

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/25/2018
NAME OF PROVIDER OR SUPPLIER TOWER HILL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1876817/IL106630	S 000			
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/09/18

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S9999	Continued From page 1 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a resident was safely transferred by staff. This applies to 2 of 13 residents (R1 and R14) reviewed for falls in a sample of 14. This failure resulted in (R1) sustaining a Right Distal Femur Fracture. The findings include: 1. R1's Face Sheet shows resident is a 78 year old female with the following diagnoses:	S9999			

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S9999	Continued From page 2 Dementia with behavioral disturbance, Immobility syndrome, abnormalities with gait and mobility, Muscle weakness, Transient Ischemic Attack, Dysphagia, Major Depression, Pain, Neoplasm of Colon and Brain, Age related Fracture, Osteopenia, Osteoporosis, History of Deep Vein Thrombosis and Embolism, and Mild Cognitive Impairment. R1's Minimum Data Set (MDS) assessment dated October 1, 2018, shows R1's cognitive status is mildly impaired. The MDS also shows R1 has limited range of motion to bilateral lower extremities and is totally dependent on (2) staff members for transferring resident with mechanical lift. R1's Care Plan dated October 11, 2018 shows R1 requires total assistance with transferring and not able to bear weight for a short period of time on bilateral lower extremities and requires (2) person assist with mechanical lift related to decreased mobility and abnormality of gait and mobility. The Facility's Incident Investigation Report faxed to the Illinois Department of Public Health shows R1 has bilateral lower extremity contractures. V14 CNA (Certified Nursing Assistant) came to R1's room at around 11 AM on October 16, 2018 to get R1 out of bed. V14 stated she lowered R1's bed level to the level of her wheelchair, had the wheelchair positioned next to the bed and pivot transferred R1 out of bed to the wheelchair. In addition, on October 17, 2018, R1 was interviewed by V2 (Director of Nursing) while at the hospital. R1 stated that V14 got her up for lunch, not at 8:00 AM as she originally told V3 (ER Physician). R1 stated V14 dropped her on the side of the bed and then V14 was able to pick her up and put her in the wheelchair.	S9999			

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S9999	Continued From page 3 On October 23, 2018 at 10:30 AM, V2 DON (Director of Nursing) stated R1 is to be transferred via mechanical lift which requires (2) staff members. V14 was the one who transferred R1 by herself doing a pivot transfer versus using a mechanical lift per R1's Care plan. V2 stated she spoke to V5 (R1's POA) and V2 told V5 the fracture did not necessarily happen from the transfer but could have been caused by movement such as the transfer. V2 stated V14 was hired on September 24, 2018 and was terminated on October 19, 2018 for improperly transferring R1 by herself instead of using a mechanical lift which requires (2) people. V2 stated V14 did not transfer R1 according to her care plan. V2 stated the only thing that was different in R1's routine on October 16, 2018 was the improper transfer. On October 23, 2018 at 3:00 PM, V8 (Emergency Room Case Manager) stated, "R1 came to the emergency room at approximately 8:40 PM on October 16, 2018. R1 stated she was dropped by the CNA (Certified Nursing Assistant) at approximately 8:00 AM. Facility told us in report they were unsure of how the resident broke her femur and the resident complained of pain to her lower extremities after lunch. The time frame of when she discussed her pain level with the nurse and when she came to the emergency room is a lot of uncounted hours and the major concern was the resident was on blood thinners." R1's X-ray report dated October 16, 2018 faxed to the facility at 4:45 PM shows R1 has an old healed impacted fracture through the left distal femur and acute displaced impaction fracture of the right distal femur.	S9999			

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S9999	Continued From page 4 On October 23, 2018 at 7:36 PM, V3 (Emergency Room Physician) stated, "R1 was clear in saying that 'the CNA (Certified Nursing Assistant) helped me up by herself and did not use a lift and she dropped me.' V3 stated she moved R1 a little bit and she was having pain. V3 stated, "I was confused if the resident had fallen in the morning why she is now just coming to the ER is the evening. The report to our hospital emergency room nurse was inconsistent on what happened to the resident. The facility nurse stated she did not know what happened to the patient of how or why her femur was broken. It is possible the transfer contributed to the resident's broken femur." V3 stated after consulting with the Orthopedic surgeon, "I cannot see how the resident could break her femur because it is such a hard bone without some type of accident occurring. Another thing I was concerned about was the resident is on blood thinners and if the resident did have pain say in the afternoon why did it take till later in the evening to bring her to the emergency room. This whole issue with this resident is suspicious. The resident arrived to the emergency room at approximately 8:40 PM." R1's Hospital Orthopedic Consultation dated October 17, 2018 documents the patient appears alert and orientated, though difficult to understand answers to some questions due to her speech pattern. The patient apparently is a non-ambulatory and has chronic bilateral lower extremity contractures and is wheelchair bound. The patient appears to have sustained a right distal fracture that is related to her fall. 2. R14's Face Sheet shows the resident with the following diagnoses: Dementia, Alzheimer's, Hypertension, Hyperlipidemia, Hypokalemia, Lichen Simplex Chronicus, Depression, Agitation,	S9999			

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S9999	Continued From page 5 Left Breast Cancer and Palliative Care. R14's Minimum Data Set (MDS) assessment dated October 1, 2018, shows R14's cognitive status is severely impaired and needs extensive assistance of 2 staff members for bed mobility, transfers, toilet use and bathing. R14's Care Plan dated July 24, 2018 shows resident requires extensive assistance with transferring of 2 staff members related to decreased mobility and memory deficits. The Facility's Incident Investigation Report faxed to the Illinois Department Health shows on October 20, 2018 at approximately 6:00 AM, V16 CNA (Certified Nursing Assistant) transferred R14 from her bed to the wheelchair, and during the transfer R14 became weak and V16 lowered her to the ground. V16 did not look at the transfer status of the resident. V16 stated she didn't think she needed to tell the nurse of this incident. On October 25, 2018 at 9:00 AM, V2 DON (Director of Nursing) stated V16 did a one person pivot transfer on R14 and this resident is a 2 person staff member assist with a transfer belt. V2 stated if a CNA lowers a resident to the ground, they must tell a nurse and that nurse will assess that resident immediately for injuries. V16 was terminated for failure to transfer a resident in accordance with resident's plan of care and failure to report an incident involving a resident. The facility staff are reminded that no work shall be performed in an unsafe manner and employees must follow the policies and procedures of the facility. The Facility's Safe Lifting and Movement of Residents shows: In order to protect the safety	S9999			

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S9999	Continued From page 6 and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices to lift and move residents... Staff responsible for direct resident care will have knowledge of residents' transfer, as well as how to tell what a resident's transfer status is... Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. The Facility's Fall Prevention Policy undated, shows individualized fall prevention approaches will be implemented by staff. The Facility's Accident and Incident Policy and Procedure undated, shows all accidents and significant injuries involving residents, staff and visitors will be documented and reported. A significant incident is defined as any incident that is unexpected or has an unexpected outcome. All employees, including contract personnel has to complete an incident report... Incidents include but is not limited to employee, resident, family members and or visitors resulting from accidents or errors. (B)	S9999			