

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032979		(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 PO BOX 79, ALHAMBRA, Illinois, 62001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2642574/2791702			S0000			03/25/2026
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 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)			S9999			03/25/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. These regulations were not met as evidenced by: 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.			S9999			03/25/2026

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S9999	Continued from page 2 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 2/23/2026 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 trow" 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			S9999			03/25/2026

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S9999	Continued from page 3 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 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			S9999			03/25/2026

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S9999	Continued from page 4 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.			S9999			03/25/2026

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S9999	Continued from page 5 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 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.	S9999				03/25/2026	

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S9999	Continued from page 6 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			S9999			03/25/2026

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S9999	Continued from page 7 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 policy of Hitz 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 Madison Co. Sheriff." (A)	S9999				03/25/2026	