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	05/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents that were cognitively impaired were free from physical abuse. This applies to 2 of 10 residents (R2 and R4) reviewed for physical abuse. The findings include: 1.Review of the Electronic Medical Record (EMR) showed that R2 was admitted to the facility on [DATE]. R2 was a [AGE] year-old female with diagnoses that included dementia, schizophrenia, delusional disorder, auditory hallucinations, hemiplegia, neuropathy, legal blindness, and hearing loss. R2 was assessed as alert and oriented times one to two, with impaired memory, judgment, and decision-making abilities, and severe cognitive impairment. Review of the EMR further showed multiple psychiatric and nursing notes documenting intermittent delusions, paranoia, medication refusal, and periods of tension. However, there was no documented history of physical aggression toward peers or staff. Review of the EMR showed that R1 was admitted to the facility on [DATE]. R1 was a [AGE] year-old male with diagnoses that included Parkinson's disease, dementia, psychosis, Alzheimer's disease, and cerebrovascular-related memory deficits, with severe cognitive impairment. The EMR documented behaviors including verbal agitation, wandering into hallways and other residents' rooms, restlessness, and refusal of care. Further review showed that on June 5, 2025, R1 struck another resident and was transferred to a behavioral health facility for evaluation and treatment. Additional records documented aggressive behavior toward staff during care on August 5, 2025; destruction of property on September 17, 2025, when R1 pushed a television off a dresser; and agitation with refusal of care on April 23, 2026.The facility incident report dated April 23, 2026, documented that R1 was ambulating in the hallway and passed R2, who was seated calmly in a wheelchair near the second-floor dining room entrance and was not interacting with R1. The report documented that R1 unexpectedly raised his hand and struck R2 on the back of the head and left upper arm. There was no identified trigger, verbal exchange, or physical interaction preceding the incident. Staff immediately intervened and separated the residents. Both residents were assessed, and no acute injuries or distress were identified. R1 was subsequently placed on one-to-one supervision due to behavioral concerns and referred for behavioral health placement.The facility investigation summary documented that V7 (Licensed Practical Nurse) witnessed R1 strike R2 on the upper left arm and back of the head. V8 (Certified Nursing Assistant) reported hearing a slapping sound and hearing R2 scream, although V8 did not witness the initial contact. R2 later reported that R1 slapped her. The facility substantiated the allegation of abuse based on the witnessed incident.On May 9, 2026, between approximately 10:00 a.m. and 11:00 a.m., V7 stated she witnessed the April 23, 2026, incident involving R1 and R2. V7 stated that R1 was ambulatory and walked past R2 while she was seated near the second-floor dining room entrance, at which time R1 slapped R2 on the back of the head. V8 stated she was near the nurse's station adjacent to the second-floor dining room when she heard R2 scream that R1 had slapped her. Both V7 and V8 stated there were no injuries noted, the residents were immediately separated, and R1 was placed on one-to-one supervision prior to transfer to a behavioral health facility. 2. Review of the EMR showed that R4 was admitted to the facility on [DATE]. R4 was a [AGE] year-old female, with diagnoses that (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included Alzheimer's disease, dementia with anxiety, cognitive communication deficits, and impaired decision-making abilities. Psychiatric evaluations throughout the admission documented R4 as generally pleasant and cooperative, without acute psychiatric or behavioral disturbances, although occasional pacing, verbal agitation, and inappropriate comments toward peers were noted. Review of the EMR showed that R3 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included dementia with severe cognitive impairment, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and hypertension. Further review of the EMR showed behavioral and psychiatric documentation consistently describing R3 as pleasant, calm, cooperative, and without significant behavioral disturbances. Psychiatric evaluations from November 2025 through April 2026 documented no aggression, combativeness, refusal of care, or peer altercations.The facility incident report documented that on May 2, 2026, R3 struck R4 in the face while both residents were present in the resident lounge. Staff immediately separated the residents. R4 was assessed and found to have no injuries. R3 was placed on one-to-one supervision pending psychiatric evaluation. The report documented that V5 (Certified Nursing Assistant) witnessed R3 strike R4 on the right cheek near the entryway of the resident lounge. Follow-up interviews revealed that neither R3 nor R4 could explain the incident. The facility substantiated the allegation of abuse based on the witnessed event.On May 9, 2026, at approximately 11:00 a.m., V1 (Administrator) and V2 (Director of Nursing) stated the facility takes necessary measures to prevent abuse and neglect and remain committed to maintaining an abuse-free environment.