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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F 516	Continued From page 96 information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure resident and employee records were not stored within accessible reach of the facility's water sprinkler system. This had the potential to effect all 46 residents living in the facility. Findings include: 1. During tour of the medical records room, on 11-30-11 at 9:30a.m., paper boxes containing resident and employee files were observed stacked on wood planks and within access of the facility's water sprinkler system. The files did not have a protective covering to prevent damage if the facility's water sprinkler system would engage. 2. E9 (Medical Records) stated, on 11-30-11 at 9:30a.m., that some resident and employee files were stored in paper boxes and that there was a water sprinkler system in the medical records room. 3. E1 (Administer) stated, on 12-6-11 at 11:20a.m., the resident and employee files had not been covered and would be. 4. The facility's CMS-672 Resident Census and Condition form dated 11/30/11 documented that the facility had 46 residents.	F 516		
F9999	FINAL OBSERVATIONS	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 97 Licensure Violations 300.610a) 300.661 300.690a) 300.690b) 300.690c) 300.1210a) 300.1210b) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 98 descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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) b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 99	F9999		

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. Restorative measures shall include, at a minimum, the following procedures:
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidence by:

A) Based on record review and interview, the facility failed to report an allegation of abuse to the Administrator immediately, allowed two Certified Nursing Assistant's to have direct contact with residents after a potential abuse incident, and failed to investigate potential abuse. This had the potential to affect all 46 residents in the facility.

B) Based on record review and interview the facility also failed to operationalize the facility's abuse policy by failing to report allegations of abuse to the Administrator immediately, not investigating the allegation, and allowing two Certified Nursing Assistant to have direct contact with residents after a potential abuse incident The facility also failed to screen employees prior to hiring them; and failed to have a policy for injuries of unknown origin. This had the potential

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 100	F9999		

to affect all 46 residents in the facility.

C) Based on record review and interview the facility also failed to investigate how a displaced fracture of the tibia/fibula occurred for 1 resident (R16) in the supplemental sample.

D)Based on record review and interview, the facility failed to prevent verbal and/or mental abuse for 1 of 2 residents (R12) reviewed for abuse in the sample of 12 and 1 resident (R14) in the supplemental sample.

Findings include:

1. During the review of the facility's grievances, a grievance documented that on 3/17/11 R14 had stated that he was unhappy with the way one aide acts towards him. It documented that a group meeting was held with E3, Director Of Nursing, (DON): E4, Social Services (SS); E5 , Social Services Director, (SSD); and the resident (R14). The resolution of the grievance was that the aide was to no longer work on R14's hall. The report did not mention the staff that was not treating him properly or what he was accusing them of.

R14's Minimum Data Set, under cognitive patterns dated 6/10/11, scored him at a 7 out of 15 possible points answering some question correctly and some not correctly.

E3 and E5 are not currently employed by the facility. E4, Social Services was still employed by the facility . E4 was interviewed at 12:15 PM on 11/30/11 about the grievance. She said she recalled that R14 stated that he said that E6, Certified Nursing Assistant, (CNA) had talked to him harsh and yelled at him. R14 stated that it

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 101	F9999		

had happened more than once. She said that E6 was fired shortly after the complaint. She was asked if it was reported to the Administrator, and E4 stated that she tells E1 everything. She said at the grievance meeting that E3, former DON, made the decision that E6 would not work on the hall where R14 resided.

On 11/30/11 at 11:50 AM, E1, Administrator, was asked about the incident, and did not recall what had happened. Additional information on the investigation was requested. On 12/6/11 at 10:15 AM E1 stated that she recalled that she was off during that time period for medical reasons. The Department was not notified of the allegation. The allegation was not investigated by the administrator.

According to E10, CNA, on 12/7/11 at 2:10 PM, she stated she recalled an incident where E6 and R14 were screaming at each other about R14 not wanting to stand for her. She said she went to R14 and took over care from E6. She said she reported it to the nurse but didn't recall which nurse.

E6's employee file was reviewed. There was a employee warning notice dated 3/22/11, five days after R14 had made the grievance/abuse allegation against E6. It documented the type of offense was neglect of resident and documented "You left a resident in his wheel chair and had the curtain pulled around him. The resident normally requests to be put in bed early evening. He was exhausted. You did not relay to staff that he was still up in chair. You need to do walk through and give the next shift information as to who still needs to be put to bed. You need to be a team player. If another complaint of this nature you may be suspended. Progressive discipline will occur." E6 refused to sign the employee warning

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 102	F9999		

notice and then did not show up for work. E1 was not notified of the allegation of abuse, the employee E6 was not suspended, and the Department was not notified and an investigation was not conducted.

On 3/29/11 the facility sent E6 a letter documenting " You are considered to have abandoned your position at (name of facility) due to the fact that you clocked out and left on March 22 after one hour of working when you were scheduled for eight hours that day. In addition you did not show up or call on your scheduled days to work on March 23, March 24, or March 25. E6's time report was reviewed for 3/5/11-4/1/11. She worked 8.5 hours on 3/18/11 the day after the first allegation of mistreatment, 8.25 hours on 3/19/19/11, 8.5 on 3/20/11, and 1 hour on 3/22/11 the day of the second allegation. No further documentation was provided concerning E6's employee warning for neglect.

2. During the review of the facility's grievances, a grievance documented that on 11/1/10 R15 had a concern that someone on the midnight shift told her to go ahead and urinate in bed since it was already wet. No staff was identified. No staff interviews were documented. It stated that the concern was reported to E7, Licensed Practical Nurse (LPN). Actions to resolve the concern was to type a written inservice to read and sign. Review of the inservice dated 11/1/10 documented being kind to residents and included " NEVER, NEVER tell a resident that they can go and wet or soil the bed / brief when they are requesting to go to the bathroom even if they are wet or soiled."

R15's MDS dated 1/30/11 under cognitive

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 103	F9999		

patterns scored 11 out of a possible 15 points answering most questions correctly.

On 11/30/11 at 12:05 PM, E7 said that R15 had reported to her daughter that an aide had told her to go ahead and wet the bed since it was already wet. She said the daughter told her the concern. She said she reported it to E5, Social Services, who no longer works at the facility.

At 11:50 AM on 11/30/11, E1 stated she recalled the grievance / allegation and stated that the resident could not identify the staff and that no staff would admit to it. She was asked for documentation of the investigation and none was produced during the survey. The only documentation was a written inservice for staff to read and sign. E1 did not do an investigation , narratives were not written of the interviews that were done, no names of staff, residents, or family members were listed. The Department was not notified of the allegation.

3. During an interview with Z1, family member of R2, on 12-2-11 at 11:30AM, Z1 stated she had witnessed E8, CNA, acting inappropriately with 2 residents on two different occasions.

a) The first incident was in the Dining Room when a male resident (R34) stepped away from his walker and fell. "It was an accident." E8 was talking mean to the resident and stated loudly that the resident needed to be seated at the "feeder table". Z1 stated she didn't remember exactly when, about 5-6 months ago. Z1 stated she reported it to the E5, SSD.

b) Z1 stated the second incident, concerned R12 in the Dining Room. R12 was on a liquid diet and didn't want to finish her liquids. R12 started to leave the Dining Room in her wheel chair. E8 pulled the wheel chair back to the table and told

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 104	F9999		

R12 she was not leaving until she finished her dinner and she would not put R12 to bed until she finished drinking her liquids. Z1 stated she reported this to E1.

On 12-2-11 at 12:10PM, E1 was interviewed about the incident of a resident falling and E8 talking mean to the resident and stating loudly that the resident needs to eat at the feeder table. E1 stated she was not aware of the incident and confirmed there was no documentation in the Grievance Log as per facility policy. E1 stated she was not informed of the complaint by E5 and that no investigation was conducted concerning the allegation. E1 stated E8 had been written up in the past and suspended for a day due to her conduct towards residents. E1 stated she would terminate E8 due to past allegations and will report immediately to the Illinois Department of Public Health and begin an investigation.

On 12-2-11, during meeting at 12:10PM, E1 was interviewed about the incident with E8 and R12. E1 stated Z1 had called her and told her of the incident. Z1 was upset. E1 provided a piece of paper with Z1 and E8's name on it with documentation, "R12 you will drink before you leave this table I'm not putting you to bed till you finish your dinner R12 looked sad was not crying Feels she is embarrassed. Very inappropriate..." E1 stated she did not fill out a Grievence Report as per facility policy.

During interview E1 stated E8 admitted she did it and E8 was suspended. When asked if she considered it abuse, E1 stated "It is abuse." E1 stated she felt if she suspended E8 she would know she is being watched. E1 stated she followed up by asking the Nurses how it was going with E8. E1 confirmed she did not document the allegation on the Grievance Form.

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 105	F9999		

E1 could not provide any documentation that a thourough investigation was done. Employee Warning Notice of 7-29-11 documents first warning for being disrespectful to a resident and confirmed E8 was given a 1 day suspension. . Description of Infraction is documented, "It was reported that you spoke to a resident in a disrespectful manner in the dining room on 7-27-11. It was reported on 7-28-11. You were very unkind in your treatment of a resident. You admitted to administrator that you did this." Employee Warning Notice was dated 7-29-11 E1 stated E8 was still working at the facility part time while going to school maybe 1-2 days every week. E1 allowed E8 to continue to work even though she determined E8 had abused R12.

Review of the facility Grievance Log shows no GRIEVANCE/COMPLAINT REPORT was documented concerning complaint of E8 being mean to a male resident who had fallen and stated loudly that he needs to eat at the feeder table.

On 12-6-11, at 10AM, E1 stated she was able to determine that R34 was the resident who fell in the Dining Room and the incident took place on 6/1/11. E1 stated she did interviews with staff, residents and family during the investigation and that E8 was terminated. E1 provided documentation of her investigation.

4) R16's MDS dated 8/15/11, under cognitive patterns she scored 4 out of a possible 15 answering most questions incorrectly. R16's MDS dated 5/15/11 documents that she is dependent on staff for transfers, hygiene/bathing, and needs extensive assist from staff for dressing, and eating. She expired at the facility on 9/18/11.

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 106	F9999		

Based on the facility's occurrence report of 6/14/11, R16 sustained an injury of unknown origin to the right lower leg. The documented resident statement was "It hurts. I don't know what happened." Other actions to be taken were to continue to make sure side rails are padded . Cradle right lower extremity with bath blanket for comfort. Minimize movement. The report documented that there was pain when range of motion was performed, transfers with a mechanical lift and she was independent in bed mobility. The facility's narrative report dated 6/21/11 documented "R16 is a 77 year old female resident first admitted to this facility on 8/11/2008. She had been living in her daughter's home. Review of her history and physical reveals a history of advanced Huntington's chorea, major depressive disorder and anxiety. The primary medical doctor was updated as well as well as her responsible party and hospice nurse." It goes on to document that "On 6/16/11 the charge nurse noticed bruising to the the right lower leg, and updated the medical doctor who ordered a x-ray. Mobile x-ray was able to get the x-ray the same day and results revealed displaced fractures of the tibia and fibula. The report goes on that R16 is typically up in a reclining chair for all meals and then repositioned back in bed. R16 may have struck her lower leg on the edge of the table before the discovery. The report did not mention if staff were interviewed or how they came up with the possibility of her hitting her leg on the table. The injury of unknown origin was faxed to the Department on 6/21/11, seven days after the discovery, and five days after the injury was identified as a fracture.

In an interview with E1 on 12/6/11 at 10AM, she confirmed that the one investigation that was

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 107	F9999		

reviewed was the complete investigation.

5. Thirteen employee files were checked on 11/29/11 for reference checks, registry checks and if checks were made with licensing boards. E15 - E24 , CNA's, files were reviewed. The facility failed to have evidence in their files that past work histories were checked for E15 - E20, E22, and E24. The nurse aide registry was not checked in a timely manor for E17, E18 and E19. E17 was hired on 7/13/11, her registry check was dated 9/23/11. E18 was hired on 6/16/11, her registry check was dated 11/29/11 the day the files were requested. E19 ws hired 3/29/11, her registry check was was dated 11/29/11 the day the files were requested.

The files of E25, Activity Assistant, and E26, Housekeeper, were checked. The facility failed to check their past work histories for concerns. The file of E27, LPN, was checked. There was no evidence that the Department Of Professional Regulations was checked to see if their had been any disciplinary action.

6) a) The facility's Abuse Prohibition Program Policies,definitions of abuse; example G. documents repeated verbal harassment such as name calling, cursing, yelling or rough tone of voice at a resident. It also defines neglect and identifies an example of allowing a resident to sit in urine or feces for an excessive amount of time, failed to change diaper, clothing, or bed clothing when needed. It documents that it is everyone's responsibility to report suspicions of neglect or abuse to the administrator immediately. It documents that if an employee is suspected of resident abuse, they will be immediately suspended. The allegation will be documented on

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 108 an Incident Report for matters of physical abuse and on a Grievance Form for matters of suspected misappropriation of resident property or verbal abuse. An initial report will be sent to the Department Of Public Health within 24 hours of alleged abuse. It defines the Administrator as the Abuse Prevention Coordinator and documents that they will discuss the situation with the resident and / or legal representative and notify staff who need to conduct the investigation assessments which will be in narrative form on the incident report or the grievance report. These will then be given to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will investigate the matter and compose a narrative report. The Abuse Prevention Coordinator will make a determination that will be sent to the Department regarding the validity of the matter. b) A review of the facility's Abuse Prohibition Policy indicated there were no procedures to follow for injuries of unknown origin and how they would be investigated and reported to the Department. E1, Administrator, was asked for their policies and none were produced. c) The facility's Abuse Prohibition Program policy documented that all employees in all departments will complete a criminal background check. All employees are checked before hired and monthly through the nurse aid registry. The policy did not include checking past employers to determine eligibility or to check licensing boards for professional staff. (A)	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 109 300.610a) 300.1010a)1) 300.1010b) 300.1010c) 300.1010e) 300.1010h) 300.1210a) 300.1210b)4) 300.1210c) 300.1210d)2)3)4)A)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies a) Advisory Physician or Medical Advisory Committee 1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician,	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 110	F9999		

he may be the advisory physician.
b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.
c) Every resident shall be under the care of a physician.
e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 111 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) 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 112 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 113 by: Based on interview, observations and record review, the facility neglected to assess and treat multiple pressure ulcers for 1of 4 residents (R1) reviewed for pressure ulcer treatment and prevention in the sample of 12. The facility failed to provide pressure relief including timely repositioning for 3 of 4 residents (R1, R3, R4) reviewed for pressure ulcers in the sample of 12 and one resident (R17) on the supplemental sample. This failure resulted in R1 having no treatment orders from admission on 11/22/11 until 11/29/11 for a stage III coccyx pressure ulcer which showed deterioration with tunneling on reassessment 12/1/11. Findings include: 1. According to the Admission Record, R1 was transferred to the facility from another nursing home on 11/22/11 with multiple pressure ulcers. He has diagnoses, in part, of Renal failure with dialysis, Diabetes Mellitus, Dysphagia, gastrostomy tube and Decubitus ulcers. Physician's Orders on transfer from prior placement did not include treatment orders for R1's pressure ulcers. The facility neglected to contact the physician regarding the need for treatment orders immediately following his admission to the facility. Current physician orders also failed to reflect any treatment orders for R1's pressure ulcers although a Skin Condition Report completed by E33, Licensed Practical Nurse (LPN)/Treatment Nurse on admission identified 6 pressure ulcers ranging from stage I to IV and unstagable on his feet and coccyx. The Interim Care Plan dated 11/22/11 under Skin Issues	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 114	F9999		

identifies the goal as "I will have no further skin issues" with interventions for lotion daily and keep clean/dry but neglects to include specifics to care including treatment of the existing pressure ulcers and prevention of further skin breakdown.

The Skin Condition Report completed by E33, Licensed Practical Nurse (LPN)/Treatment Nurse, on admission dated 11/22/11 identified 6 pressure ulcers ranging from stage I to IV and unstagable on his feet and coccyx. The Interim Care Plan dated 11/22/11 under Skin Issues identifies the goal as "I will have no further skin issues" with interventions for lotion daily and keep clean/dry but neglects to include specifics to current ulcers and the need for treatment of the existing pressure ulcers and prevention of further skin breakdown.

The facility's pressure ulcer assessments done on 11/22/11 E33 documented, on the back side of the November 2011 Treatment Record, shows R1's wound measurements on admission: 1) Stage I left outer aspect foot 3cm x 0.8cm red, 2) Ball of right foot 1.1cm x 0.7cm black/unstagable, 3) Ball of left foot 1.5cm x 1.5cm black/increased soft tissue, 4) Right outer aspect of foot stage I 3cm x 1.5cm red, 5) Right heel unstagable 4cm x 2.5cm black/red, 6) Coccyx .3 x .3cm, no depth, stage IV flesh colored.

On 11/30/11 at 9:40am, E33 confirmed she assessed R1's pressure ulcers on admission and stated R1 had the wounds previously which were treated by a wound specialist. E33 stated "she tried to get orders and called yesterday (11/29/11)." E33 confirmed she received no orders on admission stating she thought R1's physician, Z4, wanted him to see the Nurse Practitioner (NP) before orders were given. E33

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 115	F9999		

stated the facility requested an order for a wound specialist but Z4, MD, wanted R1 to be seen by his Nurse Practitioner instead. Asked if she contacted the facility's Medical Director regarding the need for treatment orders, she stated the Medical Director will not see residents that are not his own patient. E33 was unable to provide any documentation or evidence that R1's physician was aware of him having no treatment orders on transfer.

A Communication Fax form dated 11/23/11 to Z4, MD from the facility includes a statement "Need order Specialized Wound Management" with "NO" written beside it but included no treatment orders to be used in the interim as they waited for the Nurse Practitioner to come. There is no documentation present in the clinical record that Z4, MD was made aware R1 had no current treatment orders on admission and no evidence that he was notified of the status of the pressure ulcers on admission. There is no further communication from the facility between 11/23/11 and 11/28/11 when the facility faxed a communication form to Z4's office with a repeated requested for an order for a wound specialist and a request for treatment orders for R1's coccyx wound. None of the other pressure ulcers were mentioned as needing treatments.

A wound assessment dated 11/28/11 showed a slight decline in R1's coccyx ulcer in depth only and was measured at that time as being 0.1cm deep. 0.3cm x 0.3cm. All other areas showed improvement. The nurses notes dated 11/29/11 at 4:15pm show a new order received from Z4 for R1's coccyx ulcer and the unstagable ulcers on both feet with a note that R1 will be seen by Z4's nurse practitioner who will address the wounds on 12/1/11. The new orders included an order to

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 116	F9999		

turn and reposition every 1 to 2 hours and Cleanse the coccyx ulcer with normal saline (NS), apply Santyl lightly pack c (with) Calcium Alginate cover c 4 x 4 and Allevyn dressing change every day and as needed.

The treatment sheets from 11/22/11 through 11/29/11 neglect to reflect any treatments or care being done to any of R1's pressure ulcers. On 12/1/11 at 9:25am E32, LPN stated R1 had not been seen by the nurse practitioner yet and stated she knew R1 had no orders for his pressure ulcers since admission. E32 stated she worked days often since R1's admission and would cleanse all his wounds with normal saline but did not apply a dressing because she "had no order for it." E32 stated it was unusual to have no orders for so long but that she thought R1's physician wanted to wait for orders until he saw his nurse practitioner. E32 stated R1 came with no orders for pressure ulcer treatments and acknowledged that she did not notify him to obtain any.

The facility policy and procedure entitled SKIN TREATMENT PROTOCOLS indicates it is the policy of the facility to "use uniform treatment protocols for all wound types unless otherwise specifically ordered by physician." Under pressure ulcers, it identifies assessing the ulcers and providing "treatment as prescribed by physician" along with additional preventative measures that include turning/repositioning, 24 hour observation checklist for CNA's (Certified Nurses Aides) to monitor existing wounds, skin protectors, and "continue to document condition of area on treatment sheet, weekly wound sheet and to "notify physician as further and/or different treatment may be required." The policy is dated 7/7/04. The policy entitled PROTOCOL FOR

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 117	F9999		

ASSESSMENT AND PREVENTION OF SKIN PROBLEMS/DECUBITUS is dated 8/8/01 and include directives to "follow the physician's orders for the treatment of skin problems." Neither policy includes directives to notify/contact the physician for orders when ulcers are noted or to do assessments of existing pressure ulcers on admission. This failure resulted in R1's coccyx wound deteriorating.

On 12/1/11 at 10:20pm, R1 was in bed with the head of the bed elevated when Z3, NP, assessed his pressure ulcers. . R1 had two cloth incontinent pads under him and his feet had protective boots and were resting tightly against the foot board of the bed. Z3 donned gloves and assisted R1 to roll to his right side. Z3 removed a hydrocolloid dressing off R1's coccyx area. His ulcer was a dimpled area which had white surrounding tissue. Z3 assessed the ulcer measurements with a tape measure and then using a q-tip end, assessed R1's ulcer measurements as 0.5cm x 0.5cm with a have 0.7cm tunneling present which had not been previously identified, stage III. This shows a decline from the assessment done 2 days prior on 11/28/11. Z3 then moved to assess R1's feet and without changing or removing her gloves, removed R1's boots then socks and assessed his ulcers on his heels. She then started to put his socks back on when asked about the black eschar area on the ball of his left foot. Z3 measured the eschar area and moved onto the other foot with the same gloves on.

At 10:40am on 12/1/11, Z3 stated she had been on vacation the previous week and had not been out to see R1. She provided faxed communication sheets when asked if R1's physician had been notified on admission that he

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 118	F9999		

had no treatment orders. Z3 reviewed the sheets and stated the physician had no notification until 11/28/11 regarding treatment orders and that had he been told that R1 came with no orders, "he would have given an order, probably, to follow their protocol" until she got in to see him. When asked if the lack of treatment to R1's pressure ulcer could have contributed to its decline stated "yea" and agreed that a lack of treatment does not promote healing.

Z3's progress note dated 12/1/11 documents R1's coccyx ulcer as 0.5 x 0.5cm with a 0.7cm depth, wound bed pink, small amount of exudate, surrounding area appears to be an area of healed wound, stage III. Z3 ordered Prototic 0.1% Topical Ointment Apply to wound and cover with DuoDerm q (every) three days and as needed.

On 12/14/11 at 11:45 a.m, E33 was asked about the staging difference between her staging R1's coccyx as a stage IV on admission and the NP staging it a III on 12/1/11. E33 stated she staged it a IV because the wound was staged a IV at his prior placement and she didn't want to downgrade it, therefore, E33 neglected to accurately assess the current condition of R1's pressure ulcer at the time of admission.

The policy for skin treatments identify a stage IV as a "full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone." The policy also indicates for stage II, III and IV's "Charge nurse or treatment nurse should assess and measure area. Document treatment sheets or infection control check sheets and/or in nurses notes regarding date, location, stage, size, appearance, depth, drainage (color), odor (amount), and signs and symptoms of infection. E33's documentation fails to reflect a stage IV ulcer on admission.

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 119 On 12/14/11 at 11:30am, E32, LPN stated R1 has been seen weekly by the Z23, NP and that R1's coccyx wound is deteriorating. E32 stated he sits for long periods of time in dialysis three times weekly and with the tube feeding, has to have the head of the bed elevated. Nurses Notes dated 12/14/11 at 730am document "decline in coccyx wound ^ (increased) in size to 0.7cm w x 0.5cm L x 0.4cm depth with scant serosanguinous drainage" The facility's policy defines Neglect as "a failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a residents physical or mental condition. Neglect may or may not be intentional." The policy includes examples of neglect as "staff not providing medical care promptly." 2. R3's Minimum Data Set, MDS, dated 10/21/11 identifies him to be A 66 year old male admitted to the facility on 10/13/10 with diagnoses, in part, of Metabolic Encephalopathy, Renal Failure, Congestive heart failure and obesity. The MDS identifies him requires extensive assist of staff for bed mobility and is dependent on staff for transfers. According to the care plan dated 10/26/11, R3 is at risk for pressure ulcer development due to incontinence and decreased mobility and a history of ulcers. Interventions include turning schedule, monitor skin, position with pillows. On 11/29/11 during tour of the building at 9:20am, R3 was up in his wheelchair at bedside. He was identified by E33, to have a history of pressure ulcers. At 11am, R3 continued to be up in his wheelchair at bedside. At 11:07am, he was	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 120	F9999		

propelled by staff to the dining room and left at a table in his wheelchair. He remained in the wheelchair throughout lunch and at 12:32pm, was taken to his room. He was transferred via a mechanical lift to bed. There were 2 cloth incontinent pads on his bed.. He had deep red/white creases throughout his upper thighs and across his buttocks. His paper incontinent brief was saturated with urine. E36, Certified Nurse Aid, CNA provided poor incontinent care as E35 CNA, assisted in turning him. His coccyx area was red, scrotum red with discoloration. R3 had no protection on his feet and refused to float them when E36 attempted to do so. E36 stated R3 was transfered to his wheelchair between 9 and 9:30am. This was confirmed by E35. No fluids were offered. At 2pm, R3 was observed to be in the same position as he was at 12:20pm.

3. R4's Physician Order Sheet (POS) shows an order on 10/9/11, to cleanse area at right outer great toe with soap and water and apply Triple Antibiotic Ointment (TAO) and an adhesive bandage until healed. There is an order documented on 10/13/11 to apply TAO to ulcer on 1st and 3rd toe on right foot daily after cleansing with Normal Saline and cover with dressing until healed.

R4's Care Plan of 9/28/11 documents R4 has chronic reoccurring cellulitis of her lower legs with a diagnosis of PVD (Peripheral Vascular Disease). Approach is to do skin assessment with daily care and weekly bath. Assess legs daily with care for blistering , redness, warm heat.

Nurses Note of 10-9-11 documents R4's bilateral lower extremities are edematous. Right great toe has an open area. Residents says her shoes are rubbing this area...will see podiatrist

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 121	F9999		

Thursday. Nurses Note of 10-13-11 documents the Podiatrist here and gave orders for Keflex 500 mg TID (twice a day) x 7 days;
X- ray right foot for cellulitis and open lesion on 1 and 3 toes of right foot; Cleanse ulcers with normal saline solution and apply TAO with dressing until healed; Use slipper to right foot until ulcers healed; Have MD (Medical Doctor) sign for diabetic shoes.

Facility WEEKLY Pressure Ulcer Surveillance Report of 10-12-14 identifies R4 as developing an in house pressure sore on 10-9-11on her right great toe, a stage 2 measuring .9 cm wide x 1 cm long. On 10-20-11 Report identifies another Stage 2 facility acquired pressure sore on R4's 3rd digit of her Right foot measuring .6 cm long x 1 cm wide.

Podiatrist report of 10-13-11 documents R4 has two open lesions for past few days may have been caused by tight shoes. Has diabetic shoes but they are tight and the Velcro is broke.

On 11-29-11 at 1:35PM, R4 stated she developed pressure sores on her toes from wearing shoes that were too big and were rubbing.

On 11-30-11 at 9:10AM, E7 LPN was observed to do treatment on R4's toes. E7 stated she had already took off the bandages before breakfast. E7 removed R4's socks and R4 did not have dressings on her pressure sores. R4's right great toe had an open pressure sore the size of a dime, red with white edges . The right middle toe had an open red pressure sore the size of a dime and red. R4's lower legs were edematous. E7 washed the pressure sore on the right great toe with soapy water, rinsed and dried. E7 placed TAO on gauze and then on R4's toe. E7 then put another gauze R4's right great toe.

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 122	F9999		

E7 used tape to adhere the dressing. E7 then proceeded to wash, rinse and dry the right middle toe. E7 placed normal saline on a gauze pad that had been sitting on the TAR, put on clean gloves and wiped the toe with gauze and normal saline. E7 put on new gloves and placed TAO on a gauze pad and administered to the toe with the gauze and then got another gauze pad and strips of tape and bandaged the right middle toe.

On 12-14-11 at 11:30AM, E33, Treatment Nurse, stated CNA's should identify reddened areas. E33 confirmed R4's pressure sores were not identified until they were already open.

4. On 11-30-11, R17 was observed to be in an activity at 10:30AM in the Dining Room and remained at the table in her wheel chair throughout the lunch meal. R17 was observed to get her food at 11:40AM and remained up in her wheel chair without being repositioned when observation was discontinued at 1:05PM.

R17's MDS of 11-28-11 identifies R17 to be at risk for developing pressure sores; requiring extensive assistance of 1 for bed mobility; and requiring extensive assistance of 2 or more staff for toilet use and transfer.

R17's Pressure Ulcer Care Area Assessment of 9-6-11 states R17 is at risk for developing pressure sores and requires assistance with mobility and hygiene. Assessment identifies R17 as being frequently incontinent of bladder and occasionally bowel; Participates in bladder program; Barrier cream is used; Cushion for wheel chair and therapeutic mattress for bed. There is nothing on the assessment that addresses repositioning.

R17's Care Plan of 9-8-11 documents R17 is at risk for pressure areas. (There is nothing on

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 123 the Care Plan addressing repositioning R17 or on the CNA Care Plan Guide. On 12-14-11 at 10:50AM, E31, Care Plan Nurse stated R17 is at risk for developing pressure sores and should be repositioned every 2 hours. E31 confirmed there was nothing on the Care Plan about repositioning R17 and how often. E31 stated it should be on the Care Plan. (B) 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 124	F9999		

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)
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. Restorative measures shall include, at a minimum, the following procedures:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 125 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. These requirements were not met as evidence by: Based on record review, observation and interview, the facility failed to assess, analyze the circumstances of falls, re-evaluate for effectiveness of interventions, attempt alternative interventions and supervise resident to minimize the risk for recurring falls and/or serious injuries for 3 of 9 residents (R7, R11, R12) reviewed for falls. This failure resulted in R12 falling during unsupervised toileting and sustaining a right arm fracture. . Findings include: 1. R12's Occurrence Report, dated 5-29-11, documented R12 fell during unsupervised toileting and was sent to a local hospital for an evaluation. R12's Radiology Report, dated 5-30-11, documented R12 received a two part fracture of the proximal humerus, right arm. E32, Licensed Practical Nurse (LPN), stated, on 12-14-11 at 8:40a.m., R12 did not have safety awareness and that she should not leave R12 alone during care. E2, Director of Nursing (DON), stated, on 12-14-11 at 8:50a.m., that R12	F9999		

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 126	F9999		

did not have safety awareness. E31, Care Plan Nurse, stated, on 12-14-11 at 8:55a.m., R12 did not have safety awareness and that she agreed R12 could not be left alone during toileting.

R12's Minimum Data Set (MDS), dated 3-6-11, documented extensive assistance of one person physical assistance with mobility and toileting, unsteady balance and only able to stabilize with human assistance with, in part, from moving on and off toilet and bilateral lower extremity impairment.

R12's Care Plan, dated 5-30-11, documented "staff to be inserviced of falls and importance of staying supervising resident during b/r (bathroom) visits."

The facility's Fall Prevention Protocol, dated 8-27-09, documented if the resident has compromised sitting balance (check MDS) scoring and/or is cognitively impaired and/or attempts to rise from chair/bed without needed assistance, staff will be instructed and supervised to provide continuos up close supervision during toileting to prevent fall."

2. R7's Occurrence Report, dated 4-18-11, documented R7 fell in the beauty shop and received a forehead laceration. The facility's investigation, not dated, documented, in part, "Beautician stated she knew she should not leave the resident but only left her for a minute. Beautician was told that her services were no longer needed."

R7's MDS, dated 2-25-11, documented R7 was cognitively impaired, extensive assistance of one person physical assistance with mobility, functional limitation in upper and lower extremities, unsteady balance only able to stabilize with human assistance with moving from

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 127	F9999		

seated to standing position and surface to surface transfer. R7's Fall Risk Assessment, dated 2-27-11, documented R7 was a high risk for falls. It was also noted "4-18-11 fall with with injury left unattended at beauty salon reprimanded stylist procedure protocol for res (resident) while in salon."

R31 stated, on 12-14-11 at 10:45a.m., R7 did not have safety awareness

3. R11'a MDS dated 10/1/11 identifies her to be totally dependent on staff for all aspects of mobility and has contractures upper and lower extremeties According to the care plan dated 10/26/11, R11 is at risk for falls due to poor posture and safety awareness. The goal is to have no falls through the next review. Interventions include 2 assist for transfers, personal alarm at all times, address immediately if sounding. According to the care plan, R11 had two falls within 9 days (4/29/11 and 5/7/11).

An incident report dated 4/29/11 documents that R11 fell from her wheelchair while sitting at the dining room table. The incident report indicated at 10:40am, R11's alarm was sounding and R11 was found on the floor on her back laying toward the right side. R11 sustained 2 skin tears measuring 5cm x 2cm on her right arm. The only intervention implemented as a result of the fall is to have occupational therapy work with R11 for posture. There are no new interventions for direct care staff implemented at the time.

On 5/7/11, R11 is documented in the care plan as falling again and sustaining a laceration of the forehead which required a trip to the emergency room for sutures. The Incident Report dated 5/7/11 indicates the alarm was "not sounding" when R11 was observed on the floor on her left

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 _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	**201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 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
F9999	Continued From page 128 side at 10:30am. The fall was unwitnessed. R11 had a "inverted "V" shape laceration 2.5cm x 2cm to middle of forehead." R11 was sent to the emergency room and returned with sutures. The facility implemented a lap cushion upon her return from the hospital. Although the report indicates that R11's personal alarm was not sounding at the time of the fall, there is no explanation/investigation as to why it wasn't. On 12/1/11 at 1:07pm, R11 was observed in her wheelchair asleep at the nurses station. She had a splint on her left elbow and a mechanical lift sling under her. R11 appeared totally dependent on staff. (B)	F9999		