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	04/22/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident, who was at risk for skin breakdown, was kept clean and dry, and did not develop a pressure ulcer.This failure resulted in the development of a stage 2 pressure ulcer to the resident's buttock. This applies to 1 or 3 residents (R1) reviewed for improper nursing care in the sample of 8. Findings include: R1's electronic medical record showed R1 to be [AGE] years old and admitted to the facility with diagnoses that include muscle weakness, unsteadiness on feet, other lack of coordination, acute kidney failure, dysphagia, schizophrenia, schizoaffective disorder, generalized anxiety disorder, and syncope and collapse. R1's Minimum Data Set (MDS) dated [DATE], showed R1 to have severe cognitive impairment. R1's MDS also showed R1 required substantial/maximal assistance with toileting hygiene.R1's most recent readmission assessment dated [DATE], showed that R1 was at risk for developing pressure sores and showed he did not have any wounds on his buttocks on admission. R1 had the following care plans: 1) R1 is incontinent of bowel and bladder. 2) R1 has a potential for skin integrity impairment dated January 23, 2026, with interventions to observe skin during routine care and report alteration to the nurse and to provide peri-care and barrier cream after incontinent episodes. 3) R1 was at risk for alteration in skin integrity dated November 9, 2023, with one of the interventions being to provide per-care after each incontinent episode and apply barrier cream. R1's most recent skin assessment/bath/skin checklist provided by the facility was dated April 14, 2026, and showed R1 had no skin breakdown. On April 21, 2026, at 12:00 PM, R1 stated he had not gotten out of bed yet today and he was not certain when the last time he had been checked for incontinence.On April 21, 2026, at 12:50 PM, V9 (Certified Nursing Assistant, CNA) came to check R1 for incontinence. V9 stated the last time she checked R1 for incontinence care was at 10:00 A M. During incontinence care, R1 had a wet incontinence brief, and a very large, dried bowel movement that was stuck between R1's buttocks. The bowel movement had adhered to R1's skin. R1 was not cleaned thoroughly during the incontinence care and had to be prompted to complete the cleaning. There was also the presence of a new stage 2 pressure ulcer on R1's right buttock. There was also redness on R1's buttocks and scrotum. V9 confirmed it was a new open wound that she had not seen previously. On April 21, 2026, at 1:17 PM, V16 (Licensed Practical Nurse/LPN) stated that R1 did not have any wounds that she was aware of. R1's electronic medical record was reviewed with V16 and V16 confirmed R1 had no wounds. R1's progress notes dated April 21, 2026, at 2:35 PM written by V16 showed that staff noted opening on the right buttock of R1.R1's progress note dated April 21, 2026, at 4:41 PM and written by V11 (Wound Care Nurse) showed the following: Writer was informed by the [nurse on duty] that the resident has a small open area on the right buttock. The resident was assessed by the wound nurse, who contacted the wound care physician and received order for [medical] honey and foam dressing to open area and zinc cream to redness.R1's wound evaluation & management summary initial evaluation dated April 22, 2026 and written by V10 (Wound Care Doctor) showed that R1 had a facility acquired stage 2, partial thickness pressure ulcer on the right buttock, measuring: 1.2 centimeters (cm) Length X 0.9 cm Width x 0.1 cm depth; Surface area: 1.08 cm (centimeters); exudate: moderate Sero-sanguinous; dermis: open areas with exposed dermis. On April 21, 2026, at 4:51 PM, V2 (Director (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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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of Nursing) stated incontinence care should be provided to residents every 2 hours or more often as needed. V2 stated staff should be cleaning residents thoroughly and removing visible stools. V2 stated incontinence care is important for preventing infection and for sanitation. V2 stated not cleaning a resident thoroughly puts them at risk of skin breakdown. V2 stated residents should be left clean after incontinence care. V2 stated, the way you want to be left is how you should leave someone else.On April 22, 2026, at 2:03 PM, V10 stated that R1's urine incontinence and stool found on R1 yesterday as described could be a contributing factor to R1's moisture associated dermatitis and the stage 2 wound he diagnosed. V10 stated, it is important to check R1 consistently because R1 doesn't know when he has been incontinent. V10 stated you can't wait to remove stool from the skin. V10 stated stool can irritate the skin. The facility's Skin management policy revised September 2024 showed the following: It is the facility's policy that a resident does not develop pressure injury unless clinically unavoidable.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident, who was at risk for skin breakdown, was kept clean and dry. This applies to 1 of 3 residents (R1) reviewed for improper nursing in the sample of 8.Findings include: R1's electronic medical record showed R1 to be [AGE] years old and admitted to the facility with diagnoses that include muscle weakness, unsteadiness on feet, other lack of coordination, acute kidney failure, dysphagia, schizophrenia, schizoaffective disorder, generalized anxiety disorder, and syncope and collapse. R1's Minimum Data Set (MDS) dated [DATE], showed R1 to have severe cognitive impairment. R1's MDS also showed R1 required substantial/maximal assistance with toileting hygiene.R1's most recent readmission assessment dated [DATE], showed that R1 was at risk for developing pressure sores, and it showed R1 did not have any wounds on his buttocks. R1 had the following care plans: 1) R1 is incontinent of bowel and bladder. 2) R1 has a potential for skin integrity impairment dated January 23, 2026, with interventions to observe skin during routine care and report alteration to the nurse and to provide peri-care and barrier cream after incontinent episodes. 3) R1 was at risk for alteration in skin integrity dated November 9, 2023, with one of the interventions being to provide peri-care after each incontinent episode and apply barrier cream. R1's most recent skin assessment/bath/skin checklist provided by the facility was dated April 14, 2026, and showed R1 had no skin breakdown. On April 21, 2026, at 12:00 PM, R1 stated he had not gotten out of bed yet today and he was not certain when the last time he had been checked for incontinence.On April 21, 2026, at 12:07 PM V9 (Certified Nursing Assistant/CNA) stated she had changed R1 in the morning when she first got to the facility. V9 stated she changed V9 last at 10:00 AM this morning.On April 21, 2026, at 12:50 PM, V9 came to check R1 for incontinence. V9 removed the front of R1's brief and started cleaning around the genitalia. V9 had not turned resident yet and stated that R1 only had urine. V9 was asked to show R1's incontinence brief. V9 turned R1 and stated, oh he does have stool. R1's buttocks were red, purplish, and gray in areas. R1 had a large dried solid stool that was stuck/adhered to the length of the intergluteal cleft (inner part) of R1's buttocks. The fecal matter looked dried and was stuck in the buttocks folds with width of the stool being about 2 inches near the scrotum and about 5 inches wide in the middle. R1's incontinent brief was soaked with urine from the back to halfway up the front on the brief. V9 could not remove the stool readily and stated that she needed to go get some help. V9 came back with V8 (CNA) and V8 cleaned the front of R1 again and cleaned under the scrotum where redness was observed. V9 turned R1 and removed the large hardened fecal matter then proceeded to remove several layers of remaining fecal matter that had adhered to R1's skin around the anus and the inner sides of the buttocks. She filled up about 1/3 of small garbage with wipes. V9 took off gloves. Then V9 got a clean incontinence brief and was about to put it on R1. [NAME] fecal matter could still be seen within the inner sides of R1's buttocks near the anus. When V9 was cleaning R1, the wipes had not come out without having fecal matter on them yet. V9 was asked if they were done cleaning R1 and V9 replied Yes. V9 was asked if she could wipe R1 again to see if R1 was thoroughly cleaned. V9 did so and then removed more layers of fecal matter from R1's buttocks. V9 used and discarded more than 4 wipes that were stained with fecal matter. R1 then had a small bowel movement of soft stool, and more wipes were used to clean R1. No barrier cream or any emollient was applied to the red areas of R1's buttocks. R1's buttocks were red, mostly on right buttock and there was a small open wound observed on the right buttocks. V9 said it was a wound, and she didn't see it there earlier in the day.On April 21, 2026, at 3:15 PM, V9 was asked why she hadn't checked and cleaned R1 between 10:00 AM and 12:50 PM. V9 stated that it took longer for her to get to R1 because she noticed that two of her residents' lunch trays had not been passed and she had to feed three residents. V9 stated that her group was hard, including R1 and his roommates (R5, R6, and R7). V9 stated that her group (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	consists of residents who are heavy wetters, require whole body mechanical lifts, have contracted limbs, and one resident who fights sometimes. V9 stated she asked V8 to help feed R3 and V8 did help her, but she still had two other residents to feed. On April 21, 2026, at 4:51 PM, V2 (Director of Nursing) stated incontinence care should be provided to residents every 2 hours or more often as needed. V2 stated staff should be cleaning residents thoroughly and removing visible stools. V2 stated incontinence care is important for preventing infection and for sanitation. V2 stated not cleaning a resident thoroughly puts them at risk of skin breakdown. V2 stated, residents should be left clean after incontinence care. V2 stated, the way you want to be left is how you should leave someone else.R1's wound evaluation & management summary initial evaluation dated April 22, 2026, and written by V10 (Wound Care Doctor) showed that R1 had a new diagnosis of Irritant Dermatitis from body fluid to bilateral buttocks. Treatment: use house moisturizing cream as directed. On April 22, 2026, at 2:03 PM, V10 stated that R1 urine incontinence and stool found on R1 yesterday as described, could be a contributing factor to R1's moisture associated dermatitis and the stage 2 wound he diagnosed. V10 stated that the moisture associated dermatitis may have been prevented by applying a barrier cream. V10 stated, it is important to check R1 consistently because R1 doesn't know when he has been incontinent. V10 stated you can't wait to remove stool from the skin. V10 stated stool can irritate the skin. The facility's incontinence care policy revised January 2022, showed the following: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible.