Jonathan Rosenfeld's Nursing Homes Abuse Blog

Nursing Home Spotlight: Fox River Pavilion, Aurora, IL

Posted by Jonathan Rosenfeld on December 14, 2010

The IDPH quarterly report on Nursing Home Care Act violations includes a $30,000 fine for violations relating to the area of nursing. Fox River Pavilion is a large 121 bed facility in Aurora, IL.

Medicare gave the facility an overall rating of two out of five stars (below average rating) with only one out of five stars (much below average rating) for health inspections. Between July 2009 and September 2010, the facility had 15 health deficiencies, which is seven more than the Illinois and U.S. average.

The February 8, 2010 complaint report that resulted in the $30,000 fine included failure to keep the facility free of accident hazards. This failure resulted in a male resident with a known history of swallowing foreign objects swallowing rubber gloves and a female resident with a known history of suicide attempts accessing a razor blade and cutting her wrist. This put these patients in immediate jeopardy.

The male resident was a 48-year-old male with severe mental retardation and cerebral palsy and no teeth. He suffered from Pica, where the sufferer eats non-food items. Upon his admission to the facility, the caregivers were put on notice of his condition and the potential for future incidents. In order to prevent future problems, it was recommended that he have a sitter 24-hours a day.

During his stay at the facility, he swallowed several foreign objects. He had to go to the hospital twice to remove a bezoar (a ball of foreign material that is swallowed and

cannot pass through the intestines). He also had to go to the hospital to remove multiple foreign objects including a sponge and EKG leads. On a later occasion, he swallowed rubber gloves that were protruding from his rectum after he had been suffering from large, loose stool. And, on another occasion, he passed a glove in his stool. His care plan noted that he ate foreign objects but did not have a specific plan to prevent him from eating foreign objects.

Finally, after several incidents, the facility had a staff member supervise the resident when he was awake to ensure that he did not swallow anything. However, there was no documentation showing what staff member monitored the resident or how effective it was. Then, on January 30, 2010, the resident was sent to the hospital, where he required abdominal surgery to remove foreign objects including at least one full box of latex gloves. The hospital determined that the gloves had been in his gastric pouch for at least several weeks.

When IDPH visited the facility on February 3, 2010, they noticed that there were used gloves in a garbage can with no lid and another garbage can with a push lid and gloves were sitting on the counter at the nurses station, despite the facility's awareness of the resident's history of swallowing foreign objects including gloves. (See "Swallowing Foreign Objects Is No Laughing Matter for Dementia Patients in Nursing Homes")

The female resident was a 25-year-old female suffering from Bipolar Disorder and Borderline Personality. The facility was supposed to monitor her because she had attempted suicide in October 2009 and threatened to commit suicide by cutting her wrist when she was feeling depressed. The facility was supposed to monitor her to ensure that she did not have access to unprescribed mediation or razor blades. On January 3, 2010, she was sent to the hospital to have her stomach pumped because she took an unknown number of Lyrica pills that she got from her boyfriend who was visiting.

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.

This incident was not reported or investigated because the hospital toxicology report was negative, even though that toxicology screening did not actually test for the suspected medication that led to the overdose. The facility's failure to monitor the resident created a potential danger for her safety and the safety of other residents.

Then, on January 8, 2010, she had a verbal altercation with a male resident, causing her to cut her own arm with a razor blade, which required 40 stitches at the hospital. When IDPH visited the facility on February 2, 2010, they found a disposable razor in a resident's room, empty diet coke cans with sharp tabs in the garbage cans, and a cigarette lighter in another resident's room, all on floors with residents with severe mental illness. The facility did not have a policy that prohibits sharp metal objects.

In December 2009, the facility determined that the resident was at moderate risk for suicide and prescribed one-on-one counseling three times a week and monitoring every two hours. However, there was insufficient documentation to show that these practices were followed. (See "Nursing Home Fails to Intervene In Case Involving Dementia Patient With A Known Suicidal Propensity" and "Citation Issued Against Nursing Home That Failed to Intervene in Patient Suicide")

Overall, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident. The facility failed to meet this standard when it allowed the male resident to swallow foreign objects on numerous instances, several of which required hospitalization, despite being aware of the resident's diagnosis of Pica and history of swallowing objects.

The facility also failed to supervise the female resident with a history of suicide attempts and threats, which resulted in her overdosing on an unknown amount of medication and cutting herself with a razor blade. The facility should have followed through and documented preventative steps to ensure the safety of its residents. When the male

resident who swallowed foreign objects was at the hospital awaiting abdominal surgery, the hospital kept his hands in mittens and had someone sit with him 24 hours a day because of his history of swallowing objects.

This is the type of preventative action that the nursing home facility should have initiated to prevent dangerous episodes. In addition, the facility should have removed small foreign objects from the resident's room, communal areas, and better secured waste. In the case of the female resident, the nursing home facility should have monitored her better to ensure that she could not access medication that was not prescribed to her and also remove any razors or sharp metal objects from the resident areas.

Fox River Pavilion's failures put its residents at risk. It is only luck that kept the residents from suffering even more serious injuries. The male resident could have easily choked to death on rubber gloves or other foreign objects, and the female resident could have easily committed suicide by cutting her wrists or overdosing on medication. And, if this is the level of care these two patients received, it is likely that other residents at the facility were also not receiving the best possible care and service.

Thanks to Heather Keil, J.D. for her assistance with this Nursing Homes Abuse Blog entry.

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