

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 07/01/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 5.</p> <p>The findings include:</p> <p>R1 and R2's initial report dated 6/9/25 that was reported to IDPH (Illinois Department of Public Health) shows the following: (R1) allegedly struck (R2) this morning near a common area. Both residents were immediately separated and assessed for any injuries. Police were called and report filed. Medical doctors and Power of attorneys were made aware of the alleged incident. Full investigation to follow.</p> <p>R1and R2's final report shows the following: On 6/9/25, (V4-CNA/Certified Nursing Assistant) was in another resident's room providing care to that resident. Upon exiting the room, she overheard (R1) and (R2) engaged in what appeared to be a physical altercation at the opposite end of the building (West Hallway). (V4) also witnessed (R2) who was standing out of his wheelchair and back to (V4) swinging his arms at (R2). (V4) yelled down the hall to V5 (LPN-Licensed Practical Nurse) and V7 (LPN) that there was an altercation. Both nurses were at the medication room located on the front of the west hallway getting ready to start their medication passes. Both (V5) and (V7) ran to the end of hallway to intervene and separate (R1) and (R2). As the nurses approached, (R1) was observed striking (R2) in the face. (R1) and (R2) were separated immediately and assessed for injuries. (R2) was noted with a small laceration and redness to the left eye/eyebrow area and a bruise to his left hand around his thumb. (R2) reported forearm pain. (R1) was not noted with any injuries and denied pain. (R1) and (R2) were placed on 1:1. The police were contacted along with medical doctors and POA (Power of Attorneys)/Guardian of each resident. (R2)'s doctor gave the order to send him to the hospital for evaluation. Medical doctor for (R1) gave order to send him to a behavioral health hospital for evaluation and treatment. (R1) and (R2) are not interviewable due to their cognitive impairments, however staff attempted to determine a root cause to the incident. (R2) had no recollection of being involved in an altercation and (R1) shrugged his shoulders in response to questioning. Findings: The facility is substantiating abuse as staff did witness (R1) strike (R2) in the face. (R2) has visible injuries while (R1) did not have any.</p> <p>On 6/24/25 at 9:53 AM, R2 stated he did not remember what happened to him and R1. R2's face sheet shows diagnoses of Parkinson's disease without dyskinesia, without mention of fluctuations, Alzheimer's disease, unspecified, and memory deficit following unspecified cerebrovascular disease. R2's MDS(Minimum Data Set) assessment dated [DATE] shows that R2 is severely cognitively impaired.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 at 9:59 AM, R1 was unable to be interviewed. R1 was very confused and severely cognitively impaired.</p> <p>R1's face sheet shows diagnoses of Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, delusional disorders, and anxiety disorder. R1's MDS (Minimum Data Set) 4/15/25 shows that he is severely cognitively impaired.</p> <p>On 6/24/25 at 10:25 AM, V3 (ADON-Assistant Director of Nursing) stated, On Monday 6/9/25, I was at home. The incident happened in the early morning hours during the night shift. Staff called me at home. They told him that (R1) hit (R2) near the common area. The staff separated them. The nurses did an assessment. (R2) was sent to the ER (Emergency Room). He had a laceration and redness to his left eye-brow area and a bruise to his left thumb area. (R2) had no pain or injuries. He was sent to the behavioral health unit of a hospital. (R1) and (R2) don't have a history of aggressive behaviors. We changed (R1)'s room to the first floor. It's our job to prevent abuse among our residents.</p> <p>On 6/24/25 at 11:00 AM, V1 (Administrator) stated, On 6/9/25, I was at home when I got the call. I think the incident happened between 5 AM and 5:10 AM. I was not at work yet. (V5-LPN/Licensed Practical Nurse) and (V7-LPN) were the nurses that day and they were getting medications ready. V4 (CNA-Certified Nursing Assistants) was coming out of another resident's room. She saw both (R1) and (R2) at the end of the hallway. She saw (R1) swinging at (R2). Contact was made. She yelled and both nurses responded. They all broke up the fight. (R1) hit (R2) in the face. Full assessments were done. (R2) had laceration on his left eye area and a bruise on his hand near his thumb. (R2) had no injuries. (R2) was sent to the ER for evaluation and returned 2 hours later. (R1) remained on 1:1 and then was sent to a different hospital for psychiatric evaluation and treatment. We did a room change for (R1). I came to the facility and started an investigation. The police were already gone when I got to the facility. (R1) is nonverbal. (R2) is nonsensical. None of them have a history of aggression. (R2) gets agitated with care. (R1) shrugged his shoulders when we tried to interview him and (R2) didn't recall. It is definitely the facility's job to prevent abuse.</p> <p>On 6/24/25 at 11:52 AM, V4 (CNA) stated, I was coming out of another resident's room. I had just provided care to the resident. In the furthest end of the hallway, I had seen (R1) fighting (R2). I called out for help. The nurses went first and separated them. I had to throw out the garbage from that resident's room. Then I joined them. (R2) had scratches to his face. I don't know about (R1). This is the first time I'm seeing aggressive behavior from (R1). I left for home before they went to the hospital.</p> <p>On 6/24/25 at 12:01 PM, V5 (LPN-Licensed Practical Nurse), Me and the other nurse (V7) heard (V4) yelling that (R1) and (R2) were fighting. We ran to the hallway where they were. We broke up the fight. On (R2)'s left temple, there was bleeding and redness. (R1) didn't have any injuries. They were both sent to different hospitals. (V6-Social Services Aide) filled out the involuntary petition paperwork.</p> <p>On 6/24/25 at 12:31 PM, V6 (Social Services Aide) stated, Yes, (R1) and (R2) had a physical altercation. (R1) punched (R2) in the face. Neither of them has a history of aggression. I did the involuntary petition. (R1) was sent to the hospital and had psychiatric treatment, while R2 was sent to the emergency room. We also moved (R1) to the first floor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Petition for Involuntary/Judicial admission form dated 6/9/25 shows the following: (R1) who is asserted to be a person subject to involuntary in patient admission to a facility and for whom this petition is being initiated by reason of: Emergency inpatient admission by certificate. (R1) is a person with mental illness who because of his illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person of another in physical harm or in reasonable expectation of being physically harmed. (R1) is in need of immediate hospitalization for the prevention of such harm. CNA came out of another resident's room and saw (R1) punching another peer in the face causing injury to his face and pain in his arm. (R1) is currently on 1:1.</p> <p>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</p>		