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 01/24/2014

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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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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 resident to meet the total nursing and personal	S9999		

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 are not met as evidenced by:

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S9999	Continued From page 2 Based on observations, interviews, and record reviews the facility failed to transfer one resident according to policy and procedures (R29) and failed to provide specific safety measures for a confused resident with numerous falls (R13) from a total of 10 residents reviewed for falls from a total sample of 29. As a result of these failures, R29 was transferred improperly and sustained a fracture of the right humerus. The Findings Includes: 1. Review of the closed record of R29 documented that the resident had a diagnosis of Dementia and Osteoporosis. The resident's nurses notes dated 1/14/14 documented that staff had noted swelling on the right shoulder and arm, xrays being done and showing a fracture and her subsequent transfer to the hospital. The radiology report dated 1-14-14 documents under findings, "There is a surgical neck fracture of the right proximal humerus." On 1/16/2014 at 10:15 AM E2 (Director of Nurses) stated during interview that the facility investigation had indicated that R29 had been inappropriately transferred by staff. E2 also added that staff did not use a gait belt when they transferred R29. E2 stated that she had interviewed the two staff persons involved and they demonstrated how they transferred R29 by holding the resident on the right arm and in the axilla area. Both E6 (Certified Nursing Assistant/CNA) and E8 (CNA) admitted to E2 that they had not used a gait belt during transfer of R29. E2 stated that E6 and E8 placed R29 into bed and R29 didn't complain of pain. E2 continued on to say that the CNA on 11 PM to	S9999		

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7 PM shift (E9-CNA Certified Nurse Aid) noticed R29's arm was swollen while giving morning care and reported it to the nurse who assessed the resident, notified the physician, and obtained orders for x rays of the area. The results of the report were a fracture of the right humerus. R29 was then discharged to the hospital for treatment.
On 1/16/2014 at 1:10 PM E9 stated during interview that she had cared for R29 and was the person who found the right arm to be swollen when she was getting the resident up for the day. E9 stated that staff are instructed to use gait belts to help residents transfer and are randomly monitored to make sure they follow the policy.
R29's care plan dated 12-11-13 documents under Problem, "requires extensive assistance with 2 staff at all times...she is noted with shakiness upon transferring." and under interventions, "Use a gait belt during all transfers." R29's MDS (Minimum Data Set) Assessment dated 12-6-13 codes R29 as needing extensive 2 person assistance for transfers.
The facility policy: Transfers Using Gait Belt (One or Two-Person Assist), on step 7 clearly instructs staff ... " (DO NOT hold under the arms) " .

2. R13's Admission Face Sheet showed she is a 89 year old female with diagnosis including Dementia with Behavior Disturbance, Severe Osteoporosis and History of Right Hip Fracture.

The facility's Incident Report showed R13 fell on the following days:
12/14/13 at 9:30 AM, 12/07/13 at 10:45 AM, 10/17/13 at 4:30 AM, 8/09/13 at 12 AM, 7/31/13 at 3 AM, 6/16/13 at 2 PM, 5/05/13 at 9 PM and 5/25/13 at 3:45 AM.

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R13's care plan showed multiple fall occurrence was a focus of concern in her care. R13's care plan showed no nursing interventions/approaches to supervise or prevent R13 from falling. The approaches implemented focused on re-educating and reminders for R13 to call and wait for staff. R13 has Dementia and may not remember to follow safety instructions. R13's care plan showed chair and bed alarms were applied on 5/5/13 and 5/20/13, but R13 continued to have fall occurrences.

The facility's Fall Policy, not dated, showed: While preventing all unusually occurrence is not possible, it is this facility's policy to act in a practical manner to identify and assess those residents at risk for incidents and accidents, plan for preventable strategies..."

R13's CNA (certified nurses aide/E3) was interviewed on 1/23/14 at 12:15 PM. E3 said that R13 had periods of confusion, and R13 forgets. E3 stated, R13 can tell me when she needs to go to the bathroom but R13 tries to go to the bathroom by herself, or leave her room.

R13's nurse (E4) was interviewed on 1/22/14 at 12 PM. E4 stated R13 is confused and at risk for falls. E4 said that R13 was not compliant with asking for help before transferring herself.

The director of nursing (E2) was interviewed on 1/23/14 at 2:30 PM. E2 said she investigated all of R13's falls (listed above). E2 said she made changes to R13's care plan after each fall occurrence. E2 stated she re-educated R13, reminder R13 not to get up unassisted, and put alarms on her. E2 could not explain how the alarms prevented R13 from falling when she was

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S9999	Continued From page 5 already out of the chair when they sounded, and had not been effective in the past. E2 did not identify any other specific staff interventions/monitoring to prevent R13 from falling. (B)	S9999		