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	02/27/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to ensure residents were prevented from having access to a room where medical equipment in need of repair was being stored. This applies to 1 of 3 residents (R4) reviewed for accidents in the sample of 5. The findings include: The EMR (Electronic Medical Record) shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, cerebral infarction, lack of coordination, reduced mobility, muscle weakness, unsteadiness on feet, abnormal gait, cognitive communication deficit, repeated falls, gastrostomy, right shoulder pain, fatty liver, dysphagia, hemiplegia and hemiparesis of the right dominant side, dizziness and giddiness, and dementia. R4's MDS (Minimum Data Set) dated November 27, 2024 shows R4 is cognitively intact, requires supervision with eating, oral hygiene, dressing, and personal hygiene, partial/moderate assistance with showering, and substantial/maximal assistance with toilet hygiene, bed mobility, and transfers between surfaces. R4 is occasionally incontinent of bowel and bladder. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 26, 2025 at 11:50 AM, R4 was self-propelling her wheelchair in the hallway, just outside of an unlocked room with a sign posted on the wall that showed Ice Machine. No other signs were posted outside of the ice machine room. R4 had a large, empty plastic cup in her hand, and was asking for her cup to be filled with ice from the ice machine. R4 had an elastic compression wrap bandage on her right lower leg. The bandage had slid down her leg and was bunched up close to her ankle. R4 said, I will never go in that ice machine room again. I went in there to get ice and a pole fell on my leg and it really hurt me. R4 had difficulty remembering if the incident happened a week ago or yesterday. R4 demonstrated how she was able to open the door to the ice machine room by turning the door knob and pushing the door open. As R4 opened the door, she had to push hard against the door due to a self-closing device on the door. Inside the ice machine room was a large ice machine with a lid that opened from the bottom and swung upwards. The lid was approximately three feet wide by one foot, from the top of the lid to the bottom of the lid. Directly next to the ice machine were three IV (Intravenous) poles. The IV poles were approximately five feet in tall. Each pole was mounted to a stand with wheels. Three oxygen concentrators were also in the room, approximately four feet from the ice machine. R4 pointed to the IV pole and said, That pole fell and hit my leg when I came in to get ice. R4 pointed to an IV pole with a small IV pump attached to the pole. The IV pump was approximately four inches by four inches by one inch deep and was attached to the pole, approximately two feet from the top of the pole. Two of the three IV poles were extremely wobbly, including the IV pole with the IV pump attached to it, and the two IV poles swayed when moved or touched the slightest bit. The poles appeared loose at the point where the IV pole attached to the wheeled base. R4 said, when the incident happened, she had pushed the lid to the ice machine up so she could reach inside the machine to retrieve ice. R4 said as she lifted the ice machine lid, the lid to the ice machine hit one of the IV poles and caused the IV pole to fall and hit her right shin. On February 26, 2025 at 12:37 PM, R4 was sitting in her wheelchair in the hallway. V2 (DON-Director of Nursing) approached R4 and asked about the elastic compression bandage on R4's right lower leg. R4 said, Yesterday, I was in the ice machine room and a pole fell on my leg. R4 denied falling. V2 removed the elastic compression bandage from R4's right lower leg. The front of R4's right lower leg was bright red in color on her shin, approximately two inches wide, from just under her right knee to her ankle. No open skin areas were noted. V2 touched R4's right reddened shin area and said the area was not warm to the touch. R4 flinched when V2 touched her right shin. V2 rewrapped R4's right shin with the elastic compression bandage and asked R4's nurse to provide R4 with her ordered narcotic pain medication. V2 continued to say she heard commotion in the ice machine room the day before. V2 said she saw R4 come from the ice machine room but was not aware R4 had been injured. On February 26, 2025 at approximately 4:00 PM, R4 was sitting in her wheelchair in her room, sorting her colored pencils. R4 said the pain in her right lower leg had improved since she took the narcotic pain medication earlier. R4 again said, I did not fall. My leg got hurt in the ice machine room when a pole fell and hit my leg. R4's hospital discharge records dated February 25, 2025 show R4 was treated for a contusion to her lower extremity. The discharge instructions show to apply rest, ice, compression, and elevation to her lower extremity. R4's X-ray results of her right tibia and fibula dated February 25, 2025 show: Clinical indication: Bruising anterior mid-shaft right tibia. Findings: Two views right tibia and fibula were obtained. No fracture or dislocation is seen. Bones are intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital physician documentation shows: Right anterior shin tenderness and soft tissue swelling. There is ecchymosis. No erythema. No open wounds, bleeding, or lacerations. No palpable warmth. There is no obvious deformity. On February 26, 2025 at 1:42 PM, V14 (RN-Registered Nurse) said, I was the nurse on duty yesterday. I worked a double. I worked day shift and afternoon shift. [R4] came up to me and she told me she went into the ice room, and she bumped her leg on something. We offered to do an X-ray, but she said no, and the family called me after that. The family member called the doctor and the doctor said send her out. She went out to the hospital and when she came back from the hospital, the paperwork said she just had bruises. It looked like she bumped her leg. It was red. There were no black and blue marks. She did not fall. On February 27, 2025 at 8:07 AM, V20 (Maintenance Director) said, I was not aware there were any IV poles that were wobbly or needed to be repaired. That is a simple fix. There is a screw under the base that needs tightening to keep the pole from wobbling. Sometimes we have been running out of storage space, and temporarily we have been storing stuff in the ice machine room. There was an issue with the door knob, and I put a temporary one on the one door. The new door knob did not have a lock on it. The room is meant to be locked and residents are not supposed to access the room. On February 27, 2025 at 11:36 AM, V2 (DON) said, Residents are not supposed to go into the ice machine room. The room is usually locked, but the lock was broken. We should not have been storing equipment in that room.