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	04/24/2026

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 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** Based on observation, interview, and record review the facility failed to serve a resident with multiple sclerosis and dementia hot coffee in a safe manner for 1 of 6 residents (R1) reviewed for safety in the sample of 6.The findings include:On 4/24/26 at 10:02 AM, R1 was sitting in his wheelchair in the dining room watching a movie. R1 said he liked the coffee at the facility. R1 said a few days ago he spilled coffee in his lap, but it was all healed up now. R1 said the coffee is not too hot; he likes it just the way it is. On 4/24/26 at 8:45 AM, V6 Wound Licensed Practical Nurse said R1 was accidently burned when he spilled coffee in his lap. V6 said R1 sustained a second degree burn to his left inner thigh. V6 said R1 was in dining room when it happened, and staff immediately brought him to his room and removed his pants and applied ice to the area. V6 said she was notified and responded to R1's room. V6 said R1's left inner thigh was just red at that time and ice and silver burn cream was applied. V6 said the area did later form two small blisters and has been treated since. V6 said R1's burn is almost healed. R1's Skin/Wound Note dated 4/8/26 shows R1 sustained a second-degree burn. Upon assessment, writer applied an ice pack to the affected area to help prevent further skin breakdown. On 4/24/26 at 11:12 AM, R1 was sitting in the dining room for the noon meal. R1 was served coffee in a plastic coffee mug with a handle. R1 added powdered creamer to the mug and stirred the coffee. R1, with one hand on the handle of the mug and the other hand on the other side of the mug, drank the coffee. R1's hold on the cup appeared secure and R1's hands were not shaky. On 4/2426 at 12:45 PM, V3 Assistant Director of Nursing said R1 does not need feeding cues or any assistance to eat or drink. V3 said R1 has not had any issues with drinking coffee in the past. V3 said R1 was served coffee that day in a Styrofoam cup, which didn't have any handles. V3 said the facility didn't have enough handled mugs so Styrofoam was being used. V3 said the facility has since ordered more handled mugs and residents will not be served hot beverages in Styrofoam cups. R1's Facesheet shows R1 has diagnoses of multiple sclerosis and dementia.R1's Wound assessment dated [DATE] shows left inner thigh burn, 100% granulation, measure 3.50 x 2.80 x 0.10. R1's Wound assessment dated [DATE] shows left inner thigh, burn, 90% intact skin, 10% pale pink non-granulating, measures 0.8 x 0.5 x 0.10.The facility's Hot Beverage Policy dated 2017 shows Hot beverages are provided to the clients in a safe manner.

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