Jonathan Rosenfeld's Nursing Homes Abuse Blog

Nursing Home Spotlight: Shelbyville Rehab & Health Care Center

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Shelbyville Rehab & Health Care Center has 80 certified beds and a one-star (much below average) Medicare rating. The facility is located in Shelbyville, IL. Although the facility only had five health deficiencies between 9/1/08 and 11/30/09, a significant abuse incident (see below) occurred in 2009, which led to the facility's poor rating.

During an August 26, 2009 annual licensure and certification survey and complaint investigation, it was determined that the facility failed to identify one resident's willful act of assault of another resident as an act of abuse which resulted in an Immediate Jeopardy situation. According to the Centers for Medicare/Medicaid Services (CMS), Immediate Jeopardy (Level of Harm – Level 4) is defined as a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the nursing home.

On August 7, 2009, one male resident assaulted another male resident. The perpetrator (the resident who attacked the other resident) approached the other resident who was sitting in his wheelchair and placed him in a choke hold and began punching him in the head and yelling at him. The resident who was attacked was immediately removed from the area and examined. Thankfully, the resident did not suffer any injuries from the attack.

This incident was witnessed by a Registered Nurse (RN), who reported the incident to the Administrator. The perpetrator told the nurse that he attacked the other resident because he made him mad. The perpetrator received counseling and was removed from the area and was supposed to be placed on

15 minute behavior checks. Despite orders for increased supervision of the resident perpetrator following the attack, the 15 minute behavior checks never started and the Director of Nursing could not find any documentation of the order, nor could the Director of Nursing explain why the checks were never started. In the days following the attack, the resident was allowed to move about the facility in his wheelchair without any restrictions or staff observation in order to ensure that he did not have another violent outburst.

During interviews on August 18th, the resident perpetrator stated that he had been told that the other resident was occupying his dining table spot. He stated that the other resident refused to move and used a curse word and threatened to "blow [his] head off with a gun." The perpetrator said that the grabbed the other resident to see if he had a gun or other weapon before being pulled away by facility staff. The perpetrator denied hitting the other resident and stated that the other resident had threatened him on previous occasion. During the incident, both the Registered Nurse (RN) and Licensed Practical Nurse (LPN) witnessed the resident perpetrator hit the other resident in the back and side of the head with a closed fist.

The facility experienced an Immediate Jeopardy situation, beginning on August 7, following the assault. The facility failed to identify this assault as abuse and provide necessary resident protections for all residents. The facility did not identify an Immediate Jeopardy situation until August 18, over a week after the assault. The facility then took steps to remove the Immediate Jeopardy by placing the resident on visual checks, providing him with a private room, and educating staff about the facility's abuse prevention policy. The Immediate Jeopardy was removed on August 20, 2009; however, the facility remained out of compliance because of ongoing intensive monitoring of the resident perpetrator and ongoing re-education of staff.

The resident who was attacked actually died on August 12, just days following the attack. However, the resident's attending physician reported that his death was attributed to a chronic medical condition and could not correlate the death to the recent incident.

It is alarming that multiple nursing home staff members witnessed one resident attack another resident and no measure were taken to ensure the safety of the

rest of the resident population. The resident who was attacked had the right to be free of abuse and being attacked by another resident with no following investigation or efforts to ensure his safety constitutes abuse. This abuse investigation also revealed that the facility failed to investigate two of three abuse allegations, and also failed to properly and thoroughly screen two CNAs for criminal backgrounds and eligibility.

Although Shelbyville Rehab & Health Care Center has a relatively low number of health deficiencies (5), the deficiencies that did occur endangered the entire resident population. This complaint investigation survey regarding an incident of abuse reveals how even one health deficiency can have dangerous and far-reaching consequences.

Shelbyville is owned and operated by Peterson Health Care. Peterson Health Care owns and operates Nursing Facilities, Assisted Living Facilities, Independent Living Centers, Supportive Living Facilities and Developmentally Disabled Homes.

Special thanks to Heather Kiel, J.D. for her assistance with this Nursing Homes Abuse Blog entry.

Resources:

IDPH: Shelbyville Rehab & Healthcare Center

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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.

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