# Jonathan Rosenfeld's Nursing Homes Abuse Blog

## Nursing Home Spotlight: Elmwood Care, Elmwood Park, IL

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Elmwood Care is a large 245 bed nursing home located in Elmwood Park, IL, a suburb of Chicago. According to the government's Medicare website, the facility received only one out of five stars, which is a much below average rating. The facility received only one out of five stars for health inspections, which is a much below average rating. In the past year, the nursing home had 48 health deficiencies, which is an alarmingly high number of deficiencies. This is 40 more deficiencies than the average number of health deficiencies in Illinois and in the United States. This is also a serious increase in the number of yearly deficiencies, up from the 13 health deficiencies in the previous year and the three health deficiencies two years ago.

The nursing home has an obligation to provide a safe and secure facility for its residents and to provide proper care and supervision to achieve and maintain the highest level of well-being for its residents. Nursing homes must meet the Requirements for States and Long Term Care Facilities outlined in 42 CFR Part 483.

Elmwood Care received numerous violations for both quality of care and the facility environment. According to survey reports the facility received violations for failing to:

- Protect residents from mistreatment, neglect, and/or theft of personal property
- Keep each resident free from physical restraints, unless needed for medical treatment
- Give each resident care and services to get or keep the highest quality of life possible
- Give residents proper treatment to prevent new pressure sores or heal existing pressure sores
- Make sure that the nursing home area is free of dangers that cause accidents

According to survey reports, Elmwood Care failed to prevent the spread of infection by failing to implement its complete infection control program for residents with infections on two of the three floors in the facility. Nursing home staff members made several errors in technique for the isolation protocol for residents who were in isolation. These errors included allowing visiting family members to use dirty gowns to pick up new clean gowns, lack of running water in isolation room for family and staff to wash their hands, allowing family members to throw away dirty gloves in another resident's room (which was not an isolation room), and staff members

failing to wash their hands before and after entering an isolation room. Preventing the spread of infection in nursing homes is very important because many residents have weakened immune systems due to illness or age.

Nursing home residents have the right to personal privacy and confidentiality of personal and clinical records. During the survey, staff members failed to provide visual privacy for several residents. This included failing to close privacy curtains when providing treatment for residents and also failing to close window shades on windows that could be seen from nearby homes and businesses.

Residents have the right to be free from any physical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility did not meet this requirement by failing to complete the following activities for several residents: assess residents for the medical need for physical restraints, obtain physician's orders for restraints, create care plans and provide for a reduction of a physical restraint, release the restraint every two hours, and assess alternatives to provide the least restrictive measures. These failures led to one resident developing an injury to his big toe that later developed into a pressure sore from the use of a side rail restraint. This also resulted in the resident needing several restraints at the same time including the use of a chemical restraint. During the survey, the facility was unable to provide an accurate number of residents with physical restraints.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are immediately reported to the administrator of the facility and to other officials in accordance with State law. This requirement was not met when the facility failed to thoroughly investigate injuries of unknown origin for one resident. In one incident, a resident suffering from Schizophrenia and Dementia was found on the basement floor of the smoking room in the middle of the night. The resident complained of left leg pain and was brought upstairs without being assessed by a nurse before being moved.

After assessment, the resident was sent to a hospital. The nurse notes document that the resident told staff that a tall man had pushed him on the floor. However, there was no investigation or statements of how the resident suffered when the hip fracture. The facility faxed an initial incident report to the state, but failed to conduct an investigation or submit a final report of the investigation to the state.

Elmwood failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The survey revealed odors, unsanitary storage of medical supplies, and failure to maintain a clean, sanitary, and orderly environment. Findings included: dirty shower chairs, food stored in refrigerator with medication, food on activity floor, odor in bathroom, clogged bathroom sink, sewage odor in nursing supply room, no thermometer in freezer, nursing supplies stored on floor of utility room, unclean freezers, dirty feeding tube pump, dark brown stains in some resident bathrooms, urine smell in some resident rooms, cluttered equipment store rooms, and strong urine odor in hallway.

The facility is required to provide residents with the appropriate treatment and services to maintain or improve the residents' abilities. The facility failed to meet this requirement because

it lacked any restorative program, which affected every resident with restorative needs. The lack of restorative nursing program led to a physical decline in the following residents:

- Resident 1 – lack of positioning devices which led to pressure ulcers.
- Resident 5 – decrease in range of motion and new pressure ulcers
- Resident 20 – lack of assessment and devices led to the development of a wound.
- This lack of proper restorative nursing program also led to a failure to evaluate residents to ensure that the least restrictive physical restraints were used.

The facility must ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. The facility must also ensure that a resident who suffers from pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Elmwood Care did not meet this requirement as evidenced by its failure to monitor residents at risk for pressure sores, provide devices to prevent the development of pressure sores, provide care and services to residents with pressure sores to prevent the spread of infection and promote healing, and provide education and training to direct care staff in the policy and procedure for wound care. These failures resulted in immediate jeopardy.

The facility must ensure that the resident environment remains free of accident hazards and ensure that each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to meet this requirement by failing to ensure that residents received adequate supervision to prevent falls and failing to address the increased number of falls per month or the types of interventions being taken to decrease the number of falls.

These failures resulted in a significant number of falls, with one resident's fall requiring treatment at an Emergency Room for a head injury. These failures resulted in immediate jeopardy. It is important that nursing home staff reduce the chance of accidental falls because elderly nursing home residents are more susceptible to bone fractures and injuries because of weak bones.

Elmwood Care received two out of five stars for nursing home staffing. The facility has 177 total residents, compared to the national average of 94.7 and the Illinois average of 103.9. Each resident received 1 hour 7 minutes of nursing home staff time per day, which is less than the Illinois average (1 hour 12 minutes) and less than the national average (1 hour 24 minutes).

This one-star rated facility had an exceedingly high number of deficiencies over the past year, which calls into question the facility's ability to provide residents the proper care and services to achieve the best possible physical and mental health of its residents.

If you have a friend or family member who has sustained in injury during an admission to Elmwood Care, we would be honored to speak with you about the circumstances. All consultations are confidential and free of charge. (888) 424-5757

Sources:

Medicare website

IDPH website

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Jonathan Rosenfeld represents victims of nursing home abuse and neglect throughout the country. For more information please visit Nursing Homes Abuse Blog (www.nursinghomesabuseblog.com), Bed Sore FAQ (www.bedsorefaq.com) or call Jonathan directly at (888) 424-5757.