STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. BUILDING ______ B. WING ______	C 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE CENTER	5905 WEST WASHINGTON CHICAGO, IL 60644

(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 Complaint Investigation 1681408/ IL84052 -- F246 cited 1681399/ IL84044 -- F315 cited	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have a call light cord within a resident's reach while alone in the room. This applies to three of nine residents (R4, R6, and R10) reviewed for accessibility of call lights, in a sample of 10. Findings include: On 3/22/16 at 10:00am, R4 was observed lying supine in bed with call light cord lying on the floor on the left side of bed; not within reach. On 3/22/16 at 12:00pm, R10 was observed in room in a reclining chair. R10's call light cord was lying in the middle of R10's bed, two feet away from R10, not within reach. On 3/23/16 starting at 9:30am, R4 was observed	F 246		

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.

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F 246	Continued From page 1 lying supine in bed with call light cord lying on the floor on the left side of bed, not within reach. R6 was observed right side lying in bed with call light cord draped over left upper side rail, dangling 6 inches above floor, not within reach. R10 was observed lying supine in bed with call light cord draped over headboard, dangling three inches above the floor, not within reach. During interview on 3/23/16 at 2:00pm, E2 DON (director of nursing) stated that staff are expected to make sure the resident's call light cord is secured to the resident's clothing so that it is within easy reach of the resident. This surveyor informed E2 of the location of the call light cords for R4, R6, and R10. E2 acknowledged that their call light cords were not within reach for the residents to use. Review of this facility's call light policy, revised 10/2010, notes when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.	F 246		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, facility failed to follow its indwelling catheter policy to ensure a resident receives the appropriate care and management to prevent skin ulceration and pain. This applies to one of two residents (R2) reviewed for indwelling catheter care in a sample of 10. Findings include: Review of the medical record noted R2 was admitted to this facility with diagnoses including: C5 and C7 spinal cord injury, paraplegia, atrophy of muscles, osteomyelitis, diabetes, anemia, cerebrovascular disease, stage 4 sacral pressure ulcer, and indwelling catheter. On 3/23/16 at 10:15am, this surveyor observed E6 CNA (certified nursing assistant) and E7 CNA perform peri care/indwelling catheter care for R2. E6 was observed washing R2's anterior pelvic area and anterior upper medial thighs. This surveyor did not observe E6 or E7 wash R2's genitalia or indwelling catheter insertion site. On 3/24/16 at 10:00am, this surveyor observed E3 RN (registered nurse/wound care nurse) evaluate R2's indwelling catheter insertion site. A small open area was noted at R2's indwelling catheter insertion site. E3 cleansed the wound with 0.9% normal saline, vitamin A and D ointment applied and covered with gauze dressing. R2 complained of pain at catheter insertion site. During interview on 3/24/16 at 10:10am, E3 RN/wound care nurse stated that she will call	F 315		

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F 315	Continued From page 3	F 315		

R2's physician to obtain wound treatment orders for R2's skin breakdown at indwelling catheter insertion site. E3 stated that R2 had received pain medication recently. E3 stated that because R2's indwelling catheter is inserted at the base of the glans, just above the scrotum, there is increased moisture and risk for skin breakdown and infections. E3 stated that this wound could have been prevented with appropriate peri care and indwelling catheter care.

R2's alteration in elimination due to need for indwelling urinary catheter related to stage 3 or 4 pressure ulcers care plan was reviewed. The identified goal is that R1 will not develop any complications associated with catheter usage. Interventions include to provide catheter care per policy.

This facility's urinary catheter care policy, revised 10/2010, was reviewed. The following is noted: wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. With a clean washcloth, cleanse the meatus and glans. With a clean washcloth rinse the area. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.