

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 12/12/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327</p> <p>Based on interview and record review, the facility failed to safely transfer a resident through a mechanical lift from her wheelchair to her bed. This resulted in R1 having a fall. This applies to 1 of 3 residents (R1) reviewed for transfers in a sample of 6.</p> <p>The findings include:</p> <p>On 12/10/24 at 11:15 AM, V2 (DON-Director of Nursing) stated, (R1) is no longer here. She was discharged AMA (Against Medical Advice). She was a 2 person assist with a (mechanical lift). She came to us on 11/4/24. On 11/11/24, (R1) was getting transferred from her wheelchair to the bed after dialysis in her room with the mechanical lift. (V4--Former CNA/Certified Nursing Assistant) and (V3) were the CNA's that were transferring her. (V3) no longer works here. (R1) was moving around in the sling while they were transferring her. She wouldn't stop. She slid off the sling and fell to the floor. She had no injuries. (R1) was sent to the hospital. X-rays were done and everything was normal. Falls are not supposed to happen when you transfer a resident using the (mechanical lift).</p> <p>On 12/10/24 at 11:55 AM, V3 (CNA) stated, On 11/11/24, (V4) was the assigned CNA for (R1). (V4) came to get me to help her transfer (R1) from her wheelchair to her bed with a (mechanical lift). (R1) can roll and move side to side very well. She doesn't walk. Her butt and her side were sore because she had a pressure sore. She was complaining of pain. (V4) was pulling and maneuvering the (mechanical lift), while I was guiding (R1)'s legs. She was moving around too much. I told her to stop moving around. She kept saying her leg was sore and she was having a lot of pain from her buttocks to her leg. We adjusted the sling. All 4 hooks were on there. Unfortunately, she just tipped out. The lift was not malfunctioning. We got V11 (LPN-Licensed Practical Nurse) who was (R1)'s nurse that day to come assess her. She had no injuries. 911 was called and she was sent to the hospital.</p> <p>On 12/11/24 at 11:58 AM, telephone interview was done with V11 (LPN). V11 stated, Another CNA who was in passing called me and told that (R1) fell from the (mechanical lift). I went there and (R1) was on the floor. (V3) and (V4) were next to her. She had a huge wound in her body. She was wiggling and it probably hurt her while she was in the sling. She was already in a high position in the air, so I don't think it was a good idea for the CNA's to stop. She just fell out of the sling. We didn't expect this to happen. There were no injuries. But, because she hit her head, we sent her out to the hospital. Everything, all the tests was normal at the hospital.</p> <p>(continued on next page)</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's fall incident report dated 11/11/24 shows: During the transfer after dialysis, while in the air, hanging on the sling (Mechanical lift transfer), (R1) moved and slid from the sling down on the floor, hitting her head during the process. She stated that her wound was hurting, so she moved to release the pressure. Complete body assessment done. (R1) was having pain of the head. No lump/bump noted, but she did not hit the head. Pain during the movement of the lower extremities. She is on a blood thinner. MD (Medical doctor) notified with the order to send her to the ER (emergency room) via 911. 911 called, all in house parties notified. Daughter (POA/Power of Attorney) called multiple times. Message left to call us back because there was no answer. She stated that her wound was hurting, so she moved to release the pressure. Complete body assessment done. (R1) was having the pain of the head. No lump/bump noted, but she did hit the head. Pain during the movement of the lower extremities. She is on a blood thinner. MD notified with the order to send her to ER via 911. Patient was endorsed to 911 crew and was taken to the hospital.</p> <p>R1's progress note dated 11/11/24 at 9:05 PM shows: (R1) returned from the dialysis and during the transfer with mechanical lift and 2 person assist, (R1) was moving and slid out of the mechanical lift to the floor, hitting head in the process. Also complains of pain in her right hip. MD called with an order to send out via 911 for evaluation and treat. She went out to ER, returned with no new orders. No fractures. CT (Computerized Tomography) of the head done. Daughter/POA called. Message left to call us back because she did not pick up multiple calls.</p> <p>R1's progress note dated 11/18/24 shows she was discharged AMA (Against Medical Advice) with her two daughters.</p> <p>R1's fall risk screen dated 11/11/24 categorized R1 as a high risk for falls. R1 was unable to independently come to a standing position and has a decrease in muscle coordination.</p> <p>R1's face sheet shows an admitted [DATE].</p> <p>R1's face shows diagnoses of cerebral infarction, cognitive communication deficit, other lack of coordination, muscle weakness (generalized), other reduced mobility, pressure ulcer of right buttock, stage 4, pressure ulcer of right buttock, unstageable, pressure ulcer of sacral region, pain in right leg, weakness, muscle spasm of back, disease of spinal cord, unspecified, paraplegia and spina bifida.</p> <p>R1's MDS (Minimum Data Set) shows 11/11/24 shows a BIMS (Brief Interview for Mental Status) score of 12, which means her cognition was moderately impaired. Section GG-Functional Abilities shows a score of 1: E. Chair/bed to chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). This means (R1) was dependent meaning the helper does all of the effort. (R1) does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>R1's care plan dated 11/5/24 shows Focus: Potential for falls. Resident at risk for injury from falls. Goal: The facility will reduce the likelihood of (R1) experiencing a fall through next review. Interventions: Remind resident before transfers to not move while in mechanical lift sling. Educate the resident about safety. Get to know resident's habits to anticipate resident's needs. Encourage resident to transfer and change positions slowly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy titled Transfers Using a Lift (7/2017) shows: Policy: Nursing staff will be able to operate a mechanical lift for transferring a guest, if necessary. Goal: 1. Transfer guest safely and comfortably with a hydraulic lift.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>31327</p> <p>Based on observation, interview, and record review, the facility failed to follow current standards of infection control during a pressure dressing change. This applies to 2 of 2 residents (R6, R7) reviewed for infection control in a sample of 7.</p> <p>The findings include:</p> <p>1. On 12/10/24 at 2:01 PM, surveyor went with V9 (Wound Nurse/LPN-Licensed Practical Nurse) to R6's room. On R6's door, there was sign that said Contact Isolation/Precautions. V9 stated R6 had C-Diff (Clostridioides Difficile).</p> <p>On 12/10/24 at 2:08 PM, V9 washed her hands with soap and water. She put on gloves. V9 removed R6's heel boots, socks and pressure ulcer dressing. She then removed her gloves and used hand sanitizer to sanitize her hands. She put on gloves and then cleansed the wound with normal saline and gauze. V9 removed her gloves and washed her hands with soap and water. V9 put on gloves and applied medi-honey and a foam dressing with border onto R6's wound. Then she put R6's socks and heel boots on. V9 removed her gloves and washed her hands with soap and water while wearing her dirty gown. With her washed hands, she touched and removed her dirty gown. She then sanitized her hands with the hand sanitizer and left the room. V9 did not wash her hands with soap and water before leaving the room.</p> <p>On 12/10/24 at 2:52 PM, V2 (DON-Director of Nursing) stated, C-diff is contact precautions. (V9) should have washed her hands instead of using sanitizer when she removed (R6)'s dressing. She also should have washed her hands with soap and water instead of using hand sanitizer when she removed the dirty gown because only soap and water kills the C diff spores.</p> <p>R6's face sheet shows diagnoses of pressure ulcer of right heel, stage 3 and elevated white blood cell count, unspecified.</p> <p>R6's MDS (Minimum Data Set) dated 11/22/24 shows he has a BIMS (Brief Interview for Mental Status) score of 8 which means he is moderately impaired in cognition.</p> <p>R6's POS (Physician Order Sheet) shows the following orders: Cleanse right heel with normal saline. And medi-honey and dressing every day shift every Monday, Wednesday, and Friday. Contact isolation related to Cdiff Positive. All care needs provided in the room one time only until 12/18/24.</p> <p>V9's wound note dated 12/6/24 shows R6 has a stage 3 pressure sore to right heel that measure 2.00 x 1.50 x 0.00 CM (Centimeters) (Length x Width x Depth).</p> <p>Nursing note dated 12/5/24 shows R6 was diagnosed with C. Difficile and started on an antibiotic. R6 presented to the emergency room with a complaint of 4 to 6 weeks of diarrhea, weakness, and fever.</p> <p>R6's care plan (12/4/24) shows: Focus-(R6) has C. Difficile and has been started on Firvanq Oral Solution Reconstituted 25 MG/ML (Milligrams/Milliliters), 5 ML by mouth four times a day for C diff for 14 days. Intervention: Educate resident/family/staff regarding preventive measures to contain the infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's Multi-drug-Resistant Organism Isolation Guidelines for Long Term Care Facilities (Undated) shows C.difficile-infection is in stool and contact is the type of isolation. It's treated with antibiotics until diarrhea resolves. Comments: Hand hygiene with soap and water and clean surfaces and equipment.</p> <p>2. On 12/10/24 at 2:15 PM, surveyor, V9, and V10 (LPN) went to R7s room. There was no enhanced barrier precaution sign posted outside of R7's room.</p> <p>V9 did a pressure dressing change on R7's left hip and right heel with the assistance of V10 who helped move R7 and reposition her. Both V9 and V10 did not wear a gown.</p> <p>On 12/10/24 at 2:48 PM, V2 stated she was under the impression that enhanced barrier precautions are utilized only when the wound was weeping during wound care. She stated that R7's wound was not weeping. She said that's why no signs were put up.</p> <p>R7's POS shows no order for enhanced barrier precautions. It shows orders of: Apply Betadine to right heel Monday, Wednesday and Friday and PRN (As Needed). Cleanse left hip with normal saline. Apply medi-honey and dressing Monday, Wednesday, and Friday and PRN.</p> <p>R7's does not have any care plans regarding enhanced barrier precautions.</p> <p>Facility's guidelines on Enhanced Barrier Precautions (Undated) shows .the use of gown and gloves is required during high resident care activities with an MDRO (Multi Drug Resistant Organism) such as wound care.</p>