STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: _____ B. WING _____	C 02/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #2390323/IL155279	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision and assistance for a resident assessed to require assistance with toileting. This failure applied to one (R3) of one resident reviewed for accidents and supervision and resulted in R3 having a laceration to her back and being sent to local hospital for evaluation and treatment. Findings include: R3 is an 85-year-old-female who was admitted to the facility on 3/10/2022 for skilled nursing/24 hours observation, with past medical history of Nontraumatic subarachnoid hemorrhage unspecified, insomnia, anxiety disorder, weakness, difficulty walking, chronic kidney disease stage 3, history of falling, primary pulmonary hypertension, etc. Minimum Data Set (MDS) assessment dated 3/21/2022 section C (cognitive) scored R3 with a BIMS of 12 (moderate cognitive impairment), section G (functional) coded R3 as requiring extensive assistance with 2-person physical assist for bed mobility and transfer, and extensive assistance with one-person physical assist for toileting and personal hygiene. Section H (bowel and bladder) of the same assessment indicated that R3 is frequently incontinent of bowel and bladder. 2/17/2023 11:55AM, While conducting rounds in the unit, observed the paramedics in the unit stating that they are here to transport a resident to the hospital. They spoke to V3 (LPN) who is	S9999		

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S9999	Continued From page 2	S9999		

the assigned nurse for the resident, V3 stated that resident had an unwitnessed fall in her room last night and sustained a laceration to her back, was sent to the hospital for further evaluation and the hospital sent her right back without doing anything. The wound care team assessed resident and the doctor ordered for the resident to be sent back to the hospital.

At 12:00PM, R3 was observed in her room in bed, alert and awake, R3 said that she is not doing well. She stated that she is hungry and tired, she fell last night while trying to go to the bathroom, R3 was asked if her call light was on and she said yes, no one came. R3 said, "you turn that thing on for a long time and no one comes, I just got up and tried to do it by myself." When the paramedics pulled up resident's clothes to assess the wound, resident was noted with a large area on her back covered with a dressing, one of the paramedics pulled back the dressing and resident had some steri strips under the dressing, area still actively bleeding.

Progress not documented by V6 (LPN) dated 2/17/2023 at 7:01AM reads: Writer heard resident calling out and went to resident's room writer note the resident's bed side table was hold open bathroom door writer noted that resident was sitting on floor of bathroom next to toilet writer asked resident what happened resident stated that she got out of and used bed side table to walk to bathroom and once in the bathroom side tried to turn around and lost her balance and slid to the floor writer also state that she hit her back on something resident was transferred to wheelchair resident was assessed and writer that resident has laceration to mid back area resident cleaned up and dressing place to laceration son called and voice mail was full Resident sent to the

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S9999	Continued From page 3 hospital ER for further evaluation and treatment. Facility fall log provided by V2 (Director of Nursing) documented the time of the fall as 4:04AM. 2/17/23 at 3:46PM, V6 (LPN) said that R3 called out, she went to the room and noticed that the bedside table was propping the bathroom door open and the resident was on the floor. R3 does not go to the bathroom by herself, she is a fall risk and staff are supposed to be monitoring her very often and remind her to use her call light. V6 said that she last saw the resident at 12:15AM, the C.N.A saw her at 12:00AM and she was toileted at that time. Resident was put in bed at 9:00PM, she wears incontinence brief and not able to use the bathroom by herself. 2/17/2023 at 4:10PM, V9 (C.N.A) said that she usually sits with R3 in her room, she was sitting with her till she fell asleep and then she left her around 11:30AM to 12:00AM. V9 said that the nurse saw the resident when she fell, V9 was in another room assisting another resident, she saw R3 last around 2:15AM when she walked past the room and resident was still in bed sleeping. V9 said she has worked with resident for about one year, she has fallen before, resident knows how to put on the call light and will put it on sometimes, R3 is a fall risk and the only intervention she is aware of is frequent checks, maybe every 30 minutes. Progress note dated 4/4/2022 states: Certified Nurse Assistant (C.N.A) notified nurse that resident slid on floor from bed. Resident stated to writer she was sitting on side of the bed and slid out of bed to the floor.	S9999		

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S9999	Continued From page 4 IDT (Interdisciplinary Team) Fall Review: Resident fell on 4/4/22 states "I needed to go to the bathroom." Per resident she states she does not always need to go to the bathroom at night or in the morning. Resident states she did put the call light on. Fall care plan dated 3/10/2022 states in part, resident is at risk for falling. Interventions include observe frequently and place in supervised area when out of bed, give resident verbal reminders not to ambulate/transfer without assistance, keep bed in lowest position with brakes on, etc. 2/17/2023 at 3:26PM, V2 (DON) said that residents who are at risk for falls are supposed to have their bed to the lowest position, call light within reach, and fall care plans are individualized according to resident needs. For R3, V2 said that she is supposed to be frequently monitored by staff. A document presented by V2 (DON) titled falls-clinical protocol (undated) states that as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. The same document states in part under treatment and management that based on preceding assessment, the staff and physician will identify pertinent interventions to try and prevent subsequent falls and to address risk of serious consequences of falling. (B)	S9999		