STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 2/20/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM L DAWSON NURSING HOME	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	FINAL OBSERVATIONS 300.1010h) The facility shall notify the residents' physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety, or welfare of a resident. 300.1210a) Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.1210c)4) 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. 300.3240a) An owner, Licensee, Administrator, employee, or agent of a facility shall not abuse or neglect a resident. Based on reviews of the facility incident reports, policies and procedures, hospital records and clinical records, including staff and resident interviews, the facility failed : 1. To replace a cut and damaged indwelling catheter in 1 of 7 residents (R2) with catheters. This was observed by staff to be cut both at the insertion port and the balloon port as evidence of	F9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F9999	Continued From page 1 being non functioning. 2. To maintain a closed sterile urinary drainage system and attempt to replace a non-functioning indwelling catheter in a catheter dependent resident. 3. To assess and notify the doctor of a change in R2's condition. 4. To monitor the urine output and implement their plan of care for R2. 5. To instruct staff on the proper placement of indwelling catheters . R2's indwelling catheter was noted to be in R2's urethra tract, not the bladder, blocking the flow of urine for 2 straight days which was not correctly assessed by nursing home staff. All of these failures resulted in R2 being admitted to the hospital with the diagnoses of urosepsis, low blood pressure, avoidable discomfort and urinary retention. Because of the facility failure to treat and assess R2 for several days, facility neglected to provide the nursing services R2 required which caused an emergency hospital admission. Based on reviews of the facility incident reports, policies and procedures, hospital records, clinical records, and staff and resident interviews, the facility failed: 1. To assess and notify the doctor when there was a change in condition for 1of 7 residents with catheters, (R2). 2. To monitor the urine output of R2 as ordered, 3. To implement the plan of care for R2 who is catheter dependent. 4.To instruct staff on the proper placement of indwelling catheters. R2's indwelling catheter was noted in the hospital to be in his urethra, not the bladder, blocking the flow of urine for 2 days not assessed by nursing home staff.	F9999		

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F9999	Continued From page 2	F9999		

5. Identify that the indwelling catheter was not correctly placed in the bladder.

As a result of above failures, the resident R2 was admitted to the hospital with the diagnoses of urosepsis, avoidable pain, discomfort and urinary retention.

Findings include:

R2 is a 85 year old resident who was admitted to the facility on 12-11-02 from the hospital. His diagnoses included a Hiatal Hernia, Chronic Renal failure and Prostate Cancer. He requires a continuous indwelling catheter for urine expression because of these diagnoses.

Social Service and Nursing notes describe him as alert, orientated and independent. Minimum Date Set (MDS) 9-12-03 indicated that R2 was independent but required physical and hygiene assistance.

Record Review of physician orders requested that a indwelling catheter be reinserted on 11-19-03. Review of the nursing 24 hour report dated 11-19-03, indicated that R2's indwelling catheter was reinserted ,but leaking. Nursing notes also verify that a indwelling catheter was inserted in R2 at 9:45PM on 11-09-03.

On 11-21-03, the 24 hour nursing report for the 6 am-2:30pm shift indicated that R2's indwelling catheter was observed by nursing to be "cut" and requested that staff "please reinsert" it. The catheter was not replaced at this time, but passed along to the next shift.

On 11-21-03, no references were made on the nursing 24 hour report regarding R2's indwelling catheter for the 2pm-10:30pm shift. The fluid Intake/Output Record indicated that the indwelling catheter remained "out". This information was then

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F9999	Continued From page 3	F9999		

again passed to the next shift. The indwelling catheter was not replaced and no urine measurement was recorded.

On 11-22-03 10:00 pm -6:30am shift nursing report again passed along to the next shift the report that R2 needed his indwelling catheter reinserted. The intake and output record indicated that the indwelling catheter remain unattached to a bag and open to air.The facility failed to monitor R2's urine output during the period the catheter was out.

After 48 hours, on 11-22-03 at 10:00 AM, nursing notes observed the resident "lethargic, confused and diaphoretic, with inserting port still cut and not connected to a bag, dripping urine". R2 was then transferred to the hospital with an admitting diagnosis of urosepsis.

E5 (LPN) stated during interview that she was the one who wrote to have the indwelling catheter reinserted and stated that "he needed a new indwelling catheter, not a new bag".

E6 (ADON), stated during interview that "the port where you put the saline in was cut".

Review of the facility's Policy on Urinary Catheter Insertion stated:

(1) #5, states that a catheter may be reinserted immediately with a physician order when present catheter is dislodged or evidence of trauma exist.

(2) #8 stated that an out-put record must be maintained on all residents with indwelling catheters.

(3) #10 stated that a sterile, continuously closed drainage system is to be maintained if an indwelling catheter is inserted.

R2 was transferred to the emergency room on 11-22-03 at 10:25 am according to nursing notes. Emergency room notes stated that at 2pm after a new indwelling catheter was placed in, the hospital

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F9999	Continued From page 4	F9999		

received 1850cc of cloudy urine from R2's bladder.

Z1 (MD) verified that the indwelling catheter was " not in the bladder it was in the urethra". He also stated that the facility wanted him to send R2 to the hospital initially when the indwelling catheter came out to have it reinserted, but Z1 stated that he told them that the "staff there should be able to put a catheter in at the facility". "They apparently thought it was in correctly." He further stated that "because the indwelling catheter was not in the bladder, he (R2) developed urosepsis which contributed to him getting sick and needing hospitalization". Z1, further stated that " R2 died from sepsis and a bowel obstruction".

Review of R2 's hospital assessement dated 11-23-03 stated that the source of the sepsis was urine.

Hospital lab result in the emergency room on 11-22-03 stated the result of the urinalysis showed red blood cells, white blood cells, and severe bacteria, none of which are in normal urine. R2's complete blood count (CBC) results indicated an elevated white blood count (WBC) of 35.63. A normal white blood count maximum is around 14. R2's primary admission diagnosis was septicemia. His secondary diagnoses for admission included urinary tract infection.

During tour of the facility on 12-09-03, all residents identified with indwelling catheters were observed. A total of 7 indwelling catheters were observed. 6 of the indwelling catheters had dark tea color urine with white thick sedimentation in the tubing noted by surveyor.