

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 323 SS=J	<p>Investigation of Complaint 1070494 - IL45822.</p> <p>A Partial Extended Survey was conducted.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to :</p> <p>(1) monitor R14 to prevent him from swallowing foreign objects, such as Latex Gloves that were found during his Emergency Hospitalization on 1/30/10.</p> <p>The facility was aware of R14's history of swallowing foreign objects (PICA) upon his initial admission to the facility 10/23/07. While R14 has been a resident at the facility, facility staff were aware that R14 had previous episodes of swallowing foreign objects as evidenced by the 1st surgery (Exploratory Laparotomy, Gastrotomy with removal of BEZOAR) on 7/22/09 to remove foreign objects swallowed and were aware of R14 passing rubber gloves in his stool on 8/25/09 and 8/28/09 while in the facility and while under their monitoring and supervision.</p> <p>(2) monitor and ensure R13 did not have the</p>	F 323	3/5/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>access to medication that was not prescribed by the physician to her at the facility. R13 overdosed on the medication..</p> <p>(3) monitor to ensure R13 did not have the access to a razor blade that she used to cut her left arm on 1/8/10.</p> <p>The facility was aware that R13 had a history of suicide attempt in October 2009; it was also noted that when R13 feels depressed she threatens suicide by cutting herself deep in the wrist.</p> <p>As a result:</p> <p>(1) R14, since he has been in the facility, had to undergo a second Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR on 2/2/10.</p> <p>(2) R13 overdosed with the undisclosed amount of medication that could cause a potential danger for the safety of self or others.</p> <p>(3) R13 cut her self with a razor blade that resulted in 15 to 20 cm laceration that required 40 sutures in the Emergency Room.</p> <p>This is for one resident in the sample (R13) and one resident (R14) from outside of the sample.</p> <p>Failure to monitor and supervise the above residents led to an Immediate Jeopardy was identified on 2/8/10. E1 Administrator was notified on 2/8/10 and Immediate Jeopardy began on 1/30/10 when R14 was sent to the hospital with coffee ground emesis due to swallowing foreign objects leading to avoidable 2nd surgery to remove them while facility had resident under one to one supervision.</p> <p>Findings include:</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>1. R14's admission record indicated he is a 48 year old male originally admitted to the facility on 10/23/07 with multiple diagnoses including Profound Mental Retardation and Cerebral Palsy. R14 uses a rolling walker for his ambulation. R14 has no teeth per medical record. On 9/26/07 at the Hospital prior to R14's admission to the facility he underwent Esophagogastroduodenoscopy (EGD) with foreign bodies (multiple metal coins) removal. One of the recommendations to prevent further ingestion of foreign bodies was to have 24 hour daily sitter and facility was aware of the potential for further swallowing of foreign objects due to PICA diagnosis at initial admission.</p> <p>On 7/18/09 the facility sent R14 to the Hospital for the evaluation of coffee ground emeses twice and R14 was admitted to the Hospital with diagnosis of Gastric BEZOAR (mass formed with the accumulation of foreign bodies, usually in gastrointestinal track).</p> <p>At the Hospital on 7/20/09 R14 underwent EGD. The EGD report noted "multiple foreign bodies were noted in the distal esophagus and proximal stomach that included EKG leads and 4 x 4 sponge, these were retrieved during the procedure, but encountered large foreign body that appeared to be a possible plastic plate or hardened piece of cloth partially digested. This foreign body had a very hard consistency and it seems to occupy most of the stomach which posed resistance to the procedure and the procedure was stopped due to the risk of perforation."</p> <p>On 7/22/09 at the Hospital an Exploratory Laparotomy, Gastrotomy with removal of BEZOAR was performed on R14. The surgical</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 3</p> <p>procedure report indicated abundant amount of contents (gloves, tissues, napkins and even toilet paper) were removed from the gastric pouch and emptied the BEZOAR.</p> <p>R14 was readmitted to the facility on 7/30/09 with 19 cm x 2 cm x 1 cm surgical wound to the left of his abdomen. The facility neither notified the Department nor conducted the internal investigation of how R14 was able to swallow these foreign objects (gloves, tissues, napkins and toilet paper) .</p> <p>Within a month after this readmission a note in R14's Nurses Notes on 8/25/09 at 3:10 am indicated two rubber gloves noted protruding from R14's rectum when he had large loose stool. There is no documentation to show if the physician was notified of the foreign object (gloves) found in his stool nor any changes to care plan to evaluate the failure of the current order for one to one supervision..</p> <p>Again on 8/28/09 at 2:00 am it is noted in the Nurses Notes to indicate that an intact medical examination glove shaped like ping pong ball mixed with his stool passed when he had a bowel movement. Again the facility did not notify R14's physician of him passing the foreign object (glove) in his stool.</p> <p>The facility developed a plan of care for R14's diminished ability to express, his use of psychotropic medication. The care plan was dated as developed on 5/1/09 and marked as updated on 8/6/09, 10/25/09 and 1/25/10. The care plan indicated R14 eats lotion, tissue, clothing material, meaning edible and inedible materials and items. The interventions are not</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 4</p> <p>specific to ensure how the facility will prevent R14 eating foreign objects. One of such intervention noted in the care plan is '1:1 supervision to manage and monitor behavior problems.' The interventions are not revised after each episode of foreign objects were found in his stomach on 7/22/09; and in his stool on 8/25/09 and 8/28/09.</p> <p>On 2/3/10 at 4:00 pm E2, the Director of Nurses, stated on 8/6/09 the facility initiated to monitor R14 in one to one staff supervision during his wake hours (7:00 am to 8:00 pm). E2 presented a schedule to indicate certain departments are responsible to monitor R14 at certain hours. There is no formalized documentation to show which staff member monitored R14 in one to one supervision and how effective it was. Nurses have documented in the Nurses Notes to indicate ' R14 on 1:1 monitoring due to the history of eating objects,' but the documentation is sporadic and details of effectiveness of the 1:1 monitoring was not documented. Facility failed to present any specific tracking or name of staff member responsible for the actual monitoring on a one to one basis.</p> <p>After all these incident have occurred with R14 another incident documented in his Nurses Notes on 1/29/10 6:00 am indicating he had three loose bowel movement (LBM) during the night shift. On 1/30/10 at 8:00 am R14 had coffee ground emeses, also had two foul smelling watery LBM. At 8:45 am the facility sent him to the Hospital.</p> <p>Survyor went to the hospital to review medical records and observe R14 on 2/4/10 during the survey. On 2/4/10 R14 was lying on the Hospital</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5</p> <p>bed. There was a 1:1 sitter at his bed side, his both hands were in mittens. R14 had large abdominal binder covering his abdominal surgery. R14 was non-verbal, stared into space when called his name. The Hospital Unit Manager stated they have a sitter at bed side to monitor R14 1:1 for 24 hours daily, because of his history of swallowing objects.</p> <p>At the Hospital on 1/31/10 R14 underwent EGD. The EGD report indicated a large quantity of foreign material, foreign objects were seen including multiple gloves, electrodes. They appeared to be fairly thickened and matted and hard and of large diameter. Unable to remove the contents. The procedure was concluded and surgical removal of foreign material will be required.</p> <p>On 2/2/10 R14 underwent another Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR. During the surgery identified the presence of a significant amount of Latex Gloves. The gloves are removed and there is at least one full box, possibly one and a half boxes of Latex Gloves within the Gastric Pouch. The Gastric Pouch has complete absence of any further foreign bodies. No other foreign objects (electrodes) were found as appeared in EGD on 1/31/10 and were not present in the GI tract when the sugeaon actually went in to remove..</p> <p>On 2/5/10 at 9:50 am and on 2/8/10 at 2:05 pm Surveyor called the Hospital to speak to the Surgeon who operated on R14 on 2/2/10. The Surgeon confirmed the gloves that were taken out of R14's gastric pouch during the surgery on 2/2/10 would have had to have been in the gastric pouch at least several weeks gradual</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 6</p> <p>swallowing, approximately around November, and December 2009. The gloves are definitely not from within the recent seven days, because they were partly decomposed. The Surgeon could not save the gloves, they were Latex Gloves.</p> <p>On 2/3/10 at 11:50 am on 3rd floor used gloves were noted in the small garbage can (with no lid) and large garbage can (with a push in lid) at the Nurses station. Also there was an opened box of gloves (half full) was on top of the Nurses Station counter accessible to anyone. There was no one at the Nurses Station, there was no door to prevent anyone from entering into the Nurses Station. At Noon on 4th floor the soiled utility room (door shut but has no lock) there were also used gloves found into the thrash can. Anyone can open the door to enter the room. Also there was an opened box about half full on top of the Nurses Station. This glove box was accessible to any one at the Nurses Station. R14 used to live on 3rd and 4th floor at the facility. Further there were at least 2 isolation set ups outside resident rooms which also were noted to have latex glove boxes available on the top of the cart.</p> <p>The facility was aware of R14's history of swallowing foreign objects upon his admission to the facility 10/23/07. While R14 has been at the facility since then, the facility is also aware that R14 had episodes of swallowing foreign objects as evidenced by the 1st surgery (Exploratory Laparotomy, Gastrotomy with removal of BEZOAR) on 7/22/09; R14 passing rubber gloves in his stool on 8/25/09 and 8/28/09.</p> <p>The facility failed to monitor R14 to prevent another instance of swallowing foreign objects as</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 7</p> <p>a result R14, since he has been in the facility, had to undergo a second avoidable Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR on 2/2/10.</p> <p>The Immediate Jeopardy was removed 02/02/2010, when R14 was sent to the hospital. Facility presented the following plan to abate the immediacy, and because the plan must be evaluated and in servicing completed, the facility remains out of compliance at severity level 2:</p> <p>The facility took the following steps:</p> <ol style="list-style-type: none"> 1.Starting immediately, all residents evaluated for PICA symptoms. 2.All new admits will be sceened by designated person(DON) to make sure no new residents admitted with PICA into the facility. 3.Sign in sheets will be in place for all residents designated on future 1:1 supervision. 4.All small items that can be ingested will be removed and that could be ingested by a resident with PICA to ensure safety. Constant monitoring will be gien to ensure safety. 5.DON or ADON will ensure that 1:1 supervision takes place and sign in sheets are complete and signed by staff. 6. Quality Assurance Committee to monitor the residents with who are at risk for swallowing foreign object. The Director of Nurses will monitor the staff monitoring of the residents who are at risk for swallowing foreign objects. <p>2. R13 a 25 year old female was admitted to the facility on 12/18/09 with diagnoses including Bipolar Disorder and Borderline Personality. R13's 12/18/09 Social Service Assessment Narrative summary indicated she has a history of suicide attempt in October 2009; it was also noted when R13 feels depressed she wants</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 8</p> <p>attempt suicide by cutting her self deep in the wrist.</p> <p>R13's Nurses Notes indicated on 12/22/09 she was hyper, made comments that she drank energy drink and shaking. R13 also expressed suicidal ideations (I will kill myself by cutting with a sharp object on my wrist). R13 was hospitalized from 12/22/09 to 12/28/09.</p> <p>On 1/3/10 at 6:30 pm the 1st floor front desk receptionist (R13 lives on 4th floor) noticed that R13 took a pill, since then she had been drowsy and called the 4th floor to get R13 upstairs. After R13 got to the 4th floor, she showed staff several pills in her hand and swallowed them. By staff talking to R13 staff decided that she swallowed undisclosed amount of Lyrica pills, which she got from her boyfriend during his visit that day. R13 stated to staff that she took pills because she was depressed from her breaking up with her boyfriend. R13 was sent to Hospital and her stomach was pumped.</p> <p>On 2/3/10 at 11:00 am E3, the Assistant Director of Nurses stated that the facility did not treat this as an incident or investigated the incident, because the Hospital toxicology report indicated negative. The Hospital toxicology report did not show R13 having tested for the alleged overdosed medication (Lyrica) but tested for other controlled substances and street drugs which were negative.</p> <p>The facility failed to monitor to ensure R13 did not have the access to the medication that was not prescribed by the physician to her at the facility. R13 overdosed on the medication that could cause a potential danger for the safe of self</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 9 or others.</p> <p>R13's Nurses Notes also indicated that she had verbal altercations with male peers on 12/30/09. On 1/8/10 at 1:00 pm R13 had another altercation with a male peer (each called profanity and racial slurs at each other). At 4:20 pm R13 cut her left arm and noticed blood running down her arm to the floor. The cut was of 15 cm to 20 cm from antecubital to the wrist, the laceration deep enough to warrant sutures. R13 stated to the psychosocial staff that no one will listen to her, so she cut her arm and gave the razor blade that she used. R13's laceration required 40 stitches at the Hospital.</p> <p>On 2/2/10 at 12:15 pm a disposable razor was observed in resident room (323) on top of the shelf on 3rd floor. Seven empty diet coke cans with sharp tabs on it were noticed in room (318) garbage can. E9, the 3rd floor Nurse verified the observation. On 4th floor in rooms (401 and 426) there were a total of eight empty soda cans in the garbage cans with sharp tabs on them. A cigarette lighter in room (401) also found. The resident said 'I am not supposed to have it.' There are residents who have severe mental illness with impaired judgement and cognition on 3rd and 4th floors. These residents could easily access the metal sharp objects (razor and sharp metal tabs) and they could harm them self.</p> <p>On 2/3/10 at 1:30 pm E4 stated the facility has no policy to detail sharp metal objects that are prohibited, she said for sure the residents "cannot have the razors. They are supposed to locked with staff supervision." E4 also said she has given examples of contraband items in her inservice to staff to include belts, shoes that are</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 10 sharp or metal strings, liquids, hand sanitizers, alcohol, shoe strings, lighter, drugs etc., On 12/28/09 the facility identified R13 to be at moderate risk for suicidal ideations. In the comments section of the risk assessment and her 12/21/09 suicidal risk it was noted to provide 1:1 counseling three times per week; and monitor R13 every two hours. On 2/3/10 E6, the Psychiatric Rehabilitation Service Counselor (PRSC) for R13 presented R13's two hour Behavior Tracking and Episodic Intervention Response Form (BTEIRF) record that started on 12/22/09 at 3:00 pm. This record is not consistently documented at two hour intervals as planned for the days that were documented. No staff signatures to indicate which staff monitored R13 every two hours. The interventions and response columns were left blank. This was verified by E6 on 2/3/10. R13's 1/8/10 Minimum Data Set (MDS) indicate her judgement is impaired; her psychosocial assessment of 12/18/09 indicated she has history of suicidal attempts with overdose and harming herself by cutting herself. The facility failed to monitor to ensure R13 did not get a hold of medication that was not prescribed for her at the facility; and also failed to monitor to ensure she did not have the access to a razor blade that she used to cut her left arm on 1/8/10.	F 323			
F9999	FINAL OBSERVATIONS LICENSURE	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 11</p> <p>300.1210a) 300.1210b)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These regulations are not met, as evidence by tha following:</p> <p>Based on observation, record review and interview the facility failed to :</p> <p>(1) monitor R14 to prevent him from swallowing foreign objects, such as Latex Gloves that were found during his Emergency Hospitalization on 1/30/10.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 12</p> <p>The facility was aware of R14's history of swallowing foreign objects (PICA) upon his initial admission to the facility 10/23/07. While R14 has been a resident at the facility, facility staff were aware that R14 had previous episodes of swallowing foreign objects as evidenced by the 1st surgery (Exploratory Laparotomy, Gastrotomy with removal of BEZOAR) on 7/22/09 to remove foreign objects swallowed and were aware of R14 passing rubber gloves in his stool on 8/25/09 and 8/28/09 while in the facility and while under their monitoring and supervision.</p> <p>(2) monitor and ensure R13 did not have the access to medication that was not prescribed by the physician to her at the facility. R13 overdosed on the medication..</p> <p>(3) monitor to ensure R13 did not have the access to a razor blade that she used to cut her left arm on 1/8/10.</p> <p>The facility was aware that R13 had a history of suicide attempt in October 2009; it was also noted that when R13 feels depressed she threatens suicide by cutting herself deep in the wrist.</p> <p>As a result:</p> <p>(1) R14, since he has been in the facility, had to undergo a second Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR on 2/2/10.</p> <p>(2) R13 overdosed with the undisclosed amount of medication that could cause a potential danger for the safety of self or others.</p> <p>(3) R13 cut her self with a razor blade that resulted in 15 to 20 cm laceration that required 40 sutures in the Emergency Room.</p> <p>This is for one resident in the sample (R13) and one resident (R14) from outside of the sample.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 13</p> <p>Findings include:</p> <p>1. R14's admission record indicated he is a 48 year old male originally admitted to the facility on 10/23/07 with multiple diagnoses including Profound Mental Retardation and Cerebral Palsy. R14 uses a rolling walker for his ambulation. R14 has no teeth per medical record. On 9/26/07 at the Hospital prior to R14's admission to the facility he underwent Esophagogastroduodenoscopy (EGD) with foreign bodies (multiple metal coins) removal. One of the recommendations to prevent further ingestion of foreign bodies was to have 24 hour daily sitter and facility was aware of the potential for further swallowing of foreign objects due to PICA diagnosis at initial admission.</p> <p>On 7/18/09 the facility sent R14 to the Hospital for the evaluation of coffee ground emeses twice and R14 was admitted to the Hospital with diagnosis of Gastric BEZOAR (mass formed with the accumulation of foreign bodies, usually in gastrointestinal track). At the Hospital on 7/20/09 R14 underwent EGD. The EGD report noted "multiple foreign bodies were noted in the distal esophagus and proximal stomach that included EKG leads and 4 x 4 sponge, these were retrieved during the procedure, but encountered large foreign body that appeared to be a possible plastic plate or hardened piece of cloth partially digested. This foreign body had a very hard consistency and it seems to occupy most of the stomach which posed resistance to the procedure and the procedure was stopped due to the risk of perforation."</p> <p>On 7/22/09 at the Hospital an Exploratory</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 14</p> <p>Laparotomy, Gastrotomy with removal of BEZOAR was performed on R14. The surgical procedure report indicated abundant amount of contents (gloves, tissues, napkins and even toilet paper) were removed from the gastric pouch and emptied the BEZOAR.</p> <p>R14 was readmitted to the facility on 7/30/09 with 19 cm x 2 cm x 1 cm surgical wound to the left of his abdomen. The facility neither notified the Department nor conducted the internal investigation of how R14 was able to swallow these foreign objects (gloves, tissues, napkins and toilet paper) .</p> <p>Within a month after this readmission a note in R14's Nurses Notes on 8/25/09 at 3:10 am indicated two rubber gloves noted protruding from R14's rectum when he had large loose stool. There is no documentation to show if the physician was notified of the foreign object (gloves) found in his stool nor any changes to care plan to evaluate the failure of the current order for one to one supervision..</p> <p>Again on 8/28/09 at 2:00 am it is noted in the Nurses Notes to indicate that an intact medical examination glove shaped like ping pong ball mixed with his stool passed when he had a bowel movement. Again the facility did not notify R14's physician of him passing the foreign object (glove) in his stool.</p> <p>The facility developed a plan of care for R14's diminished ability to express, his use of psychotropic medication. The care plan was dated as developed on 5/1/09 and marked as updated on 8/6/09, 10/25/09 and 1/25/10. The care plan indicated R14 eats lotion, tissue,</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 15</p> <p>clothing material, meaning edible and inedible materials and items. The interventions are not specific to ensure how the facility will prevent R14 eating foreign objects. One of such intervention noted in the care plan is '1:1 supervision to manage and monitor behavior problems.' The interventions are not revised after each episode of foreign objects were found in his stomach on 7/22/09; and in his stool on 8/25/09 and 8/28/09.</p> <p>On 2/3/10 at 4:00 pm E2, the Director of Nurses, stated on 8/6/09 the facility initiated to monitor R14 in one to one staff supervision during his wake hours (7:00 am to 8:00 pm). E2 presented a schedule to indicate certain departments are responsible to monitor R14 at certain hours. There is no formalized documentation to show which staff member monitored R14 in one to one supervision and how effective it was. Nurses have documented in the Nurses Notes to indicate ' R14 on 1:1 monitoring due to the history of eating objects,' but the documentation is sporadic and details of effectiveness of the 1:1 monitoring was not documented. Facility failed to present any specific tracking or name of staff member responsible for the actual monitoring on a one to one basis.</p> <p>After all these incident have occurred with R14 another incident documented in his Nurses Notes on 1/29/10 6:00 am indicating he had three loose bowel movement (LBM) during the night shift. On 1/30/10 at 8:00 am R14 had coffee ground emeses, also had two foul smelling watery LBM. At 8:45 am the facility sent him to the Hospital.</p> <p>Survyor went to the hospital to review medical</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 16</p> <p>records and observe R14 on 2/4/10 during the survey. On 2/4/10 R14 was lying on the Hospital bed. There was a 1:1 sitter at his bed side, his both hands were in mittens. R14 had large abdominal binder covering his abdominal surgery. R14 was non-verbal, stared into space when called his name. The Hospital Unit Manager stated they have a sitter at bed side to monitor R14 1:1 for 24 hours daily, because of his history of swallowing objects.</p> <p>At the Hospital on 1/31/10 R14 underwent EGD. The EGD report indicated a large quantity of foreign material, foreign objects were seen including multiple gloves, electrodes. They appeared to be fairly thickened and matted and hard and of large diameter. Unable to remove the contents. The procedure was concluded and surgical removal of foreign material will be required.</p> <p>On 2/2/10 R14 underwent another Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR. During the surgery identified the presence of a significant amount of Latex Gloves. The gloves are removed and there is at least one full box, possibly one and a half boxes of Latex Gloves within the Gastric Pouch. The Gastric Pouch has complete absence of any further foreign bodies. No other foreign objects (electrodes) were found as appeared in EGD on 1/31/10 and were not present in the GI tract when the sugeaon actually went in to remove..</p> <p>On 2/5/10 at 9:50 am and on 2/8/10 at 2:05 pm Surveyor called the Hospital to speak to the Surgeon who operated on R14 on 2/2/10. The Surgeon confirmed the gloves that were taken out of R14's gastric pouch during the surgery on</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 17</p> <p>2/2/10 would have had to have been in the gastric pouch at least several weeks gradual swallowing, approximately around November, and December 2009. The gloves are definitely not from within the recent seven days, because they were partly decomposed. The Surgeon could not save the gloves, they were Latex Gloves.</p> <p>On 2/3/10 at 11:50 am on 3rd floor used gloves were noted in the small garbage can (with no lid) and large garbage can (with a push in lid) at the Nurses station. Also there was an opened box of gloves (half full) was on top of the Nurses Station counter accessible to anyone. There was no one at the Nurses Station, there was no door to prevent anyone from entering into the Nurses Station. At Noon on 4th floor the soiled utility room (door shut but has no lock) there were also used gloves found into the thrash can. Anyone can open the door to enter the room. Also there was an opened box about half full on top of the Nurses Station. This glove box was accessible to any one at the Nurses Station. R14 used to live on 3rd and 4th floor at the facility. Further there were at least 2 isolation set ups outside resident rooms which also were noted to have latex glove boxes available on the top of the cart.</p> <p>The facility was aware of R14's history of swallowing foreign objects upon his admission to the facility 10/23/07. While R14 has been at the facility since then, the facility is also aware that R14 had episodes of swallowing foreign objects as evidenced by the 1st surgery (Exploratory Laparotomy, Gastrotomy with removal of BEZOAR) on 7/22/09; R14 passing rubber gloves in his stool on 8/25/09 and 8/28/09.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 18</p> <p>The facility failed to monitor R14 to prevent another instance of swallowing foreign objects as a result R14, since he has been in the facility, had to undergo a second avoidable Exploratory Laparotomy with Gastrotomy and Removal of Gastric BEZOAR on 2/2/10.</p> <p>2. R13 a 25 year old female was admitted to the facility on 12/18/09 with diagnoses including Bipolar Disorder and Borderline Personality. R13's 12/18/09 Social Service Assessment Narrative summary indicated she has a history of suicide attempt in October 2009; it was also noted when R13 feels depressed she wants attempt suicide by cutting her self deep in the wrist.</p> <p>R13's Nurses Notes indicated on 12/22/09 she was hyper, made comments that she drank energy drink and shaking. R13 also expressed suicidal ideations (I will kill myself by cutting with a sharp object on my wrist). R13 was hospitalized from 12/22/09 to 12/28/09.</p> <p>On 1/3/10 at 6:30 pm the 1st floor front desk receptionist (R13 lives on 4th floor) noticed that R13 took a pill, since then she had been drowsy and called the 4th floor to get R13 upstairs. After R13 got to the 4th floor, she showed staff several pills in her hand and swallowed them. By staff talking to R13 staff decided that she swallowed undisclosed amount of Lyrica pills, which she got from her boyfriend during his visit that day. R13 stated to staff that she took pills because she was depressed from her breaking up with her boyfriend. R13 was sent to Hospital and her stomach was pumped.</p> <p>On 2/3/10 at 11:00 am E3, the Assistant Director</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 19</p> <p>of Nurses stated that the facility did not treat this as an incident or investigated the incident, because the Hospital toxicology report indicated negative. The Hospital toxicology report did not show R13 having tested for the alleged overdosed medication (Lyrica) but tested for other controlled substances and street drugs which were negative.</p> <p>The facility failed to monitor to ensure R13 did not have the access to the medication that was not prescribed by the physician to her at the facility. R13 overdosed on the medication that could cause a potential danger for the safe of self or others.</p> <p>R13's Nurses Notes also indicated that she had verbal altercations with male peers on 12/30/09. On 1/8/10 at 1:00 pm R13 had another altercation with a male peer (each called profanity and racial slurs at each other). At 4:20 pm R13 cut her left arm and noticed blood running down her arm to the floor. The cut was of 15 cm to 20 cm from antecubital to the wrist, the laceration deep enough to warrant sutures. R13 stated to the psychosocial staff that no one will listen to her, so she cut her arm and gave the razor blade that she used. R13's laceration required 40 stitches at the Hospital.</p> <p>On 2/2/10 at 12:15 pm a disposable razor was observed in resident room (323) on top of the shelf on 3rd floor. Seven empty diet coke cans with sharp tabs on it were noticed in room (318) garbage can. E9, the 3rd floor Nurse verified the observation. On 4th floor in rooms (401 and 426) there were a total of eight empty soda cans in the garbage cans with sharp tabs on them. A cigarette lighter in room (401) also found. The</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 20</p> <p>resident said 'I am not supposed to have it.' There are residents who have severe mental illness with impaired judgement and cognition on 3rd and 4th floors. These residents could easily access the metal sharp objects (razor and sharp metal tabs) and they could harm them self.</p> <p>On 2/3/10 at 1:30 pm E4 stated the facility has no policy to detail sharp metal objects that are prohibited, she said for sure the residents "cannot have the razors. They are supposed to locked with staff supervision." E4 also said she has given examples of contraband items in her inservice to staff to include belts, shoes that are sharp or metal strings, liquids, hand sanitizers, alcohol, shoe strings, lighter, drugs etc.,</p> <p>On 12/28/09 the facility identified R13 to be at moderate risk for suicidal ideations. In the comments section of the risk assessment and her 12/21/09 suicidal risk it was noted to provide 1:1 counseling three times per week; and monitor R13 every two hours.</p> <p>On 2/3/10 E6, the Psychiatric Rehabilitation Service Counselor (PRSC) for R13 presented R13's two hour Behavior Tracking and Episodic Intervention Response Form (BTEIRF) record that started on 12/22/09 at 3:00 pm. This record is not consistently documented at two hour intervals as planned for the days that were documented. No staff signatures to indicate which staff monitored R13 every two hours. The interventions and response columns were left blank. This was verified by E6 on 2/3/10.</p> <p>R13's 1/8/10 assessment indicates her judgement is impaired; her psychosocial assessment of 12/18/09 indicated she has history</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2010
NAME OF PROVIDER OR SUPPLIER FOX RIVER PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST NEW YORK STREET AURORA, IL 60505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	Continued From page 21 of suicidal attempts with overdose and harming herself by cutting herself. The facility failed to monitor to ensure R13 did not get a hold of medication that was not prescribed for her at the facility; and also failed to monitor to ensure she did not have the access to a razor blade that she used to cut her left arm on 1/8/10.	F9999			