

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/05/2024
NAME OF PROVIDER OR SUPPLIER  Tower Hill Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34410</p> <p>Based on interview and record review, the facility failed to have physician document the necessity of immediate transfer. This applies to 1 of 5 residents (R4) reviewed for transfer/discharge in a sample of 5.</p> <p>The Findings Include:</p> <p>R4 was a [AGE] year-old male admitted on [DATE], with an admitting diagnosis, including dementia, anxiety, mental disorder, depression, and Alzheimer's.</p> <p>A record review of the clinical progress note, dated 3/14/24, documents R4 was involuntarily discharged to the hospital due to aggressive behavior towards another resident.</p> <p>A record review of the clinical documentation indicates there is no evidence of any physician documentation to reflect the necessity of the transfer on 3/13/24.</p> <p>On 4/5/24 at 12:10 PM, V17 (Nurse Practitioner/Attending) stated, The Psychiatrist is supposed to document the necessity of the immediate transfer.</p> <p>On 4/5/24 at 1:10 PM, V18 (Psychiatrist) stated, When (R4) was immediately transferred to the hospital on 3/14/24, I was unaware of the documentation I should have documented in the system reflecting the necessity of the immediate transfer.</p>

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.

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