Jonathan Rosenfeld's Nursing Homes Abuse Blog

Nursing Home Spotlight: Milestone-Elmwood East

Posted at 5:48 AM on June 21, 2010 by Jonathan Rosenfeld

Milestone-Elmwood East is a small, 12-bed nursing home located in Rockford, Illinois. Milestone, Inc. is a private, not-for-profit corporation that provides "residential, developmental, vocational, and social support services for adults and children with mental retardation, autism, epilepsy, and cerebral palsy." This facility committed serious violations that led to the choking death of one resident. (See Nursing Homes Abuse Blog: Topic – Choking)

This nursing home committed several serious 4th quarter violations relating to the area of policy and procedure. (See "42 Illinois Nursing Homes Cited in 4th-Quarter of 2009 for Violations Related to Patient Care") The Illinois Department of Public Health (IDPH) fined the nursing home $25,000 on November 17, 2009. The facility provides services for persons suffering from mental retardation. These residents require more care than average residents because of reduced mental capacities.

First, the facility failed to conduct quarterly fire drills for the 2nd shift personnel, which endangered the lives of all residents. In the case of an emergency, including fire emergency, staff members should be trained and prepared. As evidenced by the IDPH report, this did not occur with all personnel.

The most serious of the violations involve the choking death of a 28-year old nonverbal male resident who was ambulatory (capable of walking), mentally retarded, and also suffered from autism and cerebral palsy. This resident died after choking on food unsupervised. (See "Failure to Follow Orders Results in Death of Patient & Hefty Fine") The facility's failures include:

- Failure to implement policy on neglect
- Failure to ensure that resident's behavior program was fully documented with certain behaviors of taking food from kitchen
- Failure to ensure that enough staff were available to manage and supervise resident in accordance with his behavior plan which allowed him to eat unsupervised

The violation report completed on September 17, 2009 notes that the facility's own policy on abuse and neglect defines abuse/neglect as to include "any willful failure to respond to an individual's obvious needs or to provide the appropriate supervision and care that the individual served should have." The facility's failure to provide adequate medical or personal care or maintenance for the resident resulted in physical injury.

Before his death, the facility's program charts (completed on May 7, 2009) had the resident on a program to ensure that he ate at a slower pace. To support this goal, a staff member sat next to him at meals to provide verbal cues and physical prompts to slow down. In the weeks before his death, staff members noticed that he was eating even more quickly and was stealing food, which suggested increased agitation.

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.

AT 7:00 AM, the Director of Nursing found the resident in the living room on his back with chewed up food next to him. The director of nursing called paramedics and performed CPR (cardio pulmonary resuscitation) until they arrived. Despite these measures, the resident died. The cause of death was asphyxiation caused by a sausage found lodged in his throat. It turns out that the resident had stolen a sausage wrap from the food that had been prepared for breakfast. A tray of food covered with foil was left on the kitchen counter.

One of the direct service providers (DSP) even saw the resident walking out of the kitchen and noticed that the foil on the food had been disturbed. Even though the resident had no documented history of stealing food from the kitchen, he did have a history of stealing food from other residents. However, the facility personnel did not put together his presence near the kitchen, the disturbed food, and the history of stealing food.

The facility's assessment for the resident stated that he required 24-hour supervision including assistance with diet, portion control, and eating rate. The DSP who saw the resident coming from the kitchen admitted that it was not unusual to catch residents in the kitchen area. The DSP also stated that the resident had stolen food from the kitchen before but she failed to document this.

The resident's Individual Habilitation Plan states that the staff should report all issues of concern to their supervisor and/or the nurse. However, the DSP never reported seeing the resident stealing food from the kitchen. This failure resulted in the resident's care plan not being updated to include measures to prevent

him from stealing food, especially in light of his problems controlling how quickly he consumes food. The DSP also admitted that mornings at the facility were "hectic," and the facility could benefit from additional staff. In addition, on the morning in question, the kitchen was left unsupervised even though there was food left out on the counter.

The facility's failure to properly monitor the resident and update his care plan allowed him to steal food from the kitchen unsupervised and ultimately choke to death. Unfortunately, the fines assessed will do nothing to benefit this resident. However, hopefully, it will do something to change the behavior and procedures of the facility in the future in order to protect the other residents.

Stories like this highlight the fact that there are problems with small nursing homes as well as large nursing homes. Even with fewer residents to care for, oversights and mistakes can occur, and these mistakes can be deadly. In this situation, Milestone-Elmwood East did not properly monitor and care for a young, 28 year-old resident. If you or a loved one have suffered injury at the hands of Milestone, Inc, you may be entitled to compensation.

Sources:

Illinois Department of Public Health (IDPH); Milestone-Elmwood East

IDPH: Milestone-Elmwood East – 4th Quarter Violations

IDPH: Nursing Homes in Illinois – Quarterly Report (October-December 2009)

Nursing Homes Abuse Blog: Failure to Follow Orders Results in Death of Patient & Hefty Fine

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Nursing Homes Abuse Blog: Topic – Choking

Nursing Homes Abuse Blog: 42 Illinois Nursing Homes Cited in 4th Quarter of 2009 for Violations Related to Patient Care

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