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 _____	09/11/2020

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform a comprehensive nursing assessment and continued monitoring for a resident with symptoms of COVID-19 for 1 of 3 residents (R3) reviewed for infection control and change of condition in the sample of 10. Findings include: R3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's Minimum Data Set (MDS) assessment shows R3 had severely impaired cognitive skills. R3's nursing note dated 5/9/20 shows R3 had a temperature of 99.1 degrees Fahrenheit at 10:00 AM and a temperature of 100.2 degrees Fahrenheit at 12:45 PM. The notes show Endorsed accordingly for next shift nurse to monitor. The notes show no evidence of a comprehensive assessment being performed. No documentation showing assessment or monitoring from 5/10/20 through 5/12/20 were in the nurse progress notes. The nursing note dated 5/13/20 at 5:02 PM documents resident in bed, noted being lethargic but responds to stimuli. Resident noted breathing through her mouth. Resident is warm to touch. Vital signs: Blood pressure 148/91. Pulse rate 94. Respirations 22. Temperature 99.8 degrees Fahrenheit. Oxygen saturation 89% on room air. Resident was placed on two liters oxygen per nasal cannula and was given [MEDICATION NAME] 650 milligrams (mg) for her fever. Head of bed elevated. Resident was able to swallow the medications but noted coughing when swallowing the medications. Doctor was notified, waiting for a call back. Continue to monitor. At 6:08 PM, the nurse's notes document R3 remained lethargic but responds when called by name. The notes document R3 was fed for dinner, however, she was noted having difficulty swallowing and would start to cough .Still waiting for doctor's return call. The 7:30 PM nurse's note documents R3's doctor ordered for her to be sent to a local hospital for evaluation and treatment. R3 remained lethargic but responsive. The nursing note of 5/13/20 at 8:30 PM documents R3 was transported by ambulance to a local hospital. The 5/12/20 orders administration notes document on 5/12/20 R3 was given Tylenol 650 mg at 4:29 PM for a temperature of 99.8 degrees Fahrenheit and again at 9:52 PM. The orders administration note dated 5/13/20 at 4:45 PM documents R3 was given Tylenol 650 mg for a temperature of 99.8 degrees Fahrenheit. R3's electronic charting weights and vitals tab shows temperature documented one to five times daily from 4/29/20 through 5/9/20 (the first day she had a temperature of 100 degrees Fahrenheit). The temperature tab shows no documentation of R3's temperatures from 5/10/20 through 5/13/20 when she was sent to the hospital via ambulance. R3's progress notes show she was last seen by the facility's nurse practitioner on 4/9/20. R3 was admitted to the facility on [DATE]. Interim guidance for Covid-19 from the Illinois Department of Public Health updated 4/20/20 shows facilities should obtain vitals (temperature, heart rate, respirations and pulse oximetry) every eight hours. Blood pressure can be taken once a day. Symptom screening to be performed every shift (every eight hours) and should include questions about and/or observations of the following: fever, shortness of breath, cough, sore throat, chills or shaking with chills, muscle pains, headache or new loss of taste or smell. The guidance shows Contact Clinical Supervisor for any of the following: new-onset fever, SOB (shortness of breath), cough, sore throat or for any decrease (underlined) in pulse oximetry from resident baseline level or any pulse oximetry reading less than 92%. Providers should strongly consider transfer to a higher level of care. Monitoring every four hours is appropriate for patients with evidence of clinical deterioration. The facility's policy and procedure titled Coronavirus Disease (Covid-19) Infection Prevention and Control Measures revised April 2020 show fever is either measured temperature greater than or equal to 100 degrees Fahrenheit or subjective fever. The policy shows 4. Residents are screened daily for fever and symptoms of Covid-19. Residents with fever or symptoms of Covid-19 are provided a facemask, immediately isolated and placed on transmission-based precautions. The facility's policy and procedure titled Coronavirus Disease (Covid-19) Identification and Management of Ill Residents show 1. Strategies used for the rapid identification and management of Covid-19 infected residents include: a. Screening and monitoring for symptoms. The policy shows residents are monitored daily for signs of respiratory infection, including temperature screening by staff and self-reporting of symptoms by residents. The CDC (Centers for Disease Control) guidance titled Preparing for Covid-19 in Nursing Homes Infection Control for Nursing Homes updated 6/25/20 shows Evaluate and Manage Residents with Symptoms of Covid-19: Actively monitor all residents upon admission and at least daily for fever (temperature equal to or greater than 100 degrees Fahrenheit) and symptoms consistent with Covid-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with Covid-19, implement Transmission-Based Precautions . The facility's May 2020 schedule shows V17 (Registered Nurse/RN) worked second shift on 5/9/20 (the shift following R3's 100.2 degrees Fahrenheit temperature). The schedule shows V19 (MDS/RN) worked the third shift on 5/9/20 and V16 (Licensed Practical Nurse/LPN) worked the third (overnight) shift on 5/10/20. On 9/9/20 at 11:15 AM, V2 (Director of Nursing/DON) stated she does not see any documentation of R3 being monitored on 5/10/20, 5/11/20 and 5/12/20. V2 stated there is no documentation in the nurse progress notes until 5/13/20 at 5:02 PM. V2 stated she would expect staff to document in the residents' electronic charting if they were monitoring them, especially if there was an exception to the resident's normal status. V2 stated there is nothing in R3's chart documenting any monitoring. V2 stated the facility had just completed their first facility-wide testing and there were a lot of positive cases. V2 stated R3 had been negative for Covid-19 during that round of testing. V2 stated R3 developed a temperature. She would expect staff to do increased monitoring of R3 and for R3 to be identified as a person under investigation. V2 stated, It is important to monitor a resident for any changes from their baseline, so you know what actions to take. On 9/9/20 at 2:08 PM, V2 stated there is no documentation on R3's Treatment Administration Record of vitals. V2 stated she believes the guidance at that time was for residents to have vitals taken every shift. V2 stated a resident would be considered as having a temperature if it was 100 degrees Fahrenheit or two degrees above the resident's normal temperature. On 9/9/20 at 12:57 PM, V19 (RN) stated she was the nurse caring for R3 on third shift (overnight) on 5/9/20. V19 stated if she would have taken any vitals or did any extra monitoring, she would have documented it in R3's chart. V19 stated she does not remember anyone saying anything during the nurse to nurse shift report regarding any concerns with R3. V29 stated, It is important to monitor someone with a temperature. It could be an infection of some kind such as Covid-19, pneumonia or a urinary tract infection. On 9/10/20 at 9:25 AM, V16 (LPN) stated she worked the overnight shift on 5/10/20. V16 stated she does not remember if the nurse doing shift report with her stated anything about the need to monitor R3. V16 stated any assessment would be documented in R3's electronic charting. V16 stated any respiratory assessment would be documented in the nurse progress notes. V16 stated a resident with an increased temperature should have a respiratory assessment including lung sounds, an assessment for acute cough, diarrhea, GI (gastrointestinal) symptoms, among other symptoms performed because an increase in temperature is one of the symptoms for Covid-19. V16 stated the assessments would be documented in the nurse progress notes if they had been done. A call was placed to V17 (RN) with no return call. V17 no longer works at the facility. On 9/9/20 at 1:00 PM, V21 (Certified Nursing Assistant/CNA) stated she worked with R3 on 5/11/20. V21 stated R3 was only on the first floor for about a week before she was sent out to the hospital. V21 stated no one stated anything to her about R3 needing increased monitoring. V21 stated

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess and treat multiple pressure injuries. This applies to 3 of 3 residents (R5, R8, R9) reviewed for pressure injuries in the sample of 10. Findings include: 1. R5's Face Sheet showed an original admission date of [DATE] and a discharge date of [DATE] with [DIAGNOSES REDACTED]. R5 was discharged from a local area hospital to the facility on [DATE]. R5's Discharge Instructions from the hospital showed, Unstageable wound to coccyx - cleanse with saline, apply ([MEDICATION NAME] ointment) (ointment that removes dead tissue to allow wound healing) and cover with (foam dressing). R5's May 2020 Treatment Administration Record (TAR) showed an order to cleanse the coccyx wound with normal saline, apply [MEDICATION NAME] ointment, then apply foam dressing. The TAR showed a start date of 5/9/2020 and a discontinue date of 5/13/2020. R5's treatment was not documented as being done on 5/11/2020, 5/12/2020, and 5/13/2020. On 9/9/2020 at 9:45 AM, V3 (Assistant Director of Nursing/Wound Care Nurse) stated if the wound care treatments had been done, they should have been documented. V3 stated treatments are important for the healing process and not doing them can delay that process. V3 stated there was not assessment done of the sacral wound until 5/15/2020 (7 days after readmission). V3 stated an assessment of the new sacral wound should have been done upon readmission. V3 stated assessments were important because it directs care and treatment orders as well as used for tracking wound progression or decline. Documentation of the sacral wound assessment being done on 5/8/2020 and treatment for 5/11/2020 thru 5/13/2020 was requested and not provided. The Facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol policy revised 2018 showed the nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic (dead) tissue . The Facility's Pressure Ulcers/Injuries Overview revised July 2017 showed, the following information should be recorded in the resident's medical record .The type of assessments conducted .The dated and time and type of skin care provided .name and title of the individual who conducted the assessment . The Facility's Charting and Documentation policy revised July 2017 showed, The following information is to be documented in the resident medical record .Treatments or services performed .changes in resident's condition . 2. R8's Face Sheet showed a current admission date of [DATE] with [DIAGNOSES REDACTED]. R8's 7/3/2020 Initial Wound Evaluation and Management Summary showed a 6 centimeter by 11 centimeter (approximately 2.25 inches by 4.25 inches) unstageable pressure injury to the left heel with intact skin and a second unstageable pressure injury to the medial left foot with intact skin measuring 2 centimeter by 2 centimeter. The evaluation showed an order for [REDACTED].) R8's Physician order [REDACTED]. R8's July 2020 Treatment Administration Record (TAR) showed no left foot treatments starting on 7/3/2020. The TAR does not show a [MEDICATION NAME] treatment starting until 7/10/2020. On 9/2/2020 at 9:45 AM at V3 stated she could not find documentation prior to the 7/3/2020 wound care physician note, when these wounds were first found, by whom, when, or if initial treatment was started. V3 stated she could not find documentation that the [MEDICATION NAME] treatment was started on 7/3/2020. 3. R9's Face Sheet showed an original admission date of [DATE] with [DIAGNOSES REDACTED]. R9's June 2020 TAR documented on the weekly skin check a new skin breakdown on 6/28/2020. R9's Electronic Health Record showed no documentation of a wound on 6/28/2020. R9's Nursing Note from 6/29/2020 at 3:48 AM, showed noted right heel with tx (treatment) and (heal protection) boots. The note does not show an assessment of the wound size, wound bed, drainage, or stage of pressure injury. R9's Nursing Note from 6/30/2020 at 11:40 AM showed an assessment of the wound (approximately 2 days after identification).