| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145795 | A. Building<br>B. Wing | 01/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tower Hill Healthcare Center | 759 Kane Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on observation, interview and record review the facility failed to ensure residents were free from physical abuse. This applies to 3 of 4 residents (R2, R4, R5) reviewed for abuse in the sample of 13. The findings include: 1. The facility's undated Final Abuse Investigation shows (R4) is male resident with diagnoses including unspecified dementia, restlessness and agitation, generalized muscle weakness, vascular dementia, and osteoarthritis. (R4) is alert and oriented x1 with severe cognitive impairments with short- and long-term memory, judgement and decision-making abilities. He relies on staff for cueing and redirection, often paces the facility and has exit seeking behaviors. He tends to wander around the unit and requires frequent redirection.(R5) is a female resident with diagnoses including other psychotic disorder, major depressive disorder, generalized anxiety, glaucoma, and cognitive communication deficit. (R5) is alert and oriented x 1-2 with severe cognitive impairments and also has impaired short- and long-term memory, judgement and decision-making abilities. On 9/29/25, V14 (Certified Nursing Assistant-CNA) responded to (R5's) room due to sounds of screaming. V14 witnessed (R4) strike (R5) in the chest.(R5) reported (R4) kept coming into her room and wouldn't leave. (R5) stated she tried to physically get (R4) to leave her room and scratched him trying to get him out. (R5) stated she grabbed (R4) to pull him out of the room and (R4) punched her. (R4) reported (R5) attacked him and that he attempted to stop her. On 01/7/26 at 9:12 AM R5 was in her room sitting in her bed. R5's room was located across the nurse's station. R5 was alert to self and forgetful. She said she was trying to get away from a man and she was not going to let the man hurt her. R5 was not able to recall the details of the incident but stated, I wanted to get away from him. On 01/7/26 at 11:10 AM, V3 (Social Services) said R4 has a history of wandering, aggressive, verbal and physical behaviors. R4 is an elopement risk with impaired cognitive deficits. On 9/29/25, R4 wandered into R5's room and put his hands on R5. A staff member witnessed R4 punch R5 in the chest. We do our best to monitor residents, but we can't keep eye on everyone. R4 should be monitored when he is out of his room because of his behaviors. R5 has dementia as well and gets very confused and has a history of past experiences of abuse and probably felt threatened by R4. R4 was sent out for his behaviors and was transferred to another facility. On 01/7/26 at 12:50 PM, V10 (Licensed Practical Nurse-LPN) said on 9/25/25, she was informed by V14 (CNA) R4 wandered into R5's room. R5 was trying to shove R4 out of her room and she witnessed R4 punch R5 in the chest. R4 has a history of wandering and is high risk of elopement. R4 is cognitively impaired with behaviors of agitation towards staff and can be difficult to redirect at times. On 1/7/26 at 1:35 PM, V1 (Administrator) said she is the abuse coordinator. Any allegations of abuse should be reported immediately. Residents are separated immediately if staff witness abuse. V1 confirmed R4 and R5's incident was witnessed by staff and physical abuse was substantiated. 2. The facility's undated Final Abuse Report shows (R2) is a female resident with diagnoses including dementia, anxiety, insomnia, GERD, rheumatoid arthritis, and spinal stenosis. (R2) is alert and oriented x2 with moderate cognitive<br><br>(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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| Tower Hill Healthcare Center | 759 Kane Street<br>South Elgin, IL 60177 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | impairment. (R3) is a female resident with diagnoses including vascular dementia with behavioral disturbances, unspecified psychosis, muscle weakness and cognitive communication deficit. (R3) has a history of both verbal and physical aggression (primarily towards late husband and staff).On 10/25/25, V1 (Administrator) received a message from second floor nurse (V9-Licensed Practical Nurse) that (R3) hit (R2) in the face (left side).it was not witnessed by staff but (R2) reported the incident.(R2) was observed with redness to the left cheek.(R2) reported (R3) wanted to set at the table she was at but there was no room.(R3) got mad and then hit her. On 1/7/26 at 9:19 AM, R2 was in her room sitting in her wheelchair. She was alert and oriented x2 with forgetfulness. R2 had difficulty recalling the incident in October 2025. On 1/7/26 at 11:52 AM, V9 said on 10/25/25, she was doing her med pass and residents were in the dining room. R2 said she got hit by R3. R3 punched R2 on the left side of her face. R2's left eye bruised right away and the next day it was dark purple. R2 reported it happened and R13 was the tablemate and said R3 got agitated and hit R2. R3 is very confused and I'm pretty sure she acted out of aggression. On 1/7/26 at 12:10 PM, R13 said he was at the table when it happened. The one that came over in the wheelchair and punched R2 was wanting her to move from the table. R2 told her (R3) no, this is my spot and (R3) punched her in the eye and gave her a black eye. R2 was in pain, and she was saying oh she punched me. R13 said the incident was unprovoked really and she was just being mean. R13 said the one who punched R2 had a mean streak and had prior verbal altercations with staff and residents.The facility's Abuse Policy dated 2019 states, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment .physical abuse is the infliction of injury on a resident that occurs other than by accidental means.physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was transported via wheelchair in a manner to prevent a resident fall for 1 (R5) of 3 residents reviewed for safety and supervision in the sample of 13.The findings include:R5's resident assessment dated [DATE] showed R5 was severely cognitively impaired.R5's care plan dated 6/18/25 showed R5 was at risk for falls related to her poor safety awareness and impulsiveness due to her impaired cognition. R5 also had diagnoses of glaucoma, previous falls with fractures, anxiety, unspecified psychotic disorder, and a cognitive communication deficit which contributed to R5's increased risk of falling.R5's progress note dated 9/15/25 showed R5 was being pushed in her wheelchair by a restorative certified nursing assistant (CNA) when R5 suddenly planted her feet down on the ground as her wheelchair was moving, causing R5 to fall forward out of her wheelchair, onto the floor. R5 landed on her knees and then rolled over onto her back on the floor. The note showed R5 was sent to a local hospital for an evaluation. R5 was assessed in the hospital and found to have no injuries from her fall. R5 returned to the facility on 9/15/25.R5's IDT (interdisciplinary team) note dated 9/16/25 showed the root cause of R5's fall on 9/15/25 was related to patient safety. The note showed, Intervention and Care plan updated: Reinforce to the staff safety awareness and techniques of proper observation and use of gait belt during transfer and placement of footrest during transport of all patients.On 1/7/26 at 9:22 AM, V17 Restorative Nurse stated R5's fall on 9/15/25 was caused by R5's wheelchair foot pedals not being down and in place for R5 to rest her feet on as she was being pushed in her wheelchair. V17 stated, (R5's) wheelchair pedals were not down and in place to support (R5's) feet so when she planted her feet on the ground as she was being pushed, she fell forward out of her wheelchair. Her feet should have been on the foot pedals of her wheelchair which would have prevented her from putting them on the floor and causing her to fall. On 1/7/26 at 11:01 AM, V22 Restorative CNA stated on 9/15/25, he didn't realize R5's wheelchair foot pedals were not in place as he pushed R5 in her wheelchair. V22 stated, I didn't realize her feet were dragging on the floor under the wheelchair. She put her feet flat on the floor as I was pushing her which made her fall out of the wheelchair. I should have made sure her feet were on the pedals before I started pushing her. The facility's Safe Resident Lifting Policy dated July 2025 showed, All residents that utilize a wheelchair and/or Broda chair for mobility will have appropriate leg/footrests during transfers unless the resident self-propels. |