STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. BUILDING ______ B. WING ______	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF NAPERVILLE	**200 MARTIN AVENUE NAPERVILLE, IL 60540**

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F 315	Continued From page 5 transferring him or how to anchor the catheter during transfer. The facility Nurse Consultant verified R3 ' s IUC tubing was on the floor next to his shoes, while he was seated in his wheel chair and stationed in front dining hall. On 8/13/13 at 11:07 am R3 stated he had Urinary Tract Infection and infection had just cleared. R3 did not know that the IUC tubing is not supposed to be on the floor, it drags all the time on the floor and he can ' t keep his feet up while he is pushing with his feet. R3 also stated the tube is not secured to his leg.	F 315		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1220b)3) 300.3240a Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

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F9999	Continued From page 6 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to develop and implement interventions for anchoring indwelling urinary catheter (IUC), to avoid excessive tugging on the catheter during transfer and care delivery. Due to the staff failure to transfer R1 safely from bed to wheel chair on 7/26/13 resulted in dislodgement of R1 ' s IUC. As a result R1 suffered from catheter related pain, urethral tear, erosion and bleeding. R1, at the hospital received blood transfusion to build up depleted Red Blood Cells, Hemoglobin and Hematocrit. On 8/10/13 R1, at the hospital underwent cystoscopy, clot evacuation, and fulguration of the bleeding site. This applies for two of three residents (R1 and	F9999		

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F9999	Continued From page 7 R3) evaluated for IUC in the sample of four residents. The findings include: R1 ' s admission record showed that he was admitted to the facility on 7/19/13 for physical rehabilitation status post motor vehicle accident. R1 had an IUC upon his admission to the facility. The facility per R1 ' s 7/31/13 admission Minimum Data Set (MDS) identified him to be alert, oriented to time, place and person and his Brief Interview for Mental Status (BIMS) score was ' 15. ' R1 ' s 7/26/13 3:45 pm Nurses Notes showed that E3, Certified Nurse Aide (cna) reported to the E4 the Nurse on duty that his IUC was out with balloon intact, bleeding from the penis and cold pack applied to site. The Nurses Notes also showed that the staff contacted urologist per attending physician recommendation, could not get appointment with the urologist to see R1. The urologist office advised the facility to send R1 to hospital if his condition worsens. On 7/27/13 at 7:54 am the facility staff inserted am IUC #16 F with 5 cc balloon, as R1 ' s bladder scan showed he was retaining urine up to 873 cc. On 7/30/13 at 4:27 pm R1 ' s blood pressure was 98/56 and heart rate was 122 per minute, seen by urologist and returned to the facility at 6:30 pm. On 8/2/13 at 7:13 pm R1 was started on antibiotic therapy for Urinary Tract Infection (UTI) per urologist order. On 8/3/13 at 0.59 am staff noticed R1 bleeding with clots from the penis around the IUC. At 4:01 pm R1 started to bleed again from the penis, at 8:11pm R1 was admitted to the hospital due to the trauma of penis urethra. R1 ' s hospital records showed that staff inadvertently stepped on IUC while standing, which resulted in acute profuse bleeding due to	F9999		

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F9999	Continued From page 8 traumatic removal of IUC balloon still inflated. R1 ' s Hemoglobin dropped due to bleeding, required transfusion of packed red blood cells. On 8/10/13 R1 underwent cystoscopy, clot evaluation, and fulguration of the bleeding site. R1 ' s 7/23/13 IUC plan of care showed no interventions to address the precautions to be taken to transfer him safely. The facility did not evaluate to resolve how R1 ' s IUC got out with its balloon intact. The facility also did not develop interventions even after R1 ' s IUC dislodged, to prevent such occurrences. On 8/13/13 at 1:30 pm E2, the Director of Nurses stated that she spoke to R1 at the hospital and staff involved when the incident occurred, but does not have any thing documented to show the investigation. E2 stated she did a change in condition assessment on 8/3/13 for R1 ' s IUC dislodgement on 7/26/13. This evaluation is not comprehensive to show what are the contributing factors for the dislodgement of IUC or what measures would prevent future such occurrences. On 8/13/13 at 3:30 pm interviewed R1 at another Long Term Care Facility. R1 was able to engage in conversation, explained circumstances surrounding the dislodgement of his IUC. R1 was alert, oriented to time, place and person. R1 stated he does not want even his enemy to go through what he went through with his urinary catheter while he was at the facility. R1 explained that on 7/26/13 night shift aide came to his room to get him up, sat him at his bed side and asked him to stand up. R1 said as he stood up, he felt the pain and screamed and sobbed from the catheter tube pulling. The tube stretched and the whole catheter fell on the floor, the balloon remained with water. At that point R1 said he then noticed E3 was standing on the urine bag and	F9999		

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F9999	Continued From page 9 some of the tubing. The aide said she was sorry and she will get help. R1 also said he fell back to bed and bled large amount of blood. R1 said the staff put ice towel on his scrotal area, the towel got wet with blood because he was bleeding profusely from his penis, but nothing helped for a while. R1 stated he could not urinate on his own, so the staff reinserted the catheter on 7/27/13. R1 continued his conversation and said he did not see the urologist until 7/30/13. R1 said by 8/3/13 he has been hurting, bleeding on and off, felt weak, had an infection and that is when they sent him to hospital. At the hospital R1 said he received blood transfusion; via cystoscopy the surgeon removed blood clots and fulgurated the bleeding site. R1 insisted he would never want to go back to the facility. On 8/13/13 at 11:00 am E5 (Occupational Therapy staff) wheeled R3 in his wheel chair from Occupational Therapy area to front dining room. R3 wheel chair had no foot rests. E5 wheeled R3 in his wheel chair and his IUC tubing and the urine collection bag was dragging on the floor. While E5 was wheeling him R3 could not hold his legs up and his right foot frequently stepped on his IUC tubing while it was dragging on the floor. R3 ' s catheter was not anchored to prevent excessive tugging and inadvertent removal of catheter. R3 7/5/13 IUC plan of care did not show interventions as to how the staff should be transferring him or how to anchor the catheter during transfer. The facility Nurse Consultant verified R3 ' s IUC tubing was on the floor next to his shoes, while he was seated in his wheel chair and stationed in front dining hall. On 8/13/13 at 11:07 am R3 stated he had Urinary Tract Infection and infection had just cleared. R3 did not know that the IUC tubing is not supposed to be on the floor, it drags all the time on the floor	F9999		

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F9999	Continued From page 10 and he can ' t keep his feet up while he is pushing with his feet. R3 also stated the tube is not secured to his leg. B	F9999		