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	12/26/2024

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 - Minimal harm or potential for 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** 31327 Based on interview and record review, the facility failed to prevent abuse between two residents. This applies to 2 of 4 residents (R1, R2) reviewed for abuse in a sample of 4. The findings include: On 12/24/24 at 8:55 AM, through the assistance of V5 (LPN-Licensed Practical Nurse) who translated in Spanish, R2 stated the following: (R1) grabs other people's food from their trays. (R1) grabbed my food in the second floor dining room. Then, I told him not to take my food. (R1) then hit me in the face. I didn't hit back. Staff came and stopped the fight. I landed on the floor. I had no injuries. I don't remember scratching (R1), but I saw a little bit of blood on his neck area. (R1) was not sitting next to me. He just came and grabbed my food. (R1) never did this before to me. I behave because I want to go home. The nurse checked me out. I don't remember if I went to the hospital, but I think got x-rays. It's just an accident that happened between us. On 12/24/24 at 8:47 AM, V4 (Social Service Director) stated, I wasn't here when the incident happened on 11/26/24. I already left for home. The next day, I heard that (R1) and (R2) got into an altercation during dinner in the dining room. Then staff went to break it up. I talked to (R2) about it and he said that (R1) tried to take his food. (R2) defended himself and snatched it back from him. That's how the altercation occurred. (R2) keeps to himself and doesn't really talk to people. (R1) can be aggressive. He got into an altercation with another resident (R4) in the summer. He did the same thing and stole his food. Both (R1) and (R2) were put on 1:1. We moved (R2) to a different room. (R1) is no longer here. He went to the hospital because he was sick and never returned to us. On 12/24/24 at 9:12 AM, V5 (LPN-Licensed Practical Nurse) stated, I wasn't here when the incident happened. I heard about it the next day. I heard that (R1) tried to take (R2)'s food and there was some fight. That's all I heard. On 12/24/24 at 10:10 AM, V2 (DON-Director of Nursing) stated, I was not there when the incident happened. The CNA's (Certified Nursing Assistants) were busy bringing other residents to the dining room. They heard a commotion and ran to the dining room. (R1) and (R2) were on each other and the CNA's separated them. I heard someone took the other's food. (R1) threw the first punch and then (R2) began to choke (R1). No one witnessed the incident. I would consider this physical abuse. It is our responsibility to protect residents from abuse. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staffing sheet shows the nurses on 11/26/24 for the second floors were V6 (LPN) and V7 (LPN). V2 (DON) stated V6 was R1's assigned nurse and V7 was R2's nurse. On 12/24/24 at 10:21 AM, surveyor attempted to reach out to V6 and V7 via telephone. However, they did not pick up their phones. On 12/24/24 at 11:05 AM, V8 (CNA) and V9 (CNA) were interviewed together. V8 stated that another resident came and told her that (R1) and (R2) were fighting. V8 said she heard the commotion and noise and went to the dining room. She stated, We separated them and took (R1) to his room. (R2) was taken to the nursing station. What I heard was that (R2) left his tray and stepped away to get something. (R1) walked in and started eating from (R2)'s tray. Then it got physical and (R1) punched (R2). V9 stated, When I got to the dining room, they were already separated. I talked to (R2) and he said that (R1) punched him. (R2) stated he didn't want any problems. They were put on 1:1. (R2) went to the hospital. Both V8 and V9 stated this was physical abuse. Final incident report between R1 and R2 shows the following: On November 26, 2024, (R1) and (R2) were both noted to be in the dining room for dinner. (R1) and (R2) were observed to be in an altercation when staff immediately intervened. Residents were separated and assessed for injury. (R1) was noted with scratches to the upper chest and neck area. (R2) was not observed to have any injuries. (R2) reported that (R1) hit him when (R2) was attempting to redirect him. (R1) was not able to provide any information. (R1) was placed on a 1:1. On November 26, 2024, (R1) and (R2) were both residing on the second floor in different rooms. (R1) and (R2) were in the dining area for dinner. Staff heard a disturbance/commotion and observed (R1) and (R2) engaging in a physical altercation. Staff immediately intervened and separated both residents to ensure their safety and assess the situation. Both residents were also assessed for injuries. (R1) was noted with scratch marks to his chest. (R2) was not noted with any injuries. Upon interviewing (R1), he was unable to identify any details of the incident other than he was hit and denied hitting anyone. (R2) when interviewed, stated that he left the dining area and then upon return, (R1) was observed to be eating his food. When he told him to stop, (R1) allegedly hit (R2) and then the two proceeded to engage in a physical altercation until staff were able to separate them. (R1) was placed on a 1:1. Both residents (R1) and (R2) were sent to the hospital for evaluation. The facility conducted a thorough investigation pertaining to an allegation of physical abuse regarding two residents. Both (R1) and (R2) provided statements that do support a resident-on-resident altercation did occur however the facility is unable to determine the aggressor or the victim or any other concrete evidence to support a clear determination regarding a victim of abuse. R1's face sheet shows an admitted on 3/16/24. R1's face sheet shows diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, restlessness and agitation, and major depressive disorder. R1's MDS (Minimum Data Set) dated 9/26/24 shows a BIMS (Brief Interview for Mental Status) score of 9 which means he is moderately impaired in cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's risk assessment dated [DATE] shows: Nurse on duty was passing medication by nurses station and heard a commotion in the dining room. Nurse went to dining room immediately and observed (R1) and another resident (R2) lying on the floor on their bottoms and in the process of standing up. Nurse was told by aides that the residents were fighting and they separated them. (R2) told nurse that (R1) took his food. (R2) said to give it back and (R1) got aggressive and hit him. (R2) hit him back and began to choke him. (R1) stated that (R2) hit him. He offered no further explanation despite nurse asking various other questions. Both residents were assessed by the nurses. (R1) was noted with a scratch under his right ear, scant bleeding, which stopped with direct pressure. Noted with scratches to the neck and upper chest. Both residents were sent to the ER (emergency room) for evaluation/treatment. R1's care plan shows (R1) may be at risk for abuse related to mental/emotional challenges as evidenced by (R1)'s current mental status, dementia. Goal: (R1) will remain free from harm through the next review date. Interventions: Assure (R1) that they are in a safe and secure environment with caring professionals. R1's progress note dated 12/9/24 at 11:00 AM shows that R1 had a large mass on neck. He was sent out to hospital for evaluation and treatment. Hence, surveyor was unable to interview R1. R2's face sheet shows an admitted [DATE]. R2's face sheet shows diagnoses of violent behavior, major depressive disorder, recurrent, moderate, Alzheimer's disease, unspecified, other amnesia, vascular dementia, unspecified severity, with other behavioral disturbance, anxiety disorder, and cognitive communication deficit. R2's MDS dated [DATE] shows a BIMS score of 8, which means he is moderately impaired in cognition. R2's risk assessment dated [DATE] shows the following: Another resident alerted the nurse and aide of possible altercation in the dining room between (R2) and (R1)-aggressor. Immediately upon notification, nurse and aides began heading towards dining room when a loud clatter and thump was heard. Upon entering the dining room, nurse observed (R1) on top of (R2) with his hands around (R2)'s neck. The aides quickly separated the 2 men and removed (R1) from the dining room. Nurse assessed (R2) and obtained vitals. (R2) stated he left the dining room for a glass of water and when he returned, (R1) was eating his food. (R2) then told (R1) that the food he was eating was his and he attempted to remove his plate from him. (R1) then punched him in the left jaw and the next thing he knew, (R1) was on the floor and (R2) was choking him. (R1) and (R2) were separated. (R1) was escorted to his room. (R2) was transferred to the hospital for further evaluation. R2's care plan shows: (R2) may be at risk for abuse related to mental and emotional challenges as evidenced by medical diagnoses of dementia. (R2) will remain free from harm through the next review date. Assure resident that they are in a safe and secure environment with caring professionals. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Abuse Prevention Program, revised 1/2019, shows, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (whether or not actually given) . Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment