The Philadelphia Inquirer

NL		AL	
Rockies 5	Expos 4	Indians 14	Angels 10
Phillies 3	Cubs 3	Rangers 5	Jays 2
Braves 3	Dodgers 6	Bosox 5	Brewers 7
Pirates 2	Astros 5	Chisox 3	Mariners 6

Ex-lover calls Smith 'suicidal'

Says he saw her 3 times on day she says she drowned sons. **A3.**

Heat 'alert' returns today

Hot, humid days are forecast; area death toll hits 35. **B1.**

What's for free?

A calculator. See coupon on **A4.**

Thursday, July 20, 1995 60 cents outside the eight-county Philadelphia metropolitan area **35 Cents**

Inspectors' June visit to city nursing home found 'total chaos'

Assault, neglect and sexual abuses are outlined in a state report. City officials say problems are corrected.

By Peter Nicholas
INQUIRER STAFF WRITER

A 74-pound quadriplegic was stripped of clothing by her elderly roommate at the Philadelphia Nursing Home last month, turned onto her stomach and pinned beneath a mattress and bedding. Her call bell was unplugged, so no one is sure how long she was trapped.

A nursing assistant allegedly hit a 97-year-old female patient in the eye and kicked her in the right leg during an overnight shift five weeks ago. The victim's right eye was red and swollen, and her right knee sported a lump the size of a baseball. The employee was suspended pending an investigation.

A 43-year-old male patient with a history of sexually aggressive behavior had oral sex with a frail, 89-year-old woman suffering from dementia. The staff offered the woman mouthwash. She was not examined by a doctor. The rape crisis center was not called, and the incident was not reported to state health officials or the police.

These are but a few of the abuses described by the state Department of Health in a 149-page report on the Philadelphia Nursing Home made public yesterday.

The report was compiled after the state completed its annual investigation of the nursing home on June 16. Its grim, detailed findings explain why the state has threatened to shut down the 500-bed home, which the Rendell administration privatized last year.

The mayor's office has often touted its decision to turn management of

See [illegible] on A10

State deta[illegible] abuses it found at city nursing home in June

HOME from A1

the home over to Episcopal Long Term Care, a subsidiary of Episcopal Hospital, as an innovative move that has saved taxpayers more than $4 million.

David L. Cohen, Rendell's chief of staff, said the state's blistering report was no reason to give up on the nursing home, a shelter of last resort for some of the city's poorest and sickest residents.

"None of those conditions are present today," Cohen said yesterday. "We took incredibly aggressive action to address all those issues in the fastest possible time frame. And, in fact, they have been addressed."

Molly Hess, executive director of the nursing home, did not return a telephone call seeking comment.

The state report, briefly summarized by the Health Department a month ago, is based on a two-week inspection in early June. The department's conclusions were so harsh that it barred new admissions to the nursing home and threatened to cut off funding. The facility was given a three-week deadline to redeem itself.

One elderly patient was offered mouthwash after a sexual assault, the inspectors reported.

Earlier this month, state health inspectors re-examined the facility and found that the most serious threats to residents' health and safety had been lifted. The Health Department has given the nursing home until September to make further improvements or risk losing its license.

Episcopal's recent attempts to reform the Philadelphia Nursing Home included firing Diversified Health Services, a Plymouth Meeting company that ran the institution on a day-to-day basis.

Diversified Health executives predict the problems won't disappear simply because they've been ousted. They contend that an ungainly bureaucracy had emerged to run the nursing home, consisting of their company, the city, the two attending physicians — Gene Newton and Theodore Burden — and a subcontractor hired to ensure compliance with state standards. The layered lines of authority hindered swift and efficient decision-making, thus allowing major problems to go unresolved, Diversified Health officials said.

One Diversified Health executive, who asked to remain anonymous, said: "Maybe we would have been better off in this project to have simply asserted, 'Listen, all the rest of you guys, stand out of our way and let us run it. . . . If you need to pick up checks or do whatever you need to do, do that. But leave us alone and let us run it right.'"

The state report depicts a nursing home in crisis, a place where doctors and family members aren't notified when patients are assaulted; where one resident was seen lying in bed covered in his own feces; where bedsores are allowed to fester; and where residents spend empty days in hot, airless rooms.

The report criticizes virtually every aspect of the institution, from the lukewarm temperature of the juice to the filthy bedclothes.

During a visit to one nursing unit on June 10, inspectors said they found "total chaos."

At 8:30 a.m. they observed:

- A resident lying in bed covered with feces.
- A resident sitting on a wheelchair in a thin gown open so that her bare buttocks were directly on the seat
- A resident sitting naked on the side of his bed, with the privacy curtain open.
- Three residents eating breakfast without assistance and spilling food on themselves, their beds and the floor.

After an hour and 15 minutes, conditions on the unit hadn't improved, the report states.

The report also alleges multiple instances of physical abuse.

For its part, management of the home failed to prevent, investigate or follow up on cases where residents assaulted each other, or staff members abused residents, the report says.

As an example, the report says that one resident burned two fellow residents with cigarettes between April and May. In the same time period, he threatened another resident with a torn soda can. The incidents were documented by nurses, but the staff took no steps to prevent a recurrence, the report says.

In March, a bedridden 65-year-old female patient suffering from congestive heart failure was punched in the face by another resident, the report says. Nothing in the medical records suggests that the staff probed the incident or tried to stop it from happening again, the report says.

As it happened, the assailant later punched another resident in the face, the report says.

The report raises sharp questions about the competence of the employees. Residents susceptible to bedsores weren't given the appropriate attention from the nursing staff, the report states.

A doctor had prescribed treatment for one patient suffering from bedsores, but there were no signs the orders were carried out. Documentation was missing. "When the matter was discussed with the staff . . . they stated, 'We didn't do it. We didn't know about it,'" the report says.

The report says infection-control practices were weak, and cites several supporting examples. On June 6, the report says, a nurse treating a patient for bedsores failed to change his gloves after they were soiled with the patient's feces. The nurse persisted in applying treatment wearing the same dirty gloves.

On June 5, inspectors found a container of urine sitting atop a bedside table next to a container of nutritional supplement.

On June 2, they watched as a resident was served breakfast while feces lay in a bedpan sitting nearby.

The inspectors say they also saw a nurse go from room to room without changing gloves. Soap was not available in five different rooms, the report shows.

The overall environment was dirty and uncomfortable, according to the report. Everywhere, it says, the floors were stained and littered with debris. Air-conditioning units were broken, raising the temperature inside to as high as 88 degrees.

Despite the heat, water was often hard to come by. The report states that water containers were not placed within residents' easy reach, that meal trays were served without beverages, that water fountains were broken, and that residents were given unwieldy drinking containers they couldn't hold.

Through it all, even the youngest residents would spend the days watching TV or sitting idly in their rooms, the report says.

"These are snapshots and correctable problems," said Cohen. "The state survey shows that there was not an acceptable level of care being provided at the Philadelphia Nursing Home. It provides specifics why that was not the case. We agree with that, and we're taking steps to deal with it."