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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145795	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tower Hill Healthcare Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35267 Based on interviews and record reviews, the facility failed to protect residents from abuse per their facility abuse prevention program. This applies to 3 of 4 residents (R1, R3 and R4) reviewed for abuse in the sample of 6. The failure resulted in R1 experiencing ongoing head, neck and shoulder pain as a result of R2 hitting R1. The findings include: 1. Face sheet, dated 5/15/24, shows R2's diagnoses included dementia, psychosis, muscle weakness, malignant neoplasm of bladder, cognitive communication deficit, reduced mobility, and history of falling. The MDS (Minimum Data Set), dated 2/3/24, shows R2's cognition was severely compromised. Face sheet, dated 5/15/24, shows R1's diagnoses included dementia, cognitive communication deficit, mild cognitive impairment, abnormal gait/mobility, and unsteadiness on her feet. The MDS, dated [DATE], shows R1's cognition was severely impaired. On 5/16/24 at 11:46 AM, R1 stated a week ago Sunday R2 punched her in her chin. R1 stated her chin, neck, and shoulders continued to hurt for over a week and her neck continued to hurt. On 5/5/14 at 11:20 AM, V4 (Registered Nurse) stated she heard yelling between R1 and R2 but did not know what they were yelling about. V4 stated she walked over to R1 and R2 and moved R2 away because she was aware R2 could become aggressive and get physical. V4 stated R1 later told her that R2 punched R1 in the chin. V4 then interviewed R2 and R2 stated she did hit R1. On 5/5/24 at 4:44 PM, V5 (Nurse Practitioner) stated after R1 was hit by R2, R1 complained of moderate head and neck pain upon movement. V5 stated R1 was not complaining of head, neck or shoulder pain prior to R2 hitting R1 and the pain was the result of R2 hitting R1. V5 stated he monitored R1's pain for a few days to see if it would subside which it did not and V5 prescribed steroids to treat R1's pain. V5 stated if the steroids did not alleviate R1's pain, his next step would be to order imaging of R1's neck to evaluate the source of the pain. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Tower Hill Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 759 Kane Street South Elgin, IL 60177	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V5's (Nurse Practitioner) progress note, dated 5/6/24, shows R1 was seen and stated she was still upset about the encounter the other day however R1 expressed she was not in pain. V5's (Nurse Practitioner) progress note, dated 5/8/24, shows R1 expressed she was still upset regarding the encounter and stated she was experiencing neck and shoulder pain for which steroid treatment was discussed. The note shows R1 was prescribed steroid 20mg (milligrams) for 5 days for neck and shoulder pain related to recent encounter with other resident. V5's (Nurse Practitioner)progress note, dated 5/10/24, shows R1 expressed minor improvement in neck pain. When asked about pain patient discussed incident again and is still upset/angry about the encounter. Witness statement, dated 5/5/24, shows V7 (CNA- Certified Nursing Assistant) came to the nursing station to respond to the incident and help separate R1 and R2. The statement shows V7 wrote that R1 stated R2 punched R1 in the chin and that the incident began because R2 was taking too long in the bathroom and R1 was trying to get R2 out of the bathroom to take a turn. Progress note, dated 5/5/24, shows R1 had a verbal altercation with her roommate and R1 was removed from the area. The note shows shortly after the altercation, R1 informed the nurse on duty that R2 punched R1 in the chin. The note shows the nurse on duty asked R2 if she punched R1 in the face and R2 responded by saying yes. The note shows R1 later complained of neck pain shortly after the assault. Incident report, dated 5/5/24, shows R1 reported that R2 hit her on the chin however the incident was not witnessed by staff. The report shows R2 stated R1 was yelling at R2 to get out of the bathroom because R2 was taking too long and R2 swatted R1 to leave her alone. The report shows R2 admitted to striking R1 after a verbal altercation and the police were called. The report shows R2 was sent to the hospital for evaluation and remained on 1:1 supervision until she left the facility. Facility staff were interviewed and no other witnesses were identified. The report shows the allegation of the abuse was substantiated by the facility investigation. Police Violation Notice, date 5/5/24, shows R2 received a citation for Disorderly Conduct - fighting (assault or battery.) Facility Abuse Prevention Program document, reviewed 1/2019, shows, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The document shows, Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident . This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish . The term 'willful' in the definition of 'abuse' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Face sheet, dated 5/15/24, shows R3's diagnoses included dementia, delirium, alcohol abuse, cannabis abuse, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, Alzheimer's disease, visual hallucinations, restlessness and agitation, aphasia, and apraxia. MDS, dated [DATE], shows R3's cognition was moderately impaired. Face Sheet, dated 5/15/24, shows R4's diagnoses included Wernicke's encephalopathy, psychosis, dementia, depression, altered mental status, and alcohol dependence. Progress note, dated 5/8/24, shows R4's diagnoses also included major neurocognitive disorder. MDS, dated [DATE], shows R4's cognition was moderately impaired. On 5/15/24 at 1:15 AM, V3 (CNA- Certified Nursing Assistant) stated she was assigned to be 1:1 supervising both R3 and R4 in their room. V3 stated R3 was confused, often walks around the facility, and V3 was having to redirect R3 while supervising him. V3 stated both R3 and R4 were ambulatory. V3 stated R3 attempted to get into R4's bed and R4 yelled, Get the f*** out of my bed [R3]! V3 stated she tried to get between R3 and R4 when R3 reached around V3 and hit R4 in the nose. V3 stated R4 then hit R3 in the chest. V3 stated staff then came to the room to assist and both residents were sent out to the hospital after the incident. V5's Nurse Practitioner note, dated 5/4/24, shows R3 was exhibiting aggressive behavior, struck a resident, and was sent out. Nursing note, dated 5/4/24, shows a CNA (Certified Nursing Assistant) reported to the nurse that R3 struck another resident on the nose and as a result the other resident struck back and hit R3 on the chest. The note shows R3 was unable to give a description of what happened. Nursing note, dated 5/4/24, shows a CNA (Certified Nursing Assistant) reported R4 was struck by a resident in the nose and R4 struck back at the resident on the chest. The progress note shows R4 stated, He hit me in my nose so I hit him back. Incident report, dated 5/4/24, shows R3 and R4 were roommates and the two residents were in their room with a sitter at the time of the incident. The report shows V3 (CNA) was assigned as R3 and R4's sitter. The report shows R3 then attempted to lay down in R4's bed, R4 yelled at R3 to get out of his bed, V3 attempted to get in between the two residents, and R3 struck R4 in the face/nose. R4 then reached around and struck R3 in the chest. The residents were then then separated and no injuries were identified. The report shows both residents were placed on 1:1 monitoring, police/physician/responsible parties were called, and R3 and R4 were sent out for evaluation. The report shows the police did not pursue any further action and both residents were sent to the hospital for evaluation. The report shows the allegation of abuse was substantiated.