or in the northern suburbs.

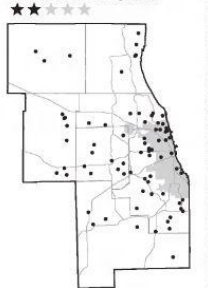
More watchdog coverage
To see the complete list of chicagoland nursing homes and ratings, go to chicagotribune.com/nursinghome

1 star: Much below average (81 homes)

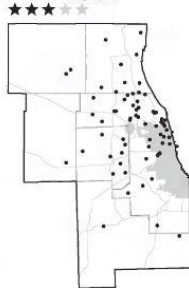


SOURCE: Centers for Medicare & Medicaid Services

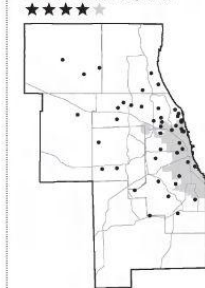
2 stars: Below average (80)



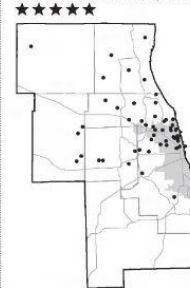
3 stars: Average (68)



4 stars: Above average (49)



5 stars: Much above average (52)



KEITH CLAXTON AND ALEX BORDENS / TRIBUNE

"This nursing home was really bad."

—Anjanette Miller, director of nursing at Berwyn Rehabilitation Center

Inside a 1-star nursing home

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haps misleading. And the detailed information behind those ratings is not readily available to the public. But the Tribune obtained the most recent inspection reports for the area's lowest-rated homes through a Freedom of Information Act request. The conditions described are grim and, at times, deadly—as the Berwyn facility demonstrates.

Last March, inspectors found workers there were improperly using side railings on beds. Four months later, records show, a 53-year-old obese resident suffocated when he got stuck between the mattress and side rails. Illinois fined the facility \$50,000 for the death, one of the largest nursing home penalties in the state last year.

A top administrator at the Berwyn facility acknowledged that, until recent months, care was poor.

"This nursing home was really bad," said Anjanette Miller, the director of nursing hired in May to oversee patient care. Workers, she said, "were punching in and doing nothing."

Since last spring, Miller said, the home has been under new management. "It's like night and day as far as improvements go," she said. "The bad, bad employees we got rid of."

According to records, all major violations found during the annual inspection last March had been corrected as of June.

But the man who suffocated did so in July—weeks after Miller and new management took over. She would not comment on that other than to say, "Accidents do happen."

State authorities said the four-profit home is owned by Berwyn Rehabilitation Center LLC. (The facility changed its name in May from the Pinnacle Health Care of Berwyn to the Berwyn Rehabilitation Center.)

One-star nursing homes meet minimum standards but are considered "much below average," according to the federal rating system. Inspection reports of those facilities show the daily despair many residents face.

At the Embassy Care Center in Will County, residents last fall complained of cold food, staff not answering calls for help, loud employees keeping them up at night, and workers not relaying phone messages from family members.

Residents said that when they voiced concerns, staff responded at times by pointing to the cemetery across the street. State investigators cited the nursing home, concluding that residents could not speak up without fear of reprisal.

When the Tribune asked the nursing home's administrator, Sue Besette, about the residents' complaints, she said: "Yes, we were cited, but those things did not happen. Anybody can say anything." She would not comment further.

One of the area's most troubled nursing homes has been the Berwyn facility, according to a review of the most recently available government records.

It received one star in all four categories of care, including overall quality. And the March inspection report resulted in 29 violations—twice as many as any other comparable one-star facility in the area.

A three-story U-shaped brick building, the Berwyn home sits along busy Harlem Avenue. When a Tribune reporter toured the home last month, it appeared old but clean. The wood and tile floors were gleaming, the hallways did not smell of urine, and the staff was busy attending patients.

One nurse's aide gently combed the hair of an elderly man in a wheel-



Embassy Care Center is across the street from the Mt. Olivet Cemetery in Wilmington. Nursing home residents told inspectors that when they voiced concerns, some staff members responded by pointing to the cemetery. The nursing home administrator denied the charges. ANTONIO PEREZ/TRIBUNE PHOTOS



Berwyn Rehabilitation Center, at 3601 S. Harlem Ave., is a one-star facility according to federal ratings.

chair. A grease board in the small but comfortable lobby presented the day's activities, which included "Juice Cart," "Chit Chat" and "Black Jack."

Almost all the patients lay in their beds, sleeping or watching TV. Miller said the vast majority of the 68 residents can't walk and are incontinent. About a quarter cannot breathe without the aid of a ventilator.

Moreover, she said, most are poor, have no family who visit and need constant care.

Such care was lacking in March when five state public health inspectors—acting on behalf of the federal Centers for Medicare & Medicaid Services—arrived for a surprise review.

Among the first things the inspectors noted was "an offensive urine odor" in the foyer that remained throughout the day, they later wrote in a report.

When they went into a room with a soiled privacy curtain, they saw a 97-year-old incontinent woman on her back in bed. "Feets was loose and completely dried on the sheet,"

inspectors wrote. The woman winced in pain while being cleaned, and an inspector noticed that she had a bed sore "on both buttocks the size of a golf ball with no treatment, and her left heel was red and mushy."

She also had severe bruising on her left arm and both legs. A nurse and nurse's aide told the inspector they did not know how the bruises occurred. Later, another nurse reported the bruises were caused by a mechanical lift used to transport the woman to dialysis treatments.

At dinner time, the woman told an inspector she was in too much pain to eat. "I've been sitting on my butt all day," she said. "It hurts so much."

The next morning, an inspector saw feces on the woman and her bed pad. A staff nurse said it appeared someone had washed her but not very well.

A nurse's aide washed her again, but incompletely. The employee also did not wash the woman's catheter tubing, which had been sitting on feces. The old woman "cried out in pain when the tubing was handled," the inspector noted.

When the woman again ate nothing at the next two meals, an inspector alerted the nursing home's administrator. One of the woman's bed sores was also getting worse, and she complained of pain. She also appeared lethargic.

Four hours later, during dialysis, the woman's blood pressure dropped and she became unresponsive. She was sent to a local hospital and admitted with pneumonia.

Inspectors found other residents suffering, including a woman with Alzheimer's disease and a gangrenous left foot. An inspector saw "a large amount of loose fecal matter, which soaked the entire heel portion of [her] left foot dressing."

Seven hours later, the same inspector found the dressing still soiled. The woman "grimaced and cried in horrible pain" when a nurse finally removed the soiled bandage and repositioned the foot.

Though records did not state why staffers took so long to change the woman's dressing, they offered an explanation for why another patient had an untreated bleeding bed sore: The patient had refused treatment. But inspectors said that was no excuse not to address it.

When inspectors checked on several other patients, they found the nursing home was using side rails on beds without determining whether residents needed them. One man, inspectors found, had injured his leg when it got caught in a rail.

Citing the home for these violations, inspectors concluded that residents have "the right to be free from any physical restraints imposed for purposes of discipline or convenience" and not required for medical reasons.

But the problem did not end there: Four months after the inspection team left, a morbidly obese resident became trapped between his inflated

mattress and the side rails. One of the first to find him was a respiratory therapist, who later told inspectors: "I've seen residents trapped like this before, so I knew what to do. I immediately deflated the mattress."

The man fell back into bed, but he was turning blue. "His neck was wedged at the rails big time," the therapist said.

The man was transported to a local emergency room, where he was pronounced dead. A Cook County medical examiner ruled he suffocated due to entrapment, inspectors reported.

Inspectors found that the man's physician had ordered one-quarter length side rails for his bed, partly to prevent falls. These rails are normally positioned at the waist. But just before the man's death, the quarter-length rails broke, nursing home officials said. An outside repairman couldn't fix them, so the repairman replaced the bed with one that had full, head-to-toe rails.

Inspectors determined that the home did not assess whether this was an appropriate switch. After the death, the nursing home removed side rails for residents who didn't need them and corrected potential entrapment gaps, records show.

Shelia Fernandez, a Legal Assistance Foundation of Metropolitan Chicago ombudsman for nursing home patients, said the facility has greatly improved in the last five years.

"That gives you insight on how bad it was," she said.

On Jan. 25, a team of state inspectors arrived at the home for its annual review, a three-day surprise visit. Results of the inspection, a state spokeswoman said, will be released soon.

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