Jonathan Rosenfeld's Nursing Homes Abuse Blog

Nursing Home Spotlight: Barry Community Care Center

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Barry Community Care Center is a 75-bed nursing home located in Barry, IL. On January 22, 2010, the Illinois Department of Public Health (IDPH) fined Barry Community Care Center $35,000 for violations in the area of policy and procedure. Even with this significant fine, Medicare rated the facility as a three-star or average nursing home facility, with only one health deficiency between February 2009 and April 2010.

This episode demonstrates that even well-regarded skilled nursing facilities can have very serious problems for patients. Barry Community Care Center's single deficiency involved its failure to provide each resident the care and services required to achieve or maintain the highest quality of life possible, which resulted in immediate jeopardy to resident health or safety.

This example serves to reinforce how important it is to thoroughly research a potential nursing home because looking at the total number of health deficiencies is not enough. Not all health deficiencies are equal with regard to the level of harm presented to residents. In this case, the facility's deficiencies and violations were very serious, resulting in the choking death of one resident. (See other Nursing Homes Abuse Blog articles on choking)

A survey conducted by IDPH on November 25, 2009 revealed that Barry Community Care Center failed to provide adequate supervision to a resident during mealtime, which resulted in the resident choking on food. Then, the nursing home did not call 911 for another hour, which led to the resident's death at the hospital later in the day.

The resident was known to have impaired cognition and limited range of motion for neck, arm, and hand. The facility's care plan for the resident required one person to physically assist and supervise with meals.

On September 26, 2009 at 1:00 pm, the resident was found in her room with a half-full plate of food from lunch in front of her. The resident was having trouble breathing and her face was ashen. A Licensed Practical Nurse (LPN) was called to the resident's room. The nurse increased the oxygen and encouraged resident to cough. The resident coughed out some food but became too weak to continue. At that point, the nurse began to suction the resident while another nurse called the physician and power of attorney (POA). When the POA arrived, she requested that the resident be sent to the emergency room (ER).

The ambulance was called at 1:56 pm, almost one hour after the facility found her having trouble breathing and choking on her food. When the ambulance took the resident to the hospital at 2:27, the resident had a rapid pulse and was still having trouble breathing. When the ambulance arrived at the hospital at 2:41 pm, the resident was unresponsive, suffering from major respiratory distress. The resident died at the hospital with a diagnosis of aspiration pneumonia (inflammation of the lungs from breathing foreign matter into your lungs), atrial fibrillation (irregular, rapid heartbeat), hypertension (high blood pressure), Type 2 diabetes, and history of chronic obstructive pulmonary disease (COPD). (See "Elderly Patients Are At Higher Risk for Developing Aspiration Pneumonia When Facilities Fail To Account For Patient Needs")

The facility never should have left the resident alone with her food tray, especially because the resident's care plan called for her to have someone assist her with eating and drinking. In addition, the staff knew that the resident had trouble eating her breakfast on the morning of her death. One of the nurses had to physically remove pieces of egg and toast from her mouth before returning the resident to her room. Furthermore, the nurse should have immediately called 911 when she found the resident choking on food and having difficulty breathing.

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.

The choking death of the resident at Barry Community Care Center is a sad reminder of how quickly a nursing home resident can suffer injury, or in this case, death, when they do not receive proper care and supervision. It took only 30 minutes for the resident to choke on food, when she should have had a staff member helping her eat, which would have prevented her death.

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Sources:

Illinois Department of Public Health: Nursing Homes in Illinois Quarterly Report

IDPH: Barry Community Care Center

IDPH: Barry Community Care Center - Quarterly Report

Nursing Homes Abuse Blog: Elderly Patients Are At Higher Risk for Developing Aspiration Pneumonia When Facilities Fail To Account For Patient Needs

Nursing Homes Abuse Blog: Choking

Choking Death Just Latest Problem At California Nursing Home

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