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	IL6004501	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

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S 000	Initial Comments Annual Licensure Survey Facility Reported Investigation of 7/7/24/IL177590	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 330.1210d)6) 300.3240a) 300.3240b) 300.3240c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to

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the resident's representative and to the Department. (Section 3-610(a) of the Act)

These regulations were not met as evidenced by:

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 6/14/2024 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 7/7/2024 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

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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.

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

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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

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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.

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.

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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

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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.

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.

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(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."

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

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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

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S9999	Continued From page 10 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." (B)	S9999		