STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145921	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hitz Memorial Home	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)
F 0600 Level of Harm - 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** 40701 Based on interview and record review, the Facility failed to prevent verbal and physical abuse and neglected to accurately assess a resident for injury prior to initiating a transfer for 1 of 2 residents (R99) reviewed for abuse/neglect in the sample of 25. This failure caused R99 to experience fear and increased anxiety and unknown potential further injury. Findings include: R99's Facesheet dated 9/11/2024 documents R99 was admitted to the facility on [DATE] with multiple diagnoses including but not limited to; osteoporosis, anxiety and post traumatic stress disorder. R99's Progress Notes dated 7/7/2024 documents R99 was attempting to self transfer out of her recliner, in her room and fell to the floor. It further documents R99 began complaining of right hip pain. R99's Minimum Data Set (MDS) dated [DATE] documents R99 was moderately cognitively impaired and required substantial assistance for chair transfers. On 9/9/2024 at 12:56 PM, V9, Certified Nursing Assistant (CNA) stated, I was going through taking people (residents) back to their rooms. I heard screaming and plates breaking. I saw (R99) on the floor and her recliner was tipped up. I said 'hold still, don't move'. The nurse (V5, Licensed Practical Nurse, LPN) came and automatically was like, 'I'm tired of your s**t. If you don't like it, you can go home'. He didn't evaluate her before he mistransferred (incorrectly transferred) her, instead of checking her, grabbed her up by the arms and put her back in her chair. He then walked out of the room. She (R99) wanted to call the cops. (R99) was still complaining of pain, worked up and upset. (R99) kept asking for the cops and an ambulance. (V5) was not nice, abusive in my opinion. The way he (V5) picked her up by her arms. It was rough and you could feel the aggression. He was yelling at her (R99). I called (V1 Administrator), like a minute after. (V1) was super busy and had me call (V6, Assistant Director of Nursing, ADON). She told me she was going to talk to him. Obviously they took care of it because he hasn't been back. It was pretty much the end of his shift. V9 stated R99's roommate is mildly cognitively impaired, depending on the day. At this time, V9 demonstrated how V5 picked R99 up from the ground. V9 demonstrated V5 picked R99 up, from the floor, by bilateral arms, between the elbows and shoulders and place her in her chair. (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

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 09/12/2024
NAME OF PROVIDER OR SUPPLIER Hitz Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Belle Street Alhambra, IL 62001	

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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 - Actual harm Residents Affected - Few	R99's Post Fall Evaluation dated 7/7/2024 at 12:03 PM documents R99 experienced a fall in R99's room attempting to self transfer, Resident was using remote to lift chair up to attempt to get out of chair. It continues, Called to resident room by CNA. Upon arrival it was noted resident had used remote to lift chair to highest position to self transfer. Resident slid out of chair causing her to fall to floor. Resident was laying supine on left side with a pillow under head. ROM (range of motion) WNL (within normal limits). 0 (no) apparent injury noted. V9's Statement, undated, documents V9 found R99 on the floor with her chair reclined forward, R99 asked for help and V9 went to get V5. It continues to state, As soon as he (V5) came into the room, he (V5) started telling her 'She needs to stop her shit and that if she doesn't f*****g like it here, go home'. He then asked me to help transfer her, but before I could help he grabbed her by the arms and put her in her chair. Then he walked out. It further documents V9 stayed with R99 to make sure she was ok or if she hurt anywhere, to which R99 stated she had hip and leg pain. It continues to document V9 told V5 about R99's complaints of pain, he went to check her out, and said she was fine. It further documents, She (R99) rung (used her call light) and asked for (V5) to stay away from her and to call the police. Then she wanted a(n) ambulance as well. I told (V12) and she told me to call the admin (administrator, V1). On 9/10/24 at 12:38 PM, V9 stated, I told her what I told you (see above interview). She fell and he (V5) came in. He (V5) was mean to her. I called (V1) as soon as I left her (R99's) room, after calming her down. I did mention him (V5) being rough and not assessing her. They had me write statement and send to them. (R99) wanted the cops called. The cops never came. On 9/10/2024 at 11:25 PM, V6 stated, (V5) called and told me she fell and had no injuries. (V9) called and said (R99) wanted to go to the hospital, was upset with (V5) and didn't want him back in the room. We suspended (V5) because we had conflicting stories. Also, a family member called (V1) and said (V5) was yelling at (R99). On 9/10/24 at 11:35 AM, V1 stated she was unsure if V9 talked to V1 or V6, reported V5 used profanity and said if R99 wasn't going to do what she needs, why doesn't she go home. V1 stated she does not feel that is acceptable behavior. V1 stated a family member (V21) called and reported the same thing V9 reported. V1 also stated the police were not called/informed. On 9/10/24 at 12:17 PM, V12, (LPN) stated, I did not observe or hear, but (V9) reported to me. I told her to report it. He (V5) wasn't going to send her (R99) (to the emergency room , ER) based on what (V9) heard. (V5) was berating (R99) about non-compliance. He wasn't making further moves to send her (to the ER) and he moved her (R99) without an assessment. I encouraged him to send her immediately. R99's Consult from the hospital dated 7/8/2024 documents R99 sustained an acute right hip fracture from the fall. (continued on next page)

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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 - Actual harm Residents Affected - Few	The Facility's Illinois Department of Public Health Report documents, Abuse Investigation for (R99) for 7-7-2024: (R99), a female resident of (Facility), has a PMH (Past Medical History) of lung cancer, renal mass, osteoporosis, osteoarthritis, (and) skin cancer. Resident had a fall with injury that occurred on the afternoon of July 7th. This was reported as well. The CNA on the floor that assisted the nurse with the fall called to report verbal abuse on resident from the nurse caring for this resident. Per CNA, nurse came into the room and said to resident You need to stop your shit. If you don't fu**ing like it here, go home. After putting (R99) in her recliner, he walked out of the room. She was requesting to go to the ER. Nurse told resident she was fine. The nurse from the other hall informed the administrator that the resident wanted to be sent out and that the nurse responsible for (R99) thought that she was fine. This is when the administrator let the nurse know that if the resident was complaining of pain and requesting to be sent out, especially after a fall, that is what we need to do. The administrator suspended the nurse pending investigation. POA (Power of Attorney) was notified. (V5), LPN, is the nurse in question. His statement is that he did not yell at the resident. He states that the resident was yelling at him and being combative. He informed the administrator that the Emergency Medical Technician's might report him because they were lecturing him about calling 911 in front of the resident and he asked them to transport the resident to the hospital like he called them to do. The CNA that reported the abuse (V9) says that the resident was not yelling or combative, but had been yelling and being disruptive earlier in the AM (morning). She was recently started on a prn (as needed) antianxiety medication to try to help her. The resident's roommate was asked for a statement. She is A&O x 4 (Alert and oriented to person, place, time and event). She reports that the nurse treated her with respect and did not yell or raise his voice at (R99). She reports that he did mumble something on his way out after getting her up off the floor. The CNA that reported the nurse and the nurse [CNA] have had previous issues in the past. Administration wondered if that had a play in this situation. Regardless of the outcome of this investigation, the nurse was going to be required to complete further training regarding properly assessing residents after a fall, as well as respecting their requests to be sent to the hospital for an evaluation at any time. On the morning of July 8th, the administrator received a call from a concerned family member that was visiting on July 7th, in the room next to (R99). She reports hearing the nurse yelling at the resident as well as arguing with the EMTs. A member of this family has also had an issue with the nurse in the past. The family member had been talking with her hands and pointing in the nurse's face and the nurse was upset. So, there is a history with this family member as well. Administrator attempted to call resident in the hospital to obtain a statement. She was not coherent enough to obtain a statement. Nurse was terminated. Nurse and roommate say that resident [V1 verified this was supposed to say (V5)] did not yell. A CNA and family member who have had issues with the nurse in the past say the nurse did. To prevent any further incidents with this nurse, felt it was in our best interest to terminate the relationship. On 9/11/2024 at 1:24 PM, V1 stated she did not feel what V5 said to R99 was intimidation, but she (V1) would not have said it in that manner. V1 stated V5's behavior was inappropriate and against their Facility policy. When asked how V1 thought a verbal altercation occurring at that time made R99 feel, V1 replied, Not good. When asked if the police should have been called, V1 stated she did not know how to answer the question. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/11/2024 at 2:47 PM, V19, CNA, stated, (R99) said, 'Please don't leave me. He (V5) just picked me up and threw me. I asked, 'Who?' and she said, 'that mean man'. (R99) grabbed me like she was scared. I held her hand. I figured it was (V5). (R99) asked me to call the police. I didn't know protocol since I couldn't tell the nurse since he was the one she was talking about. (V9) informed the other nurse. (R99) was asking about calling the ambulance and police. (V5) came back and asked (R99) why he should get the police called. Every time he (V5) walked past (R99's room), (R99) said he was mean man. Everything she told me, she (R99) told the EMTs. (V5) and the EMTs got into it (a verbal altercation). (R99) was right there. I intervened by asking if they needed help transferring (R99) on the stretcher. (V5) eventually walked off. I wish it would have been handled differently. On 9/12/2024 at 9:23 AM, V21, R11's niece and witness to the incident, stated, He (V5) didn't see me in the room (R11's). He was in the room next door. I could hear him screaming. I was actually kind of afraid of him. He was very angry and belligerent. I asked the CNA the nurses name and they said (V5). (V5) definitely does not belong in nursing. Poor little thing (R99) had fallen and he was screaming at her. She was confused and said she wanted the police. He screamed, 'what have I ever done to you?' They let him go (terminated employment). Being a nurse myself, I would have considered it verbal abuse for sure. (V5) yelled, 'If you don't want to stay here, why are you here?'. It was so demeaning. (continued on next page)

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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 - Actual harm Residents Affected - Few	The Facility's Abuse and Neglect Policy undated documents, 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 (local) Sheriff. The Policy continues to define; Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It continues to define: Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Verbal abuse includes, but is not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Mental abuse includes but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mistreatment- Inappropriate treatment or exploitation of a resident. Neglect- The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It further documents, It is the policy of (Facility) Memorial Home that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on interview and record review, the Facility failed to follow the Facility Policy by ensuring an abusive and neglectful incident did not occur as well as not notifying all required parties for 1 of 2 residents (R99), reviewed for abuse/neglect, in the sample of 25. Findings include: The Facility's Abuse and Neglect Policy undated documents, 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 (local) Sheriff. The Policy continues to define; Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It continues to define: Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Verbal abuse includes, but is not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Mental abuse includes but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mistreatment-Inappropriate treatment or exploitation of a resident. Neglect- The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It further documents, It is the policy of (Facility) Memorial Home that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. R99's Facesheet dated 9/11/2024 documents R99 was admitted to the facility on [DATE] with multiple diagnoses including but not limited to; osteoporosis, anxiety and post traumatic stress disorder. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R99's Progress Notes dated 7/7/2024 documents R99 was attempting to self transfer out of her recliner, in her room and fell to the floor. It further documents R99 began complaining of right hip pain. R99's Minimum Data Set (MDS) dated [DATE] documents R99 was moderately cognitively impaired and required substantial assistance for chair transfers. On 9/9/2024 at 12:56 Pm, V9, Certified Nursing Assistant (CNA) stated, I was going through taking people (residents) back to their rooms. I heard screaming and plates breaking. I saw (R99) on the floor and her recliner was tipped up. I said 'hold still, don't move'. The nurse (V5, Licensed Practical Nurse, LPN) came and automatically was like, 'I'm tired of your shit. If you don't like it, you can go home'. He didn't evaluate her before he mistransferred (incorrectly transferred) her, instead of checking her, grabbed her up by the arms and put her back in her chair. He then walked out of the room. She (R99) wanted to call the cops. (R99) was still complaining of pain, worked up and upset. (R99) kept asking for the cops and an ambulance. (V5) was not nice, abusive in my opinion. The way he (V5) picked her up by her arms. It was rough and you could feel the aggression. He was yelling at her (R99). I called (V1), like a minute after. (V1) was super busy and had me call (V6, Assistant Director of Nursing, ADON). V9's Statement, undated, documents V9 found R99 on the floor with her chair reclined forward, R99 asked for help and V9 went to get V5. It continues to state, As soon as he (V5) came into the room, he (V5) started telling her 'She needs to stop her shit and that if she doesn't f*****g like it here, go home'. He then asked me to help transfer her, but before I could help he grabbed her by the arms and put her in her chair. Then he walked out. It further documents V9 stayed with R99 to make sure she was ok or if she hurt anywhere, to which R99 stated she had hip and leg pain. It continues to document V9 told V5 about R99's complaints of pain, he went to check her out, and said she was fine. It further documents, She (R99) rung (used her call light) and asked for (V5) to stay away from her and to call the police. Then she wanted a(n) ambulance as well. I told (V12) and she told me to call the admin (administrator, V1). On 9/10/24 at 12:38 PM, V9 stated, I told her what I told you (see above interview). She fell and he (V5) came in. He (V5) was mean to her. I called (V1) as soon as I left her (R99's) room, after calming her down. I did mention him (V5) being rough and not assessing her. They had me write statement and send to them. (R99) wanted the cops called. The cops never came. On 9/10/2024 at 11:25 PM, V6 stated, (V5) called and told me she fell and had no injuries. (V9) called and said (R99) wanted to go to the hospital, was upset with (V5) and didn't want him back in the room. We suspended (V5) because we had conflicting stories. Also, a family member called (V1) and said (V5) was yelling at (R99). On 9/10/24 at 11:35 AM, V1 stated she was unsure if V9 talked to V1 or V6, reported V5 used profanity and said if R99 wasn't going to do what she needs, why doesn't she go home. V1 stated she does not feel that is acceptable behavior. V1 stated a family member (V21) called and reported the same thing V9 reported. V1 also stated the police were not called/informed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Illinois Department of Public Health Report documents, Abuse Investigation for (R99) for 7-7-2024: (R99), a female resident of (Facility), has a PMH (Past Medical History) of lung cancer, renal mass, osteoporosis, osteoarthritis, (and) skin cancer. Resident had a fall with injury that occurred on the afternoon of July 7th. This was reported as well. The CNA on the floor that assisted the nurse with the fall called to report verbal abuse on resident from the nurse caring for this resident. Per CNA, nurse came into the room and said to resident You need to stop your shit. If you don't fu*&ing like it here, go home. After putting (R99) in her recliner, he walked out of the room. She was requesting to go to the ER. Nurse told resident she was fine. The nurse from the other hall informed the administrator that the resident wanted to be sent out and that the nurse responsible for (R99) thought that she was fine. This is when the administrator let the nurse know that if the resident was complaining of pain and requesting to be sent out, especially after a fall, that is what we need to do. The administrator suspended the nurse pending investigation. POA (Power of Attorney) was notified. (V5), LPN, is the nurse in question. His statement is that he did not yell at the resident. He states that the resident was yelling at him and being combative. He informed the administrator that the Emergency Medical Technician's might report him because they were lecturing him about calling 911 in front of the resident and he asked them to transport the resident to the hospital like he called them to do. The CNA that reported the abuse (V9) says that the resident was not yelling or combative, but had been yelling and being disruptive earlier in the AM (morning). She was recently started on a prn (as needed) antianxiety medication to try to help her. The resident's roommate was asked for a statement. She is A&O x 4 (Alert and oriented to person, place, time and event). She reports that the nurse treated her with respect and did not yell or raise his voice at (R99). She reports that he did mumble something on his way out after getting her up off the floor. The CNA that reported the nurse and the nurse have had previous issues in the past. Administration wondered if that had a play in this situation. Regardless of the outcome of this investigation, the nurse was going to be required to complete further training regarding properly assessing residents after a fall, as well as respecting their requests to be sent to the hospital for an evaluation at any time. On the morning of July 8th, the administrator received a call from a concerned family member that was visiting on July 7th, in the room next to (R99). She reports hearing the nurse yelling at the resident as well as arguing with the EMTs. A member of this family has also had an issue with [NAME] in the past. The family member had been talking with her hands and pointing in the nurse's face and the nurse was upset. So, there is a history with this family member as well. Administrator attempted to call resident in the hospital to obtain a statement. She was not coherent enough to obtain a statement. Nurse was terminated. Nurse and roommate say that resident [V1 verified this was supposed to say (V5)] did not yell. A CNA and family member who have had issues with the nurse in the past say the nurse did. To prevent any further incidents with this nurse, felt it was in our best interest to terminate the relationship. The Report does not document the local police were notified. On 9/11/2024 at 1:24 PM, V1 stated she did not feel what V5 said to R99 was intimidation, but she (V1) would not have said it in that manner. V1 stated it was inappropriate and against their Facility policy. When asked how V1 thought a verbal altercation occurring at that time made R99 feel, V1 replied, Not good. When asked if the police should have been called, V1 stated she did not know how to answer the question. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/2024 at 2:47 PM, V19, CAN, stated, (R99) said, 'Please don't leave me. He (V5) just picked me up and threw me. I asked, 'Who?' and she said, 'that mean man'. (R99) grabbed me like she was scared. I held her hand. I figured it was (V5). (R99) asked me to call the police. I didn't know protocol since I couldn't tell the nurse since he was the one she was talking about. (V9) informed the other nurse. (R99) was asking about calling the ambulance and police. (V5) came back and asked (R99) why he should get the police called. Every time he (V5) walked past, (R99) said he was mean man. everything she told me, she (R99) told the EMTs. (V5) and the EMTs got into it (a verbal altercation). (R99) was right there. I intervened by asking if they needed help transferring (R99) on the stretcher. (V5) eventually walked off. I wish it would have been handled differently. On 9/12/2024 at 9:23 AM, V21, R11's niece and witness to the incident, stated, He (V5) didn't see me in the room (R11's). He was in the room next door. I could hear him screaming. I was actually kind of afraid of him. He was very angry and belligerent. I asked the CNA the nurses name and they said (V5). (V5) definitely does not belong in nursing. Poor little thing (R99) had fallen and he was screaming at her. She was confused and said she wanted the police. He screamed, 'what have I ever done to you?' They let him go. Being a nurse myself, I would have considered it verbal abuse for sure. (V5) yelled, 'If you don't want to stay here, why are you here?'. It was so demeaning.

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 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hitz Memorial Home	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on record review, interviews, and observation, the facility failed to follow a physicians order for wound dressing for 1 of 1 resident (R25) in the sample of 25 reviewed for wounds. Findings include: 1. R25's Facesheet documents R25 was admitted to the facility on [DATE] with diagnosis of systolic and diastolic congestive heart failure, diabetes, atherosclerotic heart disease of native coronary artery, diabetic retinopathy, acquired absence of left great toe, moderate protein-calory malnutrition, polyneuropathy, glaucoma, phantom limb syndrome with pain, gastro-esophageal reflux disease, generalized anxiety disorder, acquired absence of right leg above knee, hypertension, and hyperlipidemia. R25's Minimum Data Set, (MDS) dated [DATE] section C documents R25 has severe cognitive decline with a Brief Interview Mental Score, (BIMS) of 3. Section GG documents R25 requires use of a wheelchair and is dependent on staff for all care areas. Section H documents V25 is always incontinent of bowel and bladder. R25's Care plan dated 7/24/24 documented that R25 has problems related to activities of daily living, (ADL) self-care performance deficit, rejects care at times and becomes verbally abusive, impaired visual function, risk for impaired gas exchange, impaired nutritional status, and high fall risk. A problem for impaired skin integrity is included with a goal to be free of any avoidable pressure injuries. Interventions include to encourage to change position every 2 hours, check skin weekly and follow current treatment orders as written. R25's Physician Order Sheet dated 8/23/24 stated to cleanse umbilicus wound with wound cleanser, apply xeroform to wound bed, and cover with dry dressing. R25's August 2024 Treatment Adminstration Record documented R25's umbilicus dressing change was not performed on August 1 2024, which was left blank. On 9/10/2024 at 10:00 AM R25's Umbilicus wound was observed open to air with creamy white drainage noted. When asked V7, CNA, about the fact that there was no dressing on the umbilicus wound, V7 stated that staff had been letting it air out, especially since R25 has been picking at the dressing. V7 stated she did not know if the dressing was present ealier this morning because night shift had gotten him up. 09/11/24 10:55 AM V16, Registered Nurse (RN) stated the wound care orders for the umbilicus wound is performed by evening shift and are to apply xeroform and a dry dressing. V16 stated she put a dressing on the wound this morning because there was not one there. V16 stated R25 is constantly picking the dressing off and touching the wound. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hitz Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Belle Street Alhambra, IL 62001	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Progress notes dated 8/22/24 at 11:24 AM documented that R25 continues with open area to navel. R25 picking at navel, arms, and head. Lotion applied to skin daily. R25 picks at skin often and per baseline. Open area to navel measures 2.5 x 1.8 x 0.1 cm. Wound bed is granulation tissue with scant/light serosanguineous drainage noted. R25 removes dressing often. R25's Progress notes dated 8/30/24 at 10:09 AM documented that an open area to navel measures 1.2 x 1 x 0.1 cm. Normal peri-wound. Wound bed is white/pink. Light serosanguineous drainage present. Xeroform and dry dressing continues. R25 picking at skin less this week. R25's Progress notes dated 9/5/24 at 10:00 AM, documented that an open pen area to navel measures 2 x 1. 3 x 0.2 cm. Normal peri-wound. Wound bed is white/pink. Scant to light serosanguineous drainage present. R25 noted to be picking at skin less. Treatment same. 09/11/24 11:30 AM Spoke with V6, Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON), regarding R25's wound. When asked about R25's umbilicus wound, she stated that R25 continuously picks the dressing off. V6 stated that V15, (R25's) physician, is aware and provided a copy of an order dated 9/11/2024 from V15 that he had been informed that R25 has continued to pick at skin and open area to umbilicus continues as R25 removes the dressing often. V15 wrote an order for Aquaphor to skin areas. The not dated policy titled, (Facility Name) Policy for Skin Issues and Pressure Ulcers documents, Policy: It is the policy of (facility name) that all skin issues, pressure ulcers, and areas of concern related to skin will be documented in PCC (point click care).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40701 Based on observation, interview and record review, the Facility failed to employ a Full Time Director of Nursing (DON). This failure has the potential to affect all 43 residents residing in the Facility. Findings include: On 9/9/2024 at 8:45 AM, V1 Administrator, stated, I have been doing it (performing DON duties) until we can get someone hired. We have been looking since February (2024). We have interviewed but they wanted $70 an hour. We can't do that. V1 stated she work 65-70 hours a week doing care plans and other DON duties. During this investigation, there was no observations of a DON. The Facility provided a list of Quality Assurance Members, undated, which did not include a staff member as DON. The Facility's Central Management Services (CMS) Form-671 dated 9/9/2024 documents there are 43 residents residing at the Facility.