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 02/08/2021

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

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S 000	Initial Comments Complaint Investigation 2170670/IL130611	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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S9999	Continued From page 2 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 investigate falls, reassess residents who have fallen and determine a root cause, revise care plan interventions, and implement interventions for residents with histories of falls. These failures resulted in R1 experiencing excruciating pain and a right periprosthetic femur fracture after a fall. This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 3. Findings include: 1. Face sheet, dated 2/3/21, shows R1's diagnoses include history of falling, displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, displaced spiral fracture of shaft of right femur, dementia without behavioral disturbance, anxiety disorder, insomnia, muscle weakness, other abnormalities of gait and mobility, weakness, delusional disorders, and cognitive communication deficit. MDS (Minimum Data Set), dated 1/27/21, shows R1's cognition was severely impaired. Fall care plan, initiated 9/20/19, shows R1 was at risk for falls related to diagnoses of dementia, muscle weakness, heart failure, poor balance, unsteady gait, impulsive behavior, and R1's	S9999		

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S9999	Continued From page 3 required assistance with transfers and ambulation post fracture. Fall Monitoring Log, dated 12/2020 and 1/2021, show R1 fell at the facility on 12/14/20 (sustaining a right hip fracture), 1/6/21, 1/8/21 (sustaining a skin tear), and 1/15/21 (sustaining a right leg fracture). R1's clinical record failed to show any fall investigations, root cause analyses, or any new fall interventions implemented to attempt to prevent further falls after R1's 1/6/21 and 1/8/21 falls. Incident Note, dated 1/15/21 at 10:30 PM, shows, "At 9:20 PM a loud noise was heard in patient's room, and the staffs ran down and patient was noticed laying on the floor with head against the door and laying on his right side with legs stretched out, with his upper body pinched between the bathroom door and the room door. Upon assessment he was in excruciating pains...." On 2/3/21 at 1:25 PM, V2 (Director of Nursing) stated during 1/15/21 fall she heard a loud noise and she and the staff found him on the floor caught between two doors. When R1 was assessed, R1 was expressing facial grimacing. V2 stated R1 had non-skid socks on and there were 2 floor mats in place. Nursing note, dated 1/16/21, shows the local hospital emergency department informed the facility that R1 had a right femoral spiral fracture and R1 was being transferred to another hospital for further plan of care. Hospital physician note, dated 1/16/21, shows R1	S9999		

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S9999	Continued From page 4 was transferred to the hospital after an unwitnessed fall at the facility causing a subsequent right periprosthetic femur fracture. The note shows R1 also experienced an unwitnessed fall in December 2020 resulting in a right intertrochanteric fracture requiring an open reduction internal fixation surgery. On 2/4/21 at 2:20 PM, V7 (Physician) stated the fractures R1 acquired on 12/14/20 and 1/15/21 were the result of R1's falling and not of any confounding health variables. V7 stated he expected the facility to follow best practices and, in every case, conduct a fall investigation, perform a root cause analysis, and implement new interventions to attempt to prevent future falls for a resident. On 2/3/21 at 1:30 PM, V2 (Director of Nursing) provided R1's care plan which showed no implementation dates for any of the fall interventions. On 2/3/21 at 8:19 PM, V1 (Administrator) provided an updated care plan for R1. The updated care plan shows two fall care plan interventions, both originally initiated on R1's electronic medical record care plan and implemented for R1 on 11/27/19, were rewritten as shown: "Anticipate and meet the residents needs as needed - 1/6/21;" and "Ensure the resident's call light is within reach and encourage the resident to ask for assistance as needed - 1/8/21." Facility Accidents and Incidents document, effective/revised 8/29/20, shows, "Care Plan review...: b. The safety committee will review the incident report and preliminary investigation and implement new intervention(s) based on the	S9999		

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environmental and/or resident conditions which may be the root cause of the accident, along with staff interview and MD (Physician) recommendation. C. If a fall or fall event continues despite new interventions, analysis will be performed to determine the appropriateness of the current interventions and implement new interventions or provide rationale as to why the current plan remains relevant. The MD should be part of this process. D. Ensure any new interventions have been entered on the resident's plan of care."

2. Nursing note, dated 1/20/21, shows R1 was readmitted to the facility with an admitting diagnosis of post-op right open reduction internal fixation femur fracture, hardware removal for femoral periprosthetic fracture, and plate fixation that took place on 01/17/2021. R1's weight bearing status was non-weight bearing to his right lower extremity and R1 had an incision site along his lateral right thigh with 71 staples.

Serious Injury Incident report, dated 1/20/21, shows R1's care plan was updated to include the following fall interventions: 1. Resident on 1:1 staff close monitoring, 2. Floor mat placed on both sides of the bed as a landing mat..."

Fall care plan intervention, provided 2/3/21 at 8:19 PM, shows the care plan was updated on 2/3/21 to include R1's intervention of floor mats to be placed on both sides of his bed and R1 to receive 1:1 monitoring by staff. However, witness statements, dated 1/8/21 and 1/15/21, shows R1 had the floor mat intervention previously initiated and in place at the time of his 1/8/21 and 1/15/21 fall and prior to his care plan being updated on 2/3/21.

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S9999	Continued From page 6 On 2/3/21 at 11:24 AM, R1 was lying in his bed with one floor mat on the floor on the left side of his bed. There was no floor mat on the right side of R1's bed. R1 was wearing a white and gray sock on his left foot with no visible non-skid material on the bottom. V6 (Certified Nursing Assistant/CNA) was sitting in a chair in R1's doorway with her back facing R1 typing on a computer placed on a table in front of her. V6 stated she was providing 1:1 observation of R1 due to his recent fall. When asked why R1 only had one floor mat beside his bed, V6 walked to R1's bed, looked under the bed, and pulled out a rolled up floor mat which was tucked under R1's bed. V6 unrolled the floor mat and placed the floor mat on the floor to the right of R1's bed. V6 stated the mat should have been in place on the floor to right side of R1's bed. V6 examined R1's sock and stated the sock was not a non-skid sock. V6 pulled back R1's cover over his right foot and R1 was wearing a plastic boot on his right foot. On 2/3/21 at 2:00 PM, V1 and V2 stated R1 should have had a total of two floor mats in place - one on each side of R1's bed. V1 and V2 stated fall mat interventions include a fall mat placed on the right and left side of a resident's bed unless otherwise specified in a resident plan of care. V1 and V2 could not think of any residents in the facility who required only one fall mat in place. (A)	S9999		