STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	145795		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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	Certification and Licence Survey Complaint # 1470165/IL67535 : F323 Validation Survey for Subpart U Alzheimer Unit The facility is in compliance with Subpart U, 77 Illinois Administrative Code Section 300.7000.			
F 244 SS=B	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to act upon the resident's concerns. This applies to one of five residents (R19) reviewed for concern resolution in the sample of 29 and four residents (R35, R36, R37, and R38) in the supplemental sample . The Findings include: During the group interview on 01/22/2014 between 10:05am and 11:10am, R36 and R19 reported that they have asked E19 (Activity Director) for soup spoons at last four resident council meetings. They stated that E19 told them that she would let dietary manager know about	F 244		

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 244	Continued From page 1 their concern. R35, R37, and R38 all concurred that the residents would like soup spoons but the facility never gives them any. R36 also stated that they have asked E19 (Activity Director) for coffee pots to be left on the tables longer during meal times. R19, R35, R37, and R38 all concurred that the coffee is taken away from tables by dietary staff before some residents even have any and they don't ask residents if they want more coffee before taking carafe. R19, R35, and R36 said that the another concern they had was that the banker should be in the First Floor Main Dining Room on Mondays and Thursdays at 3:00pm. They said that the banker hasn't been in there and they had to go downstairs to office during that time to find her. Review of monthly Resident Council Meeting Minutes from prior annual survey March 2013 to January 2014 shows no concerns/issues. On 01/22/2014 at 11:43am observed notice on announcement board outside of First Floor Main Dining Room indicating "Banking will be held on Monday and Thursday at 3:00pm in the Main Dining Room unless otherwise announced." On 01/22/2014 at 1:12pm E2 (DON) said that E19 (Activity Director) handles complaints and grievances, will notify the appropriate departments, and keeps records of complaints. On 01/22/2014 at 4:50pm Main Dining Room tables were set for dinner. No soup spoons noted on tables with other cutlery. Soup was listed on menu for dinner each night from 01/20/2014	F 244		

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F 244	Continued From page 2 through 01/24/2014. On 01/23/2014 at 12:40pm E20 (Food Service Director) said that she was notified by E19 (Activity Director) beginning of this month that residents requested soup spoons. On 01/23/2014 at 1:30pm E21 Business Manager) explained that banking had changed from dining room to business office for resident privacy about one month ago. She said that she makes an overhead announcement on Mondays and Thursdays at 3:00pm to notify residents that banking is available in the business office.	F 244		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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.	F 323		

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F 323	Continued From page 3 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 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	F 323		

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F 323	Continued From page 4 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) " .	F 323		
	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. 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			

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F 323	Continued From page 5 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 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.	F 323		

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F 328	Continued From page 6	F 328		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide oxygen therapy as ordered by the physicians. The facility also failed to follow their policy for labeling gastric tube feeding container. This applies to two of three residents (R30,R31) reviewed for oxygen therapy, breathing treatment, and two of three residents (R11, R32) reviewed for gastric tube feeding in the sample of 29 and three residents (R30, R31, R32) in the supplemental sample. Findings include: 1. According to Physician Order Sheet dated January 2014, R30 has diagnoses including Asthma with orders for continuous oxygen at 3 liters per minute per nasal cannula. On 01/23/2014 at 1:05pm R30 told E15 (Certified	F 328		

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F 328	Continued From page 7 Nurse's Aide, CNA) that she was having trouble breathing. R30 was wearing nasal cannula connected to portable oxygen tank. Oxygen regulator indicates tank full with oxygen valve set to 2 liters per minute. Open/Closed valve set at closed. E15 (CNA) got E16(Registered Nurse, RN). E16 (RN) replaced oxygen tank with new tank,oxygen regulator indicates full with oxygen flow valve set to 3 liters per minute. Open/Closed valve set at closed. At 1:08p E16 (RN) said R30's lungs sounded clear with some wheezing and had slight neck muscle retractions during inspiration. R30's pulse oximeter reading indicated oxygen saturation of 89%. E16 (RN) brought R30 to her room by wheelchair at 1:12pm, connected oxygen tubing from portable tank to oxygen concentrator with flow set at 2 liters per minute and started Albuterol nebulizer treatment. E16 (RN) said that she had placed R30 on portable oxygen tank around 12pm. She said that these are new oxygen tanks and she had not been inserviced on using them. E16 (RN) said that only way she knew to tell if oxygen was coming out of nasal cannula was by feel of air against hand. She demonstrated turning oxygen flow valve on but no air was coming from oxygen valve on portable tank. Open/Closed valve remained closed and E16 (RN) said she did not know why oxygen wasn't coming out. After looking at tank for several minutes, she stated that maybe Open/Closed valve needs to be turned to indicate Open. 2. According to Physician Order Sheet dated January 2014, R31 has diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, and bronchitis with order for continuous oxygen at 3 liters per minute	F 328		

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F 328	Continued From page 8 per nasal cannula. On 01/23/2014 at 1:40pm, R31 was observed sitting in wheelchair near nurse's station with oxygen nasal cannula on and connected to the portable oxygen tank. Regulator indicated tank was full and oxygen flow set at 2 liters per minute. Open/Closed valve set at closed. E17 (Licensed Practical Nurse, LPN) said R31 was placed on new oxygen tank about fifteen minutes prior to observation because old oxygen tank was low on oxygen. R31's pulse oximeter reading indicated oxygen saturation of 69%. E17 (LPN) said she would take R31 back to her room and would give the albuterol treatment. At 1:47pm E17 (LPN) connected R31's oxygen tubing from portable tank to oxygen concentrator with flow set at 4 liters per minute and started Albuterol nebulizer treatment. E17 (LPN) stated that rate of oxygen should be set to keep R31's oxygen saturation levels above 90%. E17 (LPN) said that only way she knew to tell if oxygen was coming out of nasal cannula was by feel of air against hand. She demonstrated turning oxygen flow valve on but no air was coming from oxygen valve on portable tank. Open/Closed valve remained closed. E17 (LPN) placed nasal cannula prongs into cup of water with no bubbles coming out. The Oxygen Cylinders in Nursing Homes-Safety Rules policy received from E2(Director of Nursing, DON) on 01/23/2013 at 2:00pm, states to "Fully open the cylinder valve when the cylinder is in use." E2(DON) stated that E17 (LPN) did receive inservice on new tanks but E16 (RN) did not.	F 328		

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F 328	Continued From page 9 3. According to Physician's Order Sheet dated 01/07/2014, R11 has diagnoses including Diabetes Mellitus, Hyperlipidemia, and Vitamin D deficiency with order for gastrostomy tube feeding of Jevity 1.5 calorie at 56 cc per hour for fifteen hours from 4:00pm to 7:00am. On 01/22/2014 at 4:20pm, R11 was observed sleeping in her bed with Jevity 1.5 calorie infusing through the gastrostomy tube at 56millileters per hour. Total volume delivered according to the pump was 4 milliliters. Feeding and tubing was not labeled with resident's name, date and time the feeding was started. 4. According to Physician's Order Sheet dated January 2014, R32 has diagnoses including Diabetes Mellitus, Hyperlipidemia, Hypokalemia, Hypercalcemia, and Gastroesophageal Reflux Disease with order for Jevity 1.5 calorie at 65 cc per hour for thirteen hours from 4:00pm to 5:00am. On 01/22/2014 at 4:20pm, R32 was observed awake in her bed with Jevity 1.5 calorie infusing through gastrostomy tube at 65millileters per hour. Total volume delivered according to the pump was 14 milliliters. Feeding and tubing was not labeled with resident's name, date and time the feeding was started. On 01/22/2014 at 4:23pm E18 (Registered Nurse, RN) said she started R11's and R32's feeding at 4:00pm. She also said that she was unsure if the feeding container needed to be labeled with resident's names, date or time started. Facilities Gastric Tube Feeding policy shows that	F 328		

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F 328	Continued From page 10 tubing spike sets will be replaced every 24hours and must be labeled with resident's name and date.	F 328		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to service dairy food items at appropriate temperatures, which would conserve the taste and nutritional value of the food. This applies to two residents (R17 and R42) in the supplemental sample, who are outside of the sample of 29 residents. This also has the potential to effect the 4 other residents (R43, R44, R45 and R46) being served dairy food items in the first floor dinning room. Findings include: A Group meeting with alert and oriented residents was conducted on 1/22/14 at 10 AM. R36 (One of the five residents present in the group.)complained that food items were served to her which did not taste good. R36 stated the food taste was poor because the food item was not at the right temperature. On 1/22/14 during the noon meal, four cups of	F 364		

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F 364	Continued From page 11 yogurt and one cup of cottage cheese were a chart near the stream table. The cups of yogurt and cottages cheese were not on ice or being kept cool. The dietary supervisor was present and she was asked to check the temperature of the food items. The two cups of yogurt and cottage cheese were both 50 degrees Fairheit. E5 said that cottage cheese and yogurt were being served to specific residents who may need nutritional supplements. E5 stated that the yogurt and cottage cheese should be maintain at 41 degree or below. E5 said residents will not be served the yogurt and cottage cheese. However, the certified nurses aides serving the noon meal gave R42 the warm cups of cottage cheese and one cup of yogurt to R17. The dietary list of residents, from E5, showed R43, R44, R45 and R46 were to be served yogurt during the noon meals.	F 364		