

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145921	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Hitz Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Belle Street Alhambra, IL 62001	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the Facility failed to follow its abuse policy in preventing, reporting and investigating allegations of abuse for 1 of 1 resident (R42) reviewed for abuse in the sample of 26. Findings include:R42's face sheet documents an admission date of 2/19/2024. Diagnosis includes Hypertension with Heart Failure, Dementia, Narcolepsy, Chronic Respiratory Failure, Primary Osteoarthritis.R42's Minimum Data Set, MDS, dated [DATE] documents R42 is severely cognitively impaired.R42's care plan updated 2/23/2026 documents R42 has a self-care deficit related to weakness, dementia, hypertensive heart disease with heart failure, osteoporosis, osteoarthritis. R42's hospital records dated 3/5/2026 at 3:10PM stated V39 (family member) stated R42 has always been mentally slow, and she does not like to be touched.On 3/3/2026 at 8:00AM V1, Administrator was informed that a sexual abuse allegation was made to Illinois Department of Public Health (IDPH). V1 stated she was not aware of any sexual abuse allegations in the facility currently. V1 provided sexual abuse investigations dated 1/2/2025 and 7/17/2025.On 3/3/2026 at 11:00AM, Surveyor entered R42's room. R42 sitting up in chair with V17 (family member) and V39, Power of Attorney, POA. V39 stated R42 does not speak. Surveyor noted video camera in R42's room and sign on door stating please knock family visit.On 3/5/2026 at 8:30AM V17 (family member) noted to be entering facility alone. At 9:00AM V17 noted to be leaving facility.R42's sexual abuse allegation dated 1-2-2025 states at 2:20pm, V15, Certified Nursing Assistant, CNA, reported an encounter that made her uncomfortable with R42 and V17(Family Member of R42) to V27, Social Services Director. V27 immediately came to V1, Administrator, to report this. V1 called V15 to her office to investigate what had happened. V15 reports that she walked into R42's room without knocking to check on R42. The door was shut and V15 did not knock before entering. V15 reports that V17 makes her feel uncomfortable when V15 walks in the room. V15 reports walking in the room and V17 moving his hands from the R42's lap area quickly. V15 reports going back into the room a second time without knocking again and the same thing occurring. V15 reports that she did not see V17 touching R42 inappropriately. V15 reports the encounter just made her feel uncomfortable. V1 reported incident to V8, Ombudsman, V35, Medical Director, local police and V39, Power of Attorney. POA Spoke to local Police Department who came to investigate allegation. It is the determination of the investigation conducted by V1 and V27 that no sexual abuse or abuse of any kind occurred involving V17. Relevant parties, including V44, Police Officer, V35,Medical Director, V17, Family member and V39 Power of Attorney, were notified that the allegation was unsubstantiated. According to V15's Certified Nursing Assistant, CNA, written statement dated 1/2/2025, she entered R42's room during report and observed V17 quickly moving his hands away from the resident's stomach/lap area. Later, while obtaining vital signs, V15 again observed V17 moving his hands from the same area, at which time R42 reportedly had her hand near the waistband of her pants. V15 reported these observations to V1.On 3/6/2026 at 7:33 AM, V1, Administrator and V28 Business Office Manager (BOM), confirmed that the investigation dated 1/2/2025 represents the complete investigation.R42's abuse investigation dated 7/17/2025 documents two staff members reported possible inappropriate behavior between R42 and her V17. V16, Certified Nursing Assistant, CNA, reports that when she (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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>went into R42's room to obtain vitals V17 was standing over R42 and jumped up when V16 entered and grabbed the electronic device. V17 then told V16 to come back later because they were busy. V16 and V24 returned to room, and they reported that V17 was standing over R42 with his hands down by her wheelchair. They reported V17 jumping when they entered the room. They did not see V17 touching R42 inappropriately. County Police Department, V28, Medical Director, V39, Power of Attorney, POA, V8, Ombudsman, and Adult Protective Services were all notified of the incident. V40, local police arrived. V40 stated they will make note of the incident but stated there was nothing they can do regarding this incident as no evidence of any abuse is noted. Adult Protective Services came out to facility. She also noted that there was nothing that they could do as there was no evidence of abuse. V39 noted that this incident is absurd. V17 stated 'Not again, I didn't do anything. We were just playing on the computer. I understand you must investigate.' Based on the statements from the staff members, this abuse is unfounded. No evidence to support abuse. On 3/5/2026 at 10:15AM V10, CNA, stated in December I went into R42's room to get a mechanical lift. When I went into the room I saw V17 (family member) standing next to the bed with 1 leg on a chair and R42's shirt was pushed up below her breasts. V17 was dressed. V17 was very rude and said they were playing cards, R42 didn't need anything, and I didn't need to be in there. Then he started yelling out cards. The room was silent before I entered. I told V1 and she asked me to write a statement. I wrote a statement and left it at the nurse's desk. I don't know if V1 got it. On 3/5/2026 at 1:00PM V1, Administrator, stated R42 went out to local hospital for a sexual assault kit. It was suggested by the police. The nurse did a head-to-toe assessment. I called V39 Power of Attorney. and she consented. V39 was very angry about it. They are looking for different placement for R42. As far as we know R42 is coming back here this afternoon. In December V10 told us about seeing V17 having his leg on a chair and R42's shirt being pushed up. V17 was here at the time, and we went and talked to him. R42's room is under video surveillance. It is V17's video. When we went in room V17 replayed the video for us. V27 and V28, Business Office Manager, BOM, both watched the video and saw nothing out of the ordinary. I did not investigate because we watched the video and talked to V17. The video was not confirmed by date or time and was viewed on V17's personal cell phone. On 3/5/2026 at 1:05PM V28 Ombudsman, stated I watched the video in December 2025 when V10 CNA made an allegation of V17 being inappropriate with R42. V10 said V17 had his leg up on a chair and that R42's shirt was pushed up under her breasts. V17 was here at the time. V17 denied anything and played the video for us. It is V17's video footage. The video did not show anything inappropriate. We did not see V17's leg up or R42's shirt pushed up. On 3/10/2026 at 12:00PM V38 CNA, stated I am not sure of the date, but I want to say it was back in December. I went in R42's room and V17 had his leg up on R42's wheelchair and his pant leg was up to his thigh. He had on nylon shorts I remember that. When I came in the room V17 jumped back and his pant leg went down. He was very anxious. It was time for R42 to go to lunch. I reported this incident to V28. I had heard rumors of R42's breast being out and V17 being inappropriate. I used to notice when V17's wife was with him he wore pants, but when he came in by himself, he would wear gym shorts. On 3/10/2026 at 2:00PM V1, Administrator stated V10, CNA, told V28 BOM, and V1 that V17, Family Member, was in R42's room and had leg on chair and jumped back when V10 entered without knocking. V10 did not report that any body parts were exposed. V17 was still in facility when V10 made the allegation. V17 came into V1's office. There is a camera in R42's room that is the family's camera. The camera footage did not show anything inappropriate. V17 said V10 startled him. We did not tell V17 to leave, and we did not investigate because the camera footage did not show anything wrong. V10 said he wrote a statement of what he saw in R42's room but I never got the written statement. On 3/10/2026 at 2:20PM V28, BOM, stated in December 2025 V10 came in and told V1 and I that he saw V17 with his leg up on a chair holding R42's computer. V17 jumped back when V10 came into R42's room. V17 and R42 were both clothed. V10 wanted to share what he had seen. V17 is 'different.' He gets close when he talks. V10 said he wrote a statement, but it was never given to us. V17 said he was just startled when V10 came in without knocking. V17 showed us the video, (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and we saw nothing inappropriate. We did not investigate because we did not think anything happened. The video was viewed without confirming date, time, and was viewed on V17's personal cell phone. On 3/6/2026 at 9:55AM V1 and V28 brought in forms to surveyor and stated We are making a checklist, so this situation never happens again. We are talking to all our staff, and they will sign that they have read and understand how to report any abuse. Anyone can call the police and report this. V28 and I are both the abuse coordinators and staff are to come to us. On 3/10/2026 at 1:00PM V35 (Medical Director) stated R42 is unable to consent to any type of sexual advancement and in a normal person psychological harm of Posttraumatic Stress Disorder, PTSD or anxiety could occur and it is really unknown the impact long term of psychological harm but had the Potential for serious harm. Facility's undated abuse policy states It is the policy of [NAME] Memorial Home to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility does not discriminate in providing services on account of membership in any protected class, including, without limitation, race, color, creed, religion, national origin, sex, disability, or sexual orientation. A board member, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator. The nursing home administrator or designee will report abuse to the state agency per state and federal requirements. Nursing Home 1150B Rules and Regulations state all employees are required, to any reasonable suspicion of a crime committed against a resident, to call 911 or [NAME] Co. Sheriff.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct thorough investigations for allegations of sexual abuse and failed to protect a resident during active investigations for 1 (R42) of 1 resident reviewed for abuse in the sample of 26. This failure resulted in R42 being vulnerable with no protective measures from future potential abuse implemented. R42 subsequently was subjected to additional abuse allegations, by V17 (family member) on 1/2/25, 7/17/25 and 2 not dated allegations from December 2025. A reasonable person would expect to be free of abuse, and protected from further allegations of abuse. Following these circumstances, a reasonable person would potentially experience severe psychological harm with feeling shame, guilt, anger, and embarrassment. Findings include: The Immediate Jeopardy began on 1/2/2025 when V15, Certified Nursing Assistant, CNA, reported an allegation of sexual abuse involving R42. No protective measures were implemented to ensure R42 remained free of abuse following the allegation, subsequently allowing another sexual abuse allegation to occur on 7/17/2025 and 2 more reported allegations in 12/2025 that were not investigated. V1, Administrator, and V28, Business Office Manager, BOM, were notified of the Immediate Jeopardy on 3/10/2026 at 3:55 PM. The surveyor confirmed by observation, interview, and record review, that the immediacy was removed on 3/11/2026, but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of the in-service training. R42's face sheet documents an admission date of 2/19/2024. Diagnosis include: Hypertension with Heart Failure, Dementia, Narcolepsy, Chronic Respiratory Failure, Primary Osteoarthritis. R42's Minimum Data Set, MDS, dated [DATE] documents R42 is severely cognitively impaired. R42's hospital records dated 3/5/2026 at 3:10PM stated V39 (family member) stated R42 has always been mentally slow, and she does not like to be touched. On 3/3/2026 at 8:00AM V1, Administrator was informed that a sexual abuse allegation was made to the Illinois Department of Public Health (IDPH). V1 stated she was not aware of any sexual abuse allegations in the facility currently. V1 provided sexual abuse investigations dated 1/2/2025 and 7/17/2025 both regarding R42. On 3/5/26 at 9:46 AM, V14, Police Officer, stated one of the staff he interviewed stated they saw V17 (family member) drop [NAME] and had his penis in R42's face. V14 continued by saying, at this point the facility just needs to take action and remove V17 from the facility and find a new Power of Attorney, POA. R42's sexual abuse allegation dated 1-2-2025 states at 2:20pm, V15, Certified Nursing Assistant, CNA, reported an encounter that made her uncomfortable with R42 and V17 to V27, Social Services Director. V27 immediately came to V1, Administrator, to report this. V1 called V15 to her office to investigate what had happened. V15 reports that she walked into R42's room without knocking to check on R42. The door was shut and V15 did not knock before entering. V15 reports that V17 makes her feel uncomfortable when V15 walks in the room. V15 reports walking in the room and V17 moving his hands from the R42's lap area quickly. V15 reports going back into the room a second time without knocking again and the same thing occurring. V15 reports that she did not see V17 touching R42 inappropriately. V15 reports the encounter just made her feel uncomfortable. Spoke to V17 to inform him of statement made by V15. He says V15 came into the room to check on R42 without knocking and it startled him. He was holding her computer so she could play solitaire so yes when v15 came in the door V17 moved his hands away because he was startled. V17 reports that he would never do anything to harm R42 and has never touched her inappropriately. He reports that R42 has always been not fond of being touched by anyone. He says that if it makes the staff member more comfortable, he will visit with the door open. V17 and V39 close the door for privacy. It is the determination of the investigation conducted by V1 and V27 that no sexual abuse or abuse of any kind occurred involving V17. According to V15's written statement dated 1/2/2025, she entered R42's room during report and observed V17 quickly moving his hands away from the resident's stomach/lap area. Later, while obtaining vital signs, V15 again observed V17 moving his hands from the same area, at (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>which time R42 reportedly had her hand near the waistband of her pants. V15 reported these observations to V1. On 3/6/2026 at 7:33 AM, V1 and V28 confirmed that the investigation dated 1/2/2025 represents the complete investigation. Review of the investigation includes no acknowledgement a computer to have been in use versus V15's written statement account, no interventions implemented to safeguard R42 during the sexual abuse allegation investigation or identify R42's vulnerability and risk for future allegations. On 3/5/2026 at 1:50 PM, V15 stated that while working at the facility in January 2025, she was caring for R42. After assisting with changing R42's shirt, V15 returned to the room and observed R42 seated in her wheelchair facing the window, with V17 seated very close beside her. V15 observed V17's hand in the resident's lap/stomach area and noted that R42's shirt was lifted, exposing her breast. V15 stated R42 would not have been able to expose herself. When V15 attempted to adjust the resident's clothing, V17 quickly intervened and then began moving about in a hurried manner. V15 reported the incident to V1 and spoke with law enforcement, noting that V17's behavior caused concern. The facility investigation on 1/2/2025 did not contain information that R42's breast was exposed and V17 adjusted R42's shirt. No other statements for the 1/2/2025 investigation were provided. The investigation dated 7/17/2025 into alleged abuse involving R42 and V17 was initiated after two staff members reported potentially inappropriate behavior. V16, CNA, observed V17 standing over R42 and reacting abruptly when staff entered the room, by quickly moving away and requesting privacy. A second observation with V24 noted similar behavior, with V17 positioned close to R42's wheelchair and again reacting suddenly when staff entered. However, neither staff member witnessed any inappropriate physical contact. V24's, Dietary Aid, written statement states I, V24, was taking R42's vitals. I came to R42's room. When I walked in V17, I had his hands under R42's blanket. V17 jumped and stood up and said, 'Sorry I didn't know anybody knocked.' On 3/5/26 at 11:30 AM, V16 stated she did write the statement from 7/17/25. V16 stated when she went to room V17 had his chair pushed up almost touching R42's wheelchair. Her wheelchair was laid about halfway back. V17 was sitting in the chair and from the waist up he was over the top of her. Could not tell exactly which parts of him were touching which parts of her but she could not see his hands. It was just weird. V16 reported it to her nurse. Later that day V24 was taking dietary orders and I told her I would go with her because I kind of wanted to see what was happening in the room and he jumped up fast, it was just weird. V16 stated at baseline R42 is calm and nice and typically doesn't get upset or cry. When V17 visited it seemed like R42 didn't want to get touched. I noticed she cried after V17 left. When I first started working here, I was told I needed to watch V17 because R42 can't speak for herself. I can't remember who told me that or why. On 3/5/26 at 11:55 AM, V24, Dietary Aid, stated she went in to take R42's food order in July and R42 was in her wheelchair and V17 was sitting beside her with his arm under the blanket. V17 jumped up fast causing the pillow to fall to the ground. The pillow was on R42's lap propping up her computer. V24 reported this to V28. When V17 comes in he puts a sign on the door, one sign says do not disturb and the other says family is in, please knock. The signs started going up after this incident happened in July. V39 rarely visits. R42 can tell me her favorite color some days, other days just smiles and waves, some days she is not able to even obtain R42's meal order. The day of the incident R42 looked shocked with her eyes wide and seemed jumpy too. The investigation dated 7/17/2025 regarding R42 did not mention V16's allegation of V17 sitting very close to R42 and V16 being unable to see V17's hands upon entering R42's room or V24's allegation that V17's arm was under R42's blanket. On 3/6/2026 at 7:33AM V1 and V28 stated the investigations dated 7/17/2025 is the full investigation. On 3/3/2026 at 11:00AM Surveyor entered R42's room. R42 sitting up in chair with V17 and V39. V39 stated R42 does not speak. Surveyor noted video camera in R42's room and sign on door stating please knock family visit. On 3/5/2026 at 8:30AM V17 was observed to be entering facility alone. At 9:00AM V17 noted to be leaving facility. On 3/5/2026 at 9:00AM V1 stated I did not begin the sexual abuse investigation when you told me on 3/3/2026 since I did not know who it was about. On 3/5/2026 at 10:15AM V10, CNA, stated in December of 2025 I went into R42's room to get a (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>mechanical lift. When I went into the room I saw V17 standing next to the bed with 1 leg on a chair and R42's shirt was pushed up below her breasts. V17 was dressed. V17 was very rude and said they were playing cards, R42 didn't need anything, and I didn't need to be in there. Then he started yelling out card numbers. The room was silent before I entered. I told V1 and she asked me to write a statement. I wrote a statement and left it at the nurse's desk. I don't know if V1 got it. On 3/6/2026 at 2:00PM V1 stated V10 said he wrote a statement of what he saw in R42's room but I never got the written statement. On 3/5/2026 at 11:30AM V25, CNA, stated in December 2025 V10 told me he went in R42's room and V17 was in room alone with R42. V17 had his leg up on a chair and R42's shirt was pushed up under her breasts. V10 reported it. I didn't report it since V10 did. On 3/5/2026 at 1:00PM V1 stated in December 2025 V10 told us about seeing V17 having his leg on a chair and R42's shirt being pushed up. V17 was here at the time, and we went and talked to him. R42's room is under video surveillance. It is V17's video camera. When we went in room V17 replayed the video for us. V27 and V28, Business Office Manager, BOM, both watched the video and saw nothing out of the ordinary. I did not investigate because we watched the video and talked to V17. The video was watched on V17's cell phone and no confirmation of date and time or if video had been edited. No formal investigation was initiated. On 3/5/2026 at 1:05PM V28 stated I watched the video in December when V10 made an allegation of V17 being inappropriate with R42. V10 said V17 had his leg up on a chair and that R42's shirt was pushed up under her breasts. V17 was here at the time. V17 denied anything and replayed the video for us. It is V17's video footage. The video did not show anything inappropriate. We did not see V17's leg up or R42's shirt pushed up. On 3/10/2026 at 12:00PM V38 (CNA) stated I am not sure of the date, but I want to say it was back in December 2025. I went in R42's room and V17 had his leg up on R42's wheelchair and his pant leg was up to his hip. He had on nylon shorts I remember that. When I came in the room V17 jumped back and his pant leg went down. He was very anxious. It was time for R42 to go to lunch. I reported this incident to V28. I had heard rumors of R42's breast being out and V17 being inappropriate. I used to notice when V17's wife was with him he wore pants but when he came in by himself, he would wear gym shorts. On 3/10/2026 at 2:00PM V1 stated V10 told V28 and V1 that V17 was in R42's room and had leg on chair and jumped back when V10 entered without knocking. V10 did not report that any body parts were exposed. V17 was still in facility when V10 made the allegation. V17 came into V1's office. There is a camera in R42's room that is the family's camera. The camera footage did not show anything inappropriate. V17 said V10 startled him. We did not tell V17 to leave, and we did not investigate because the camera footage did not show anything wrong. V10 said he wrote a statement of what he saw in R42's room but I never got the written statement. On 3/10/2026 at 2:20PM V28 stated in December 2025 V10 came in and told V1 and I that he saw V17 with his leg up on a chair holding R42's computer. V17 jumped back when V10 came into R42's room. V17 and R42 were both clothed. V10 wanted to share what he had seen. V17 is 'different.' He gets close when he talks. V10 said he wrote a statement, but it was never given to us. V17 said he was just startled when V10 came in without knocking. V17 showed us the video, and we saw nothing inappropriate. We did not investigate because we did not think anything happened. The video was viewed without confirming date, time, and was viewed on V17's personal cell phone. On 3/10/2026 at 1:00PM V35 (Medical Director) stated R42 is unable to consent to any type of sexual advancement and in a normal person psychological harm of Posttraumatic Stress Disorder, PTSD, or anxiety could occur and it is really unknown the impact long term of psychological harm but had the Potential for serious harm. R42's care plan updated 2/23/2026 documents R42 has a self-care deficit related to weakness, dementia, hypertensive heart disease with heart failure, osteoporosis, osteoarthritis. No potential for abuse and/or interventions to keep R42 safe is included in R42's care plan. On 3/6/2026 at 9:55AM V1 and V28 brought in forms to surveyor and stated We are making a checklist, so this situation never happens again. We are talking to all our staff, and they will sign that they have read and understand how to report any abuse. Anyone can call the police and report this. V28 and I are both the abuse coordinators and staff are to come to us. Facility's undated abuse policy states It is the (continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>policy of [NAME] Memorial Home to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility does not discriminate in providing services on account of membership in any protected class, including, without limitation, race, color, creed, religion, national origin, sex, disability, or sexual orientation. A board member, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator. The nursing home administrator or designee will report abuse to the state agency per state and federal requirements. Nursing Home 1150B Rules and Regulations state all employees are required, to any reasonable suspicion of a crime committed against a resident, to call 911 or [NAME] Co. Sheriff. Facility remains out of compliance at level 2. Abatement Plan for F610- Investigate/Prevent/Correct Alleged Violation Facility failed to ensure R42 was free from abuse. The facility has ensured R42s safety by issuing a visitor restriction notice to V17 on 3-5-26 by Social Services Director. Abuse Coordinating Team called C39 to inform her of the restriction moving to indefinitely and the reasoning of these findings on 3/10/26. The letter was mailed on 3/11/26 as well as emailed to V17 and V39 on 3/10/26. Email returned with acknowledgement of receipt on 3/10/26. They were told that this was done to keep our residents, staff, and visitors safe. V17 was informed that this is in effect indefinitely and related to safety concerns regarding incidents from January 2, 2025, July 17, 2025, and two unknown dates from December of 2025. The facility (Administrator) ordered a camera system on to go in our public areas such as the hallways on 3/7/26. The purpose is to aid in staff and resident safety and to monitor visitors in the building. All residents could be affected by abuse. R42 is located at the end of the hallway so this can help monitor visitors to R42 and all residents. Nursing will round at the end of every shift to verify resident has remained free of abuse entered by administrator on 3/10/26. The Social Services Director initiated visits with resident 2x/weekly to monitor for psychosocial changes on 3/10/26. All residents were interviewed and report feeling safe and free of abuse and neglect on 3/6/26 by Social Services Director and Business Office Manager. Administration to round on every shift on 3/11/26 to monitor activities. Sexual abuse care plan has been initiated for R42 by administrator on 3/10/26. Dr. [NAME] updated on 3/10/26 and 3/11/26. R42 remains in the facility as of 3/11/26.2. Facility failed to ensure a thorough investigation for 4 allegations of sexual abuse on 1/2/25, 7/17/25, and 2 unknown dates in December. Facility initiated an Abuse Checklist to ensure compliance and document all required steps with abuse reporting on 3/6/26. All staff have been in-serviced on the checklist by the Social Services Director, ADON, Infection Preventionist, Business Office Manager on 3/6/26 and 3/7/26. All investigations will be a team effort (more than one Abuse Coordinator) to ensure accuracy and complete investigation every single time an allegation is received moving forward.3. Facility failed to ensure a system in place for thoroughly investigating alleged abuse allegations. All residents report feeling safe and free from abuse as interviewed by the Business Office Manager and Social Services Director on 3/6/26. Abuse Checklist is in place to ensure all required notifications and items are available for the investigation as of 3/6/26. The Abuse Coordinators will then use all received documentation including statements to perform a thorough investigation which includes resident assessments, interviews, etc.4. Facility failed to ensure staff are educated and knowledgeable of identification, reporting, and investigation of abuse policy. All staff have been re-instructed on facility Abuse and Neglect Policy on 3/6/26. Abuse Coordinators to conduct 10 random competency checks on 3/10/26. New Abuse Checklist is now part of new staff on-boarding.5. Facility failed to ensure ongoing monitoring compliance. QAPI members to hold monthly QAPI meeting on 3/11/26 to discuss abuse investigations, staff compliance, and staff understanding of facility policy.</p>		