STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145795	A. BUILDING _____ B. WING _____	09/03/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to supervise and implement fall prevention measures for a resident deemed high risk for falls. The facility also failed to follow therapy recommendations. This failure led to R1 falling and sustaining a right [MEDICAL CONDITION]. This applies to 1 of 4 residents (R1) reviewed for incidents/accidents in a sample of 10. Findings include: The Face Sheet documents R1 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 5/18/2020 documents R1 has cognitive impairment and requires extensive assistance from staff for ambulation and transfers. Speech pattern - rarely or never understood. The Fall Risk Assessments dated 1/24/2020 and 5/13/2020 document R1 is high risk for falls. The Care Plan for falls documents R1 is at risk for falls related to decreased cognition, unaware of safety needs, wandering, pacing, and the use of [MEDICAL CONDITION] medication. Follow facility fall prevention policy. The incident reports show R1 fell on the following dates: 1/28/2020 at 12:05 PM - noted lying on the floor in a side lying position, Location - resident's room, no injury, no witnesses; 3/4/2020 at 10:35 AM - noted lying on the floor on her back, in pain, Location - resident room, no injury; no witnesses; 3/20/2020 at 4:00 PM - found in a sitting position in another resident's room, no injury, no witness; 5/30/2020 at 7:15 PM - heard loud noise, found resident on floor next to wheelchair, resident does not use wheelchair, Location - resident room, no witness, injury - [MEDICAL CONDITION] requiring surgery; 6/23/2020 at 13:31 PM - sliding from wheelchair - lowered to floor by staff, Location - nursing station On 8/28/2020 at 3:26 PM, V2 (Director of Nursing) was interviewed about R1's falls and care plan interventions. V2 stated R1 is non-verbal and has cognitive impairment, dementia and [MEDICAL CONDITION]. R1 requires supervision. V2 stated R1 has both receptive and [MEDICAL CONDITION]. R1 is fearful of everybody and must be shown redirection. V2 also stated R1 wanders. Prior to fall 1/28/2020, V2 stated interventions in R1's plan of care included assisting R1 to nursing station, chair and toilet. Regarding R1's fall on 1/28/2020, V2 stated R1 fell in her room and it was an unwitnessed fall. V2 stated the fall intervention was to encourage and assist to nursing station, although this intervention was already in place. Also, physical therapy referral for unsteady gait. The Care Plan also includes intervention 1/28/20 refer to physical therapy for unsteady gait. However, there was no therapy documentation in R1's medical record for this time period. The physical therapy evaluation note shows R1 was not referred until 3/4/20, after she sustained another fall. Regarding R1's fall on 3/4/2020, V2 stated R1 fell in room, the fall was unwitnessed, and R1 displayed guarding, pain. R1 was unable to communicate her needs, just says ouch. V2 stated she does not see any interventions for this fall. The care plan documented no new interventions for R1 continuing to fall in her room unwitnessed. Regarding R1's fall 3/20/2020 in which R1 was found in another resident's room on the floor, V2 stated she does not see interventions for this date. The care plan did not document interventions for this fall. Regarding R1's fall on 5/30/2020, V2 stated R1 again had an unwitnessed fall in her room. This time, R1 sustained a fractured left hip for which she was sent to the emergency room 2 days later. V2 stated V26 was the CNA (Certified Nursing Assistant) working with R1 on 5/30/20. The hospital H&P (History and Physical) dated 6/1/2020 documents: Patient has left [MEDICAL CONDITION]. This occurred 2 days ago. The left leg shortened and externally rotated, moaning with movement. Severe dementia and cannot tell what happened. The H&P dated 6/2/2020 reads: This patient requires inpatient hospital services for medical treatment or medically required diagnostic studies. The reason the patient requires hospital services is because of left [MEDICAL CONDITION]. The surgical report dated 6/2/2020 shows R1 had ORIF (Open Reduction and Internal Fixation) of displaced left intertrochanteric fracture. R1 had another fall on 6/23/2020 as a result of sliding out of chair by nursing station. V2 stated staff lowered R1 to the floor. When asked if the facility reviewed R1's fall interventions in Quality Assurance meeting and made any adjustments, V2 could not provide the information. On 8/27/2020 at 1:00 PM, V22 (Certified Nursing Assistant/CNA) was at the bedside feeding R1 lunch. R1 did not speak when spoken to. V22 stated R1 is non-verbal and confused. On 8/27/2020 at 12:15 PM, V21 (Nurse) stated R1 is confused and requires supervision. R1 ambulates per self but can go in her room alone. V21 stated R1 does not look where she is walking and just goes anywhere. V21 stated R1 does not speak and she does not know if R1 is a fall risk. On 9/3/2020 at 2:19 PM, V25 (Physical Therapist) stated there was no therapy referral for R1 on 1/28/20. R1 was referred to physical therapy on 3/5/2020 according to V25. V25 stated R1 was discharged to restorative on 3/24/2020 because she reached her maximum capacity. V25 also stated R1 was ambulating 150 ft with therapists. R1 was treated for [REDACTED]. V25 stated R1 has cognitive impairment and requires supervision for ambulation and contact guard assist with transfers. V25 also stated recommendations were given to nursing on 3/18/2020 for ambulation and range of motion restorative programming. The Electronic Health Record (EHR) did not show documentation of R1 receiving ambulation programming. The physical therapy discharge summary for 3/24/20 reads: Treatment [DIAGNOSES REDACTED]. Discharge to Long Term Care nursing and restorative. The restorative nursing recommendation dated 3/18/20 reads: Restorative and/or maintenance programs recommended at time of discharge. Please check all that apply - ambulation, active and passive range of motion. On 9/3/2020 at 3:02 PM, V10 (Restorative Nurse) stated R1 has been on active range of motion and bed mobility programming since 4/16/20. V10 stated those are the only programs R1 has been on this year. V10 checked the EHR and stated there is no other programming. V10 stated she recently started working with R1 but does not see programming for ambulation. Although V2 stated V26 was R1's assigned CNA when she sustained the fracture, on 9/3/2020 at 3:50 PM V26 stated she was not working with R1 on 5/30/20. V26 stated R1 is confused and prior to the fracture R1 would wander into other resident rooms. R1 would also ambulate in her room alone. V26 stated R1 needed everyone to keep an eye on her. On 9/2/2020 at 11:26 AM, V5 (Medical Director) stated the facility should be updating care plan interventions when residents sustain a fall. V5 added nothing is 100%, but prevention is the key. The best policy is to intervene before something happens. V5 also stated he is on the Quality Assurance Committee and does not recall the facility informing him of R1's falls. The policy for Falls reads: Treatment/Management 1). Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. 2). The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 4). If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current intervention.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow their policy for pain management. This failure led to R1 having a delay in treatment for [REDACTED]. This applies to 1 of 4 residents (R1) reviewed for accidents/injuries and pain management in a sample of 10. Findings include: The Face Sheet documents R1 is [AGE] years old

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

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and has [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 5/18/2020 documents R1 has cognitive impairment and requires extensive assistance from staff for ambulation and transfers. Speech pattern - rarely or never understood. The Care Plans show: R1 has impaired cognition and is unable to communicate her wants and needs. R1 relies on staff to anticipate her needs. The radiology report for R1 dated 6/1/2020 reads: Displaced left intertrochanteric fracture. R1 fell and sustained a [MEDICAL CONDITION] on 5/30/2020. R1 remained in the facility in pain for 2 days before being sent to the hospital. The Comprehensive Pain Assessments were reviewed to determine if the facility established baseline pain for R1. The EHR (Electronic Health Record) contained no comprehensive pain assessments for R1 prior to 5/30/2020 even though R1 fell 3 times in 01/2020 and 03/2020 with pain noted. On 8/28/2020 at 3:26 PM, V2 (Director of Nursing) checked R1's EHR for pain assessments. V2 stated, I do not see anything for years 2019 and 2020. V2 also stated the policy is to complete a Comprehensive Pain Assessment on admission, readmission, with every fall, new onset of pain and change in condition. The policy for pain management reads: The nursing staff will assess each individual for pain upon admission, at the quarterly review, whenever there's a significant change in condition and when there is onset of new pain or worsening of existing pain. On 9/2/2020 at 11:26 AM, V5 (Medical Director) stated comprehensive pain assessments need to be completed according to policy. The facility should have completed R1's comprehensive pain assessments. That is part of the treatment.
F 0777 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow physician's orders to obtain stat x-rays for a resident who fell and sustained a left [MEDICAL CONDITION]. This applies to 1 of 4 residents (R1) reviewed for accidents/injuries and pain management in a sample of 10. Findings include: The Face Sheet documents R1 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 5/18/2020 documents R1 has cognitive impairment and requires extensive assistance from staff for ambulation and transfers. Speech pattern - rarely or never understood. The Care Plans show: R1 has impaired cognition and is unable to communicate her wants and needs. R1 relies on staff to anticipate her needs. The radiology report for R1 dated 6/1/2020 reads: Displaced left intertrochanteric fracture. Nursing notes dated 5/30/2020 at 21:30 reads: Alerted by loud sound in hallway. This writer noted resident on the floor laying on the left side next to wheelchair. Resident does not use wheelchair. Upon assessment res was holding left leg with facial grimacing. Resident unable to verbalize rate of pain or state what happened. This writer tried to palpitate left leg, but resident would resist pushing my hand back. No apparent shortage in extremities was noted. No other apparent injury noted .Resident was placed in bed still expressing left leg pain. This writer notified MD (Medical Doctor), per MD to order STAT x-ray of the left hip and femur. The incident report dated 5/31/2020 reads: Confused. Occasional moan or groan. Low level of speech with negative quality. Facial expression - sad, frightened, frown. Body language - tensed. Mental status confused. No injuries observed. The nursing notes dated 5/31/2020 at 2:44 AM reads: Fall without apparent injury. X-ray ordered on PM shift as STAT to left hip due to non-verbal pain indicators . Review of the POS [REDACTED]. Medical record showed no X-ray being done. The nursing notes dated 6/1/2020 (2 days later) at 2:00 PM documents resident had a fall Saturday as noted on chart and is complaining of left leg pain while being changed. Resident unable to describe/determine severity of pain. STAT x-ray of the left hip and femur ordered on Saturday. Company was contacted today for ETA (Estimated Time of Arrival). The note also documents resident is lying in bed and no signs of pain/and discomfort but has facial grimacing upon movement. The physician was notified and gave orders to send R1 to the local emergency room . The hospital H&P (History and Physical) dated 6/1/2020 documents: Patient has left [MEDICAL CONDITION]. This occurred 2 days ago. The left leg shortened and externally rotated, moaning with movement. Severe dementia and cannot tell what happened. The H&P dated 6/2/2020 reads: This patient requires inpatient hospital services for medical treatment or medically required diagnostic studies. The reason the patient requires hospital services is because of left [MEDICAL CONDITION]. The surgical report dated 6/2/2020 shows R1 had ORIF (Open Reduction and Internal Fixation) of displaced left intertrochanteric fracture. On 8/27/2020 at 11:30 AM, R1 was asleep in bed. At 1:00 PM, V22 (Certified Nursing Assistant/CNA) was at the bedside feeding R1 lunch. R1 did not speak when spoken to. V22 stated R1 is non-verbal. On 8/27/2020 at 12:15 PM, V21 (Nurse) stated R1 is confused and does not speak at all. V21 stated on 5/30/20 when she noticed R1 on the floor she called the physician who ordered an X-ray. When asked when the X-Ray was completed, V21 stated when she came to work on Monday (6/1/2020) and noticed the X-ray wasn't done she called the physician. However, V21 stated she worked Sunday (5/31/2020) as well. When asked the policy for STAT orders, V21 replied they must be done within 4 hours. On 8/27/2020 at 12:51 PM, V2 (Director of Nursing) confirmed R1's physician ordered STAT X-rays on 5/30/2020 which were not done. The X-ray company did not show up according to V2. V2 stated on Monday R1 was still in pain. V2 also stated the policy for STAT X-rays that are not completed within 4 hours is to follow up, which the nursed did not do. V2 stated all nurses working with R1 received disciplinary action. The policy titled Medication and Treatment Orders reads: 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order. And must include prescribers last name, credentials, and date and time of order. The policy titled Verbal Orders reads: The order will always be based on verbal exchange with the prescribing practitioner or on approved written protocol. The policy titled Telephone Orders reads: 2. The entry must contain instructions from the physician, date, time, and the signature and title of the person transcribing the information. The policies did not provide instructions for implementing orders/STAT orders. On 9/2/2020 at 11:26 AM, V5 (Medical Director) stated he cannot speak on R1's surgery, as ortho is not his specialty. V5 stated he agrees not carrying out orders for X-ray causes delay in treatment. V5 stated when the physician orders an X-ray they are to be done STAT. X-rays should not be delayed. V5 also stated he is on the Quality Assurance committee and does not recall the facility informing him about this incident with R1.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to perform hand hygiene, wear gloves, and sanitize medical equipment while caring for residents on transmission-based precautions while under investigation for COVID 19. This applies to 4 of 6 residents (R5, R6, R7, R8) reviewed for infection control in a sample of 10. Findings include: On 8/26/2020 R5, R6 and R7 all resided on the unit designated as transmission-based precautions (TBP). The unit was separated from other units in the facility by a plastic barrier wall. The physician's orders [REDACTED]./23/2020 Covid Monitoring; Maintain Droplet/contact Isolation, FULL SET OF VITALS every 4 hours, COVID-19 Person Under Investigation or COVID-19 Positive On 8/26/2020 at 4:17 PM, V7 (Certified Nursing Assistant/CNA) went to R5's room to take her vital signs (VS). V7 used an automatic blood pressure machine (Sphygmomanometer) and [MEDICATION NAME] thermometer to take R5's blood pressure (B/P). V7 was wearing an isolation gown but no gloves. V7 then exited (R5's) room without performing hand hygiene and went to R6's room. While not wearing gloves, V7 adjusted items on R6's bedside table with her bare hands. V7 also placed the sphygmomanometer and thermometer on the table while writing on paper. V7 then took R6's blood pressure with the same machine. V7 did not sanitize the machine nor perform hand hygiene between residents. V7 exited R6's room without performing hand hygiene and went to R7's room. Once again, V7 did not sanitize machine or perform hand hygiene prior to taking the R7's vital signs. V7 did not don gloves or sanitize hands prior to providing care to R7. V7 then exited the isolation unit and proceeded to R8's room which is not considered TBP. V7 took R8's blood pressure with the same medical equipment she used on the isolation unit without sanitizing the equipment. The Care Plan for R6 reads: at risk for COVID-19 infection related to age and comorbidities. Interventions included: Meticulous hand hygiene before and after each encounter with resident and others. On 8/26/2020 at 4:33 PM, V7 stated the policy is to perform hand hygiene pre and post resident care. V7 stated she did not perform hand hygiene between residents because she just went to take vital signs and pick up trays. V7 stated she did not feel the need to wear gloves. V7 also stated she will sanitize the equipment when she is done with all her assigned residents. On 8/26/2020 at approximately 4:45 PM, V2 (Director of Nursing) stated R5-R7 are on the TBP unit for persons under investigation (PUI) for COVID 19 precautions. The residents are on contact and droplet precautions which require staff to wear gowns, gloves, mask and face shield prior to entering the rooms. V2 stated the facility's policy is to dispose of gown and gloves when exiting resident rooms. V2 added if employees touch any item in the room, they are to wear gloves. The policy is to remove gloves and perform hand hygiene prior to exiting the resident's room. V2 also stated every resident should have designated medical equipment. If shared equipment, then the policy is to disinfect the equipment between resident use. The policy titled Isolation Techniques reads: 6. PPE (Personal Protective Equipment) must be worn for touching infective equipment. 6.1 gloves and gowns must be worn by anyone who comes in contact with an infected

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) person. The policy titled Isolation reads: 6. When transmission-based precautions are in effect, non-critical resident care equipment items such as a stethoscope, sphygmomanometer, or digital thermometer, will be dedicated to a single resident (or cohort of residents) when possible. a. If reuse of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident. The policy titled Handwashing/Hand Hygiene reads: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap and water for the following situations: i. after contact with a resident's intake skin; k. after handling used dressings, contaminated equipment, etc l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; n. before and after entering isolation precaution settings; 8. Handwashing is the final step after removing and disposing of personal protective equipment.