Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003263	A. BUILDING: ______ B. WING ______	C 07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER HILL HEALTHCARE CENTER	759 KANE STREET SOUTH ELGIN, IL 60177

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1974719/IL113494	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), 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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

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.

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These requirements were not met as evidenced by:

Based on interview and record review the facility failed to implement interventions for a resident at high fall risk.

This failure resulted in the resident falling while walking unattended and sustained facial fractures and a laceration to the forehead requiring stitches.

This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 12.

The findings include:

According to the Electronic Health Record (EHR) R1 had diagnoses including Alzheimer's disease, dementia with behavior, hypertension, diabetes, anxiety, depression, restlessness and agitation, eating disorder, mood disorder, wandering, and history of healed traumatic fracture of the left hip.

The quarterly Minimum Data Set (MDS) dated 04/30/19 showed R1 needed extensive assistance of one staff member for walking and used either a walker or wheelchair for ambulation. The MDS showed R1 had one fall without injury since the previous MDS assessment. The MDS showed R1's cognition was severely impaired.

A care plan dated 05/13/19 showed R1 was alert and oriented to person only and ambulates. A care plan dated 02/24/19 showed "(R1) is risk (for) falls due to confusion, unaware of safety needs, wandering, vision impairment, (diagnoses of) anemia and diabetes, and use of cardiac meds...She is able to ambulate independently."

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The fall care plan had interventions including Physical Therapy to evaluate and treat dated 04/25/19 and Physical Therapy to evaluate and treat dated 05/19/19. The care plan did not show any changes in interventions to include the Physical Therapy recommendations dated 05/06/19 for R1 to have hand hold and contact guard assistance during walking. An updated care plan for R1 having a self care deficit with interventions including to walk in the corridor with extensive one person physical assistance was not initiated until 06/11/2019, more than three weeks after R1's fall with facial fractures.

The Nursing Progress Notes showed R1 had a fall on 01/18/19 in which R1 sustained a laceration to the left forehead; a fall on 04/25/19; and a fall on 05/19/19 in which R1 sustained a laceration and facial fractures.

A Morse Fall Scale Assessment dated 05/09/19 showed R1 was a high risk for falling with a score of 65. The Morse Fall Scale shows a score equal to or higher than 51 the person was at a high fall risk with an action to implement high fall risk prevention interventions. The assessment showed R1's gait was weak, stooped but able to lift head without losing balance, steps are short, resident may shuffle.

The hospital Emergency Room records show R1 had a three centimeter laceration to the right superior orbital ridge repaired with six sutures. A Computerized Tomography (CT) scan dated 05/19/19 showed R1 had right sided maxillary antral and posterior wall fractures. The posterior wall fracture was minimally displaced. R1 had a mildly depressed fracture of the right orbital floor, large volume sided hemosinus, and a nasal bone fracture.

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The Physical Therapy evaluation dated 04/17/19 showed R1 was referred to skilled Physical Therapy due to a recent decline noted with transfers and gait. The evaluation shows R1's current level of functioning was ambulating 50 feet with minimal assistance with hand hold physical assist for safety.

The Physical Therapy Progress and Discharge Summary dated 05/06/19 showed R1 needed hand held physical assist and contact guard assist due to unsteadiness when walking. The analysis of functional outcome clinical impression showed R1 was able to ambulate up to 200 feet with hand held assistance and contact guard assistance.

On 07/03/2019 at 11:00 AM V10, Physical Therapist (PT), said R1 needed somebody to walk with her and they would be holding her hand for added stability. When R1 was discharged from therapy on 05/06/19 she needed hand held contact guard assist meaning someone would always be with her and they would be touching the resident at the waist and also on the arm or hand. R1 would need a gait belt at all times when ambulating.

V10 said when R1 was discharged from therapy on 05/06/19, R1 was referred to restorative nursing. V10 said she would expect the care plan and care to reflect that R1 needed someone to walk with her and giving constant verbal and tactile cues for safety. At 1:49 PM V10 said the Discharge Summary mobility sections walking 50 feet with two turns and walking 150 feet may seem a little vague because they are based on a drop down box which was chosen closest to the residents current level. V10 said the drop down

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box does not mention hand hold or contact guard assistance so the PT recommendation for R1 was listed on the first page for "Gait, Assistive Device" and "Gait, Level Surfaces" which R1 would need "hand held physical assist and contact guard assist (contact with patient due to unsteadiness)."

On 07/02/2019 at 2:38 PM V6, Certified Nursing Assistant (CNA), said R1 was walking down the hall on her own because she wanders. V6 said they (V6 and R1) were headed down the hallway at the same time but V6 was not assisting R1. V6 said she went into another resident room and had been in the room for approximately five minutes. When V6 returned to the hallway R1 was lying on the floor. R1 was awake and bleeding from the forehead. R1 doesn't really talk but seemed a little shaky, kept blinking her eye and trying to touch the area.

On 07/02/2019 at 3:56 PM V7, Licensed Practical Nurse (LPN), recalled seeing R1 leaving the dining room after dinner with the CNA holding her hand. A couple minutes later V7 was alerted by the CNA that R1 was on the floor. When V7 arrived at R1 in the hallway she was bleeding from the forehead and another nurse was applying pressure to R1's right forehead above the eyebrow. V7 said R1 was ambulating well and was not on the list of residents needing ambulatory assistance so V7 was unsure why the CNA was holding her hand while she was walking with her. V7 said R1 did not need assistance of a walker or a wheelchair at that time. V7 said R1 was sent to the hospital emergency room and returned from the hospital the same night before the end of the shift. V7 said the CT scan did show that R1 had facial fractures. V7 said R1 was not impulsive.

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On 07/03/2019 at 9:46 AM V11, Registered Nurse (RN), stated R1 was ambulating in the west hallway after dinner. V11 said she was near the dining room when a CNA called out that R1 was lying on the floor toward the end of the west hallway. V11 could see blood on the floor from where she was at and immediately got the treatment cart and brought it to R1. R1 had a gash above her eyebrow and there was quite a bit of blood. V11 said R1 didn't need anyone with her and was independent for ambulation. V11 said the CNAs will ask the nurses about the type of assistance the residents need and they also have in the computer what a residents transfer and mobility status are.

On 07/03/2019 at 10:15 AM V12, LPN Restorative Nurse, said the CNAs get their information from a computer program kardex tasks which were tied to the care plan. V12 said when care plan was updated then the kardex tasks are updated. V12 said R1 needed extensive assistance of one person which would need a gait belt. V12 said staff could use a gait belt for a person with limited assistance also to guide a person in the right direction. V12 said the April 2019 MDS showed R1 needed extensive assistance of one person for walking which meant R1 needed one person to actually walk with her. According to V12, when a resident was discharged from therapy they give their recommendations to restorative and then it would be put into the residents care plan to let staff know what they should be working on with the resident.

The facility's Incident Report dated 05/19/19 showed R1 ambulates independently with a steady gait. The report showed V6 (CNA) saw R1

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S9999	Continued From page 7 ambulating down the middle of the hallway toward her room. On 07/03/2019 at 11:49 AM V2, Director of Nursing (DON), said R1 was ambulating independently at the time of the fall on 05/19/19. V2 said she didn't know if R1 would allow someone to hold her hand when she was walking. V2 thought R1 had always been an independent walker and was unsure if R1 needed hand held physical assist or contact guard assistance at the time of her fall. V2 said R1 just needed supervision with someone keeping an eye on her and maybe some contact guard assistance. V2 agreed that contact guard assistance would mean someone was within reach of R1 to be able to touch her. V2 said just because it said that on paper (referring to the MDS and the PT discharge summary) didn't mean that was what R1 needed on a day to day basis. V2 said the MDS was an assessment of the highest level of assistance she needed during the look back period and not necessarily what R1 needed everyday. V2 was unsure when R1 would have went from needing hand hold physical and contact guard assistance at the completion of therapy on 05/06/19 to being an independent walker when R1 fell on 05/19/19. V2 was unsure what prompted R1 to need physical therapy starting 04/17/19. On 07/03/19 at 1:14 PM V2 said R1 needed the PT evaluation on 04/17/19 due to a decline in her mobility. V2 stated R1's ambulating independently care plan was reviewed and signed off 06/03/19 so that would mean R1 was ambulating independently as of that date. The care plan reviewed on 06/03/19 indicated R1 was ambulating independently, two weeks after the fall with fractures. A care plan dated 06/11/19 showed	S9999		

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R1 needed extensive assistance of one person physical assistance with the use of a gait belt and a rolling walker with a wheelchair to follow. V2 said she did not know how to answer how R1 was ambulating independently on 06/03/19 two weeks after the fall but then needed extensive assistance of one person on 06/11/19 without any other incidents. V2 wasn't sure if the PT recommendations of the hand hold and contact guided assistance dated 05/06/19 were to taken into account or any interventions were implemented for R1. V2 said the Physical Therapy discharge note seemed to be contradictory. V2 said if there was confusion about what was meant, then she would refer to a nursing assessment for R1's ability for walking. V2 did not say she would ask therapy for clarification. V2 was unsure if a care conference was done regarding R1's mobility status after the fall.

On 07/03/2019 at 12:23 PM V13, Doctor of Osteopathic Medicine (DO), said if R1 was a high fall risk and therapy made recommendations for hand holding assistance and a staff member to be walking with her to give constant verbal and tactile cues, then he would expect the staff to be following the physical therapy recommendation and have somebody walking with her. V13 said R1's fractures were caused by the fall.

The facility's undated Fall Prevention Policy included once a comprehensive fall risk assessment is completed, care interventions will be planned to reverse or address each risk identified on the falls assessment instrument. Individualized fall prevention approaches will be implemented by staff and reviewed quarterly for appropriateness and as needed after each incident of fall.

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