STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

PAVILLION OF FOREST PARK
Facility Name

0043778
I.D. Number

8200 WEST ROOSEVELT ROAD, FOREST PARK, IL 60130
Address

MARCH 2, 2005
Date of Survey

Complaint Investigation and Incident Report Investigation
Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210a)

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.

300.1210 b)3 General nursing care shall include at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT.

Findings include:

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300.1210b)3
300.3240a)
(Cont.)

Based on record review, staff and other interview, review of facility abuse policy, and observation, the facility failed to provide one resident (R4) with timely assessment and treatment for pain and swelling of the left knee for five days.

Based on staff interviews and other interviews, record review, facility abuse policy review and observation, the facility failed to thoroughly investigate an injury of unknown origin for one resident (R4) which resulted in the resident being in periods of prolonged pain and finally being diagnosed with a fractured left femur.

On February 16, 2005, R4 was sent to the hospital and diagnosed with a left femur fracture.

Based on record review, R4 started complaining of pain on the evening shift of February 11, 2005 which was not being relieved by ordered pain medication and MD was called for a stronger pain medication. Staff did not evaluate the pain and its origin. Records indicate that R4 did have Arthritis as part of her diagnosis but has not complained of any discomfort from arthritis pain and has not been medicated for any arthritis pain. There was no follow-through after Ibuprofen was given.

Record dated February 12, 2005 during breakfast, R4 started vomiting while up on a chair. On interview, Z3 who visited in the afternoon stated that she noted R4 grimacing a lot and was restless. Z3 stated that the staff nurse gave Z3 an explanation of R4's conditions such as vomiting and being given pain medication for her knee.

On interview, Z2 stated that on February 13, 2005 at 11:30 a.m., Z2 came in to visit R4 and noted that R4 was up in a chair grimacing. Z2 noted that the left knee and thigh were very swollen and discolored. Z2 stated that R4 was leaning on her left side while she was up in a wheelchair. Z2 brought R4 to the TV room and called that nurse to show her R4's leg. Z2 stated that Z4 (the agency nurse) came in and touched the reddened area on the left thigh side and R4 screamed in pain. Z2 indicated that Z4 came back and gave R4 pain medication and left. Z4 did not document the pain, the medication given nor come back to assess R4 after this episode. No further follow-up was noted as no charting from any of the nurses noted on February 12, 2005 and February 13, 2005.

E6 confirmed on interview that R4 did have emesis on February 11, 2005 and again on February 12, 2005. E6 indicated on interview that on February 13, 2005, during the day shift, agency nurse took care of R4. The emesis on February 12, 2004 was not documented.

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Record indicated that facility only started looking at R4's condition on February 14, 2005 at 6 p.m. Nurse's note indicated swelling and bruising to the left knee and side of left thigh. MD was notified at 8:45 p.m. and X-ray of the leg was ordered. R4 continued to complain of pain on February 14 and February 15, 2005. It was not until 9:30 p.m. of February 15, 2005 that the facility staff checked if the X-ray was actually done. On February 15, 2005, at 11:45 p.m., MD ordered immobilizer for the left leg which showed a fracture of the distal femur. On February 16, 2005, nurse's note indicated that R4 continued to have pain with minimal movement she made while in bed rest. R4 was sent to the hospital at 10:00 a.m. where she needed a surgery of open reduction and internal fixation of the left distal femur.

R4 has a diagnosis of Alzheimer's and is very confused and cannot communicate her needs and discomfort consistently. Assessments indicate her needs have to be anticipated. The facility failed to provide timely and appropriate assessment and follow-up of R4's condition leading to a prolonged period of time with pain and delayed proper treatment of her fracture.

Records show this as an incident of a reddened swollen left knee occurring on February 15, 2005 reported to IDPH on February 16, 2005. The incident was not investigated to find out how or when this fracture actually happened.

The lack of assessment and follow-up on R4's conditions lead to an extended period of discomfort and pain for R4 and the timely provision of proper care for R4's fracture from February 11, 2005 to February 16, 2005.

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