STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055053	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET , SOUTH HOLLAND, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		08/22/2025
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 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 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	S9999		08/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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 evinced by: Based on observation interview and record review, the facility failed to prevent an avoidable wound for R32 who was identified as high risk for skin breakdown and dependent on staff for turning and repositioning, and failed to ensure air mattress pumps were appropriately set to the resident's weight per manufacture recommendations. This affected three of three residents (R32, R3, and R64) all reviewed for pressure ulcer prevention. This failure resulted in R32 having a facility acquire stage (3) three pressure wound of the left ear measuring 1.00 cm (length) x 0.50 (width) x 0.00 (depth). Findings include: R32's Braden scale for predicting pressure sore risk dated 6/26/25 documents: high risk. Mobility: very limited: makes occasional slight changes in body or extremely position but unable to make frequent or significant changes independently. Nutrition: adequate. Friction and Shear: problem: requires moderate to maximum assistance in moving. Tissue test dated 6/27/25 documents: Resident requires more frequent turning and positioning then every 2 hours: No. Minimal data set section GG (functional abilities) date 7/2/25 documents: dependent with rolling left and right. Wound assessment detail report dated 7/30/25 documents: Wound: left ear, Status: active, Type: trauma, Classification: abrasion, Source: facility acquired. Date Identified: 7/30/25 Clinical Stage: partial thickness, Exudate: Scant: Type: serous (clear, watery fluid), Measurement: 1.00 cm (centimeters) x 0.50 cm x 0.00cm (LengthxWidthxDiameter). Progress note dated 7/30/25 documents: Noted abrasion to left ear, 100% red, small amount, no odor, serous drainage and intact. On 07/30/2025 1:39 PM, R32 was observed in bed on laying on the right side towards the door with the call light cord across the upper left body, laying on chest and clamped on the right side of her gown. R32 had an opened boarder gauze dressing on the left ear dated 7/30/25. V6 (nurse) removed the opened dressing. R32 was observed with an open area on the left upper cartilage of her ear that was white on the open outer portion of the opening and red in middle. V6 (nurse) said, R32 did not have this wound yesterday. V6 said,	S9999		

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S9999	Continued from page 2 R32 has a facility acquired pressure stage two ulcer to the ear. On 7/31/25 at 10:36am, V5 (wound nurse) said, when she entered R32's room yesterday. R32 was down lower in the bed, R32 was lying on a pillow without a pillowcase. R32's left ear wound is facility acquired. R32's wound could be caused by trauma or pressure. R32's wound came from R32 laying on the pillow without a pillowcase. V5 said, R32's wound was caused by the top of the fabric folds when it was gathered under R32's head. On 7/31/25 at 10:54am, V11 (CNA/Certified Nurse's Assistant) said, R32 is dependent on staff for being turned and repositioned. V11 said, when she did her wound rounds with V5 yesterday when they found R32's left ear wound, R32 was in bed, facing the window, on her left side, on the air mattress and her head was not on the pillow. V11 said, R32's pillow had a pillowcase on it. V11 said, when R32 was turned she saw R32 with a white area on the cartilage (curved prominence of cartilage located on the outer ear) of the left ear that wasn't there the day before. On 7/31/25 at 11:09am, R32 was observed in bed laying on the right side towards the door with the call light cord across the upper left body, laying on chest and clamped on the right side of her gown. V5 said, this is the pillow R32 had in place yesterday. V5 removed the pillow from R32's head. V5 removed R32's pillowcase. R32's pillow was observed with a blue loosely covered outer plastic soft pillow. R32's pillow was observed without thick seams consistent with R32's left ear wound indentation. The plastic covering on R32's pillow was easily gathered and moveable. V5 gathered the plastic to demonstrate the folds/creases that R32 was laying on when she found the wound. V5 said, when she entered the room yesterday, R32 wasn't laying on any cords. V5 lifted R32's call light cord and placed it above (without touching the wound) R32's wound in the same direction of the wound. V5 said, R32's wound has a similar width measurement as R32's call light cord. V5 said, R32's wound was classified as an abrasion until the wound doctor visits. V5 said, R32 was not turned every two hours as required to prevent her ear wound. On 7/31/25 at 11:37am, V5 (wound nurse) said, R32's wound on the ear was avoidable. On 7/31/25 at 12:20pm, V3 (DON/Director of Nursing) said, R32's left ear wound came from not being turned and repositioned by staff. V20's (Wound Doctor) Wound Physician Evaluation dated	S9999		

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S9999	Continued from page 3 8/1/25 documents: Stage (3) three pressure wound of the left ear full thickness. Etiology: Pressure. Pressure/Skin Breakdown – clinical protocol dated 1/2017 did not apply. 2. On 7/29/25 at 11:18AM R3 was seen in bed. Air mattress pump was at 200. R3 nonverbal to respond. On 7/30/25 at 10:15AM accompanied by V5, R3's air mattress observed at 200. V5 said it is set at 200 pounds. Record reviewed R3 most current weight is 117 pounds. On 7/29/25 at 10:52 am observed R64 in bed. R63 not answering surveyors questions. Air pump on mattress set at 280. On 7/30/2025 10:15AM accompanied by V5, Wound Nurse, observed and said R64's air mattress is set at 280 pounds. R64's current weight in her chart is 63.6 pounds. On 7/30/25 at 10:17AM V5, Wound Nurse, said the mattress is not benefiting the patients at risk for pressure ulcers if they are at the wrong settings. On 7/30/25 at 10:41AM V12, Maintenance, said our department puts out the mattress. V12 said the settings on the mattress are set according to the residents' weights. If the setting is too high then it's too hard. If it's too low it's too soft. V12 said I will be in servicing my staff on how to properly set the mattress. We don't have a policy for this. I was told how to set the mattress by the nurses. On 7/30/25 at 1:03PM V5 said R64 is at risk for pressure ulcers. She has a history of contractures. V5 said R3 is at risk for developing pressure ulcers. She has contractures that contribute to her risk. (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.615e) 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	S9999		

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S9999	Continued from page 4 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 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to follow their policy to ensure and request the criminal history background for newly admitted residents within 24 hours of admission to the facility. This affects five of six residents (R90, R123, R78, R89, and R120) and has the potential to affects all 117 residents residing in the facility. R90's admission date on facility census denotes 7/10/25, R90's criminal background history check is dated for 7/14/25. R123's admission date on facility census denotes 7/25/25, R123's criminal background history check is dated for 7/29/25. R78's admission date on facility census denotes 7/22/25, R78's criminal background history check is dated for 7/29/25. R89's admission date on facility census denotes 7/10/25, R89's criminal background history check is dated for 7/14/25. R120's admission date on facility census denotes 7/25/25, R120's criminal background history check is	S9999		

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S9999	Continued from page 5 dated for 7/29/25. On 7/31/25 at 10:40am V1 (Administrator) said herself and her staff was under the impression that the criminal history can be completed on the next business for residents admitted on Fridays or Saturdays. V1 said she has to implement training for the identified offenders program related to conducting background checks. Facility policy titled Identified Offenders Program last revised date 3/9/2018 denotes in-part to promote the safety of residents, visitors, and staff, facilities not exempted by 210ILCS must screen potential residents for information relevant to determining each person potential for placing others at risk of harm. Requesting UCIA criminal history records. Within 24 hours of an admission, facilities must request a Uniform Criminal Information Act name-based criminal history record from the Illinois State Police using the Criminal History Information Response Process. (C)	S9999		