STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Holland Manor Hth & Rhb	2145 East 170th Street South Holland, IL 60473

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedures for notice of change in condition by not ensuring resident's family members were notified of changes in resident health status and medications. This failure applied to three of four residents (R4, R5, and R7) reviewed for notice of change. Findings include: 1. R4 is a [AGE] year-old female who was admitted to the facility 03/09/2023 with a diagnoses history of Lower Back Pain, Spinal Stenosis, Generalized Muscle Weakness, and Difficulty in Walking. On 06/14/2024 at 4:25 PM R4 is observed in her room sitting in the wheelchair. R4 stated she did select V21 (R4's Family Member) as her emergency contact and had informed the facility that she did want her sister notified about any changes in her health. R4's face sheet documents V21 is her emergency contact. R4's Thyroid Labs collected 04/12/2024 and 04/24/2024 documents abnormal Thyroid Hormone levels. R4's current physician orders document an order effective 04/23/2024 for thyroid medication to be given once daily for Hypothyroidism. R4's progress notes and medical records from 04/01/2024 - 06/14/2024 do not include documentation that V21 was notified of R4's abnormal labs or changes in her medication orders. 2. R5 is a [AGE] year-old female who was admitted to the facility 11/27/2023 with a diagnoses history of Schizoaffective Disorder, Recurrent Major Depressive Disorder, Spondylosis, Dorsalgia (Pain in top of foot), Visual Loss in Both Eyes, and Repeated Falls. On 06/14/2024 at 2:47 PM R5 stated she never had physical therapy and needs some because she developed a pain in her left side. R5 stated her sister is probably the one that would be called if there are any changes in her health status. R5's face sheet documents V22 (R5's Family Member) is her emergency contact and responsible party and V23 (R5's Family Member) is her second emergency contact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress note dated 5/29/2024 at 12:49 AM documents Per nurse practitioner, upon assessment a knot was observed on the left side of R4's breast, due to continued pain. Orders were noted and carried out. An appointment will be set up for mammogram. R5's physician order history documents an order effective 05/29/2024 for a Bilateral diagnostic mammogram related to a diagnosis of lump in left arm pit area. R5's Comprehensive Metabolic Panel Lab Report dated 05/30/2024 documents multiple abnormal labs. R5's progress note dated 6/13/2024 at 2:23 PM documents an assessment was completed due to complaints of pain. R5 states she was dropped off because she did not feel good, reporting pain to the right and left side of her body which is unrelieved by the ordered lidocaine patches. Informed nurse practitioner of the condition, and a new order for labs was entered. R5's progress notes and medical records from 05/01/2024 - 06/14/2024 do not include documentation that V22 or V23 were notified of R5's abnormal labs, or changes in her condition or treatment orders. 3. R7 is a [AGE] year-old female who was admitted to the facility 09/09/2023 with a diagnoses history of Alzheimer's Disease, Age Related Osteoporosis, Low Back Pain, Abnormal Posture, Weakness, Disorders of Bone Density and Structure, Repeated Falls, Unsteadiness on Feet, and Sprain of Right Knee. On 06/14/2024 1:44 PM V3 (R7's Family Member) stated when she was visiting R7 at the facility R7 began complaining of pain behind and pointing to her left ear. V3 stated when she reported R7's pain to the nurse the nurse responded in a nasty tone that she was already aware of it and had already medicated her for it. V3 stated the nurse was aware of R7's pain but she wasn't aware of it. V3 stated the nurse had not informed her about R7's pain. V3 stated she was told by the nurse that it's not their policy to inform family of every little pain the resident has. V3 stated at this time she had been at the facility for 20 minutes and R7's pain had not been mentioned to her. V3 stated she didn't find out until a week after this incident that R7's thyroid labs were abnormal, and her thyroid medication had been increased. V3 expressed concerns that if she had taken R7 out on pass and was attempting to give her thyroid medication without being informed it was increased, she may have given her the wrong amount which may have caused a reaction or issue. V3 asked if R7's lab work revealed that she needed an increase in her medications shouldn't she know so that she can be aware of this when she takes her out of the facility. R7's face sheet documents V3 as her emergency contact. R7's progress note dated 5/7/2024 at 12:12 AM documents she began to complain of a headache and when assessed was observed to grab the left side of her face and with guarding and grimacing noted. Notified V13 (Nurse Practitioner) and a new a order was entered for Tylenol pain medication every 6 hours as needed; at 2:31 AM Notified V13 (Nurse Practitioner) of continued pain after administering Tylenol, and a new order was carried out for a one time dose of 300 mg of Gabapentin to be given. R7's Basic Metabolic Panel report dated 05/10/2024 documents abnormal labs including abnormal Thyroid hormone levels. R7's current physician orders documents an order effective 05/11/2024 for thyroid medication related to Hypothyroidism. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's progress note dated 5/11/2024 at 11:32 AM documents R7 was observed with a complaint of pain and Tylenol was administered along with scheduled medications. Physician was notified of high thyroid hormone levels and waiting for a call back; at 12:55 AM an order was placed by the physician for an immediate thyroid hormone. Left message to notify of previous thyroid hormone levels as requested and waiting for a call back; at 1:13 AM The physician requested orders be made for increased thyroid medication and repeat thyroid hormone labs in 10 days. Orders noted and carried out. R7's progress note dated 5/12/2024 at 10:12 AM related thyroid hormone lab results to physician and a new order was requested to redraw labs in 10 days. Order noted and scheduled. R7's progress note dated 5/17/2024 at 11:50 AM R7 was observed with discomfort and to be grabbing/guarding the left side of her face and her shirt is pulled up to cover her mouth. R7 verbalized pain when addressed. R7's Thyroid Lab report dated 05/24/2024 documents abnormal Thyroid Hormone levels. R7's progress note dated 5/24/2024 documents the physician was notified lab results and a new order was requested to redraw thyroid hormone labs in one week. Order noted and carried out. R7's progress notes from 05/01/2024 - 06/14/2024 do not include any documentation of notification to V3 of R7's abnormal labs, changes in medication, new or increased pain, or changes in her condition. On 06/17/2024 at 11:45 AM V2 (Assistant Director of Nursing) stated representatives should be notified about any abnormal labs or changes in their health especially if there are new orders placed regarding abnormal labs. V2 stated when family/representatives are notified of changes in their health status or orders it should be documented in the resident's medical record. V2 stated if family is present during an observation or complaint of new or significant pain, she would expect the nurse to evaluate the resident, report their observations to the physician, and inform the family/representative of each step of this process. V2 stated she would also expect the nurse to inform family of what the physician's orders are. On 06/18/2024 at 1:34 PM V2 (Assistant Director of Nursing) stated the family members listed as emergency contacts should be contacted regarding abnormal labs, changes in health status, or changes in medications or treatments. V2 confirmed that V22 (Family Member) and V23 (Family Member) should have been made aware of R5's abnormal labs, lump found in her armpit, and mammogram ordered as a result, and V3 (Family Member) should have been notified regarding R7's newly developed and increased pain, abnormal thyroid labs, and changes in her thyroid medications. V2 stated R4 is alert and oriented and responsible for herself and therefore V21 (Family Member) would not have been notified however R5 and R7's family members listed as her emergency contacts should have been notified of their changes in health related to abnormal labs, changes in medications, changes in treatments, increased or new complaints of pain, and changes in health status. V2 stated if R4 elected to have V21 notified regarding changes in her health status she should be notified. V2 stated we do notify R4's emergency contact when she's being sent out to the hospital but not regarding abnormal labs or changes in medications, treatment, or health status. V2 stated in emergencies the family is notified even if the residents are alert and oriented times 3 unless they opt not to have this done which is documented in their medical record. V2 stated she was not aware of any record of R4's request to have V21 notified of any changes in her health status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/2024 at 3:36 PM V26 (Admissions Director) stated that usually patients verbally inform us if they want to have a family member notified of changes in their health status which can be added to their face sheet. V26 stated the facility usually adds contacts based on the information received from the hospital or the resident's request to add family to their contact preferences. V26 stated otherwise there's no specific paperwork for requesting a resident's family member to be added as a contact for health changes. The facility's Notification of Change Policy received/reviewed 06/17/2024 states: It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident representative, according to their authority. Significant Change in Status (includes) deterioration in health. Significant Alteration in Treatment (includes) a need to alter treatment significantly. A significant treatment alteration includes the need to commence a new form of treatment. For requirements for notification of the resident representative: A significant change in the resident's physical status. A significant change includes deterioration in health or clinical complications; A need to alter treatment significantly. A significant treatment alteration includes the need to commence a new form of treatment. The facility shall promptly notify the resident representative and consult with the physician with changes in the resident's condition or status. Educate the resident representative about the proposed plan to treat, manage or monitor the resident's condition. Educate the resident representative about the risks and benefits of the proposed treatment change.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40718 Based on observations, interviews, and record reviews the facility failed to follow their housekeeping policy and procedures by not ensuring the memory care unit was clean and free of odors. This failure applied to all 21 residents currently located in the memory care unit. Findings include: On 06/14/2024 at 2:42 PM Observed the memory care unit with strong odors including urine just before entering the unit and directly near the entrance of the unit. On 06/14/2024 at 2:47 PM Observed a strong urine odor near R5's room located on the memory care unit. On 06/14/2024 at 2:56 PM Observed strong odors including urine near R7's room located on the memory care unit. The facility's census report documents a total of 21 residents located on the memory care unit. On 06/17/2024 at 11:45 AM V2 (Assistant Director of Nursing) stated she had observed strong odors just as you enter the memory care unit. V2 stated she did wonder what the source of the smell was. V2 stated she believes V9 (Environmental Manager) was notified of the smell but could not confirm. V2 stated it would be expected that V9 identified the source of the smell and cleaned, shampooed, or performed any necessary procedures to remove the odor. V2 stated this should be done because it's unpleasant, we have a lot of visitors over there and we wouldn't want there to be an unpleasant odor. V2 stated the residents should have a comfortable and clean environment. The facility's Housekeeping Policy Received/Reviewed 06/17/2024 states: If is the policy of this facility to maintain a clean, odor free, comfortable environment in all healthcare and public areas, which meet the sanitation needs of the facility and the resident's rights for a safe, clean, comfortable home-like environment. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to ensure that a resident received physical therapy services for which the resident was assessed and care planned for, with physician orders in place. This failure applied to one of one resident (R4) reviewed for physical therapy services. Findings include: R4 is a [AGE] year-old female who was admitted to the facility [DATE] with a diagnoses history of Lower Back Pain, Spinal Stenosis, Generalized Muscle Weakness, and Difficulty in Walking. On [DATE] at 4:25 PM R4 is observed in her room sitting in the wheelchair. R4 stated she has been in the facility since March of 2023, was discharged from PT (Physical Therapy) October of 2023 and wanted to know when she could resume but even after repeated requests there was no follow up from the PT department. R4 stated her family requested to have a meeting regarding her Physical Therapy and only wanted to speak with the Physical Therapy Director. R4 stated the facility included the Director of Nursing and Assistant Director of Nursing in the meeting and there was no mention of insurance issues regarding her PT. R4 stated it was mentioned in January that she would complain of pain during therapy. R4 stated she also experienced pain in her vagina during therapy and ever since she requested a female physical therapist because she was uncomfortable expressing this pain to a male therapist, there has been a shift in the physical therapy staff's attitude towards her. R4 stated when the Physical Therapy Director was asked by her family about her status the only response that was given was that she complained of leg pain during therapy. R4 stated she was evaluated by PT the following week and her insurance approved her for 15 therapy sessions in February. R4 stated she never received those therapy sessions because she was not informed they were approved until four days before the sessions expired. R4 stated she was told she was only approved for PT and not OT (Occupational Therapy) and she wanted to know if she could receive one without the other. R4 stated there was no communication from therapy. R4 stated if she is rehabilitated, she can return home which has been her goal since she arrived to the facility. R4 stated she has experienced significant anxiety over this issue which has discouraged her hope of leaving. R4 stated the worst thing that has ever been stated about her therapy progress was them telling her family she wasn't motivated. R4 stated she diligently works on her physical rehabilitation on her own and diligently seeks out rehabilitative services and wanted to know based on this how can anyone accuse her of not being motivated. R4's physical therapy evaluation dated [DATE] documents she was referred to therapy due to a decline in her physical functioning, was concerned that she has been in the nursing facility longer than expected with increased difficulty in standing transfers due to multiple health issues and desires to return to the community, there were no contraindications to receiving physical therapy, and she requires skilled PT services in order to facilitate an in home exercise program, increase her physical and functional abilities, and eliminate risk factors for further functional and health decline. R4's PT progress notes from [DATE] - [DATE] document she participated in 6 PT sessions, completed activities and responded well to treatments and interventions implemented during treatment sessions. R4's Physical Therapy discharge summary dated [DATE] documents she was discharged due to exhausted benefits. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Insurance notice of authorization for PT coverage dated [DATE] documents she was authorized for 15 physical therapy visits and one PT evaluation. R4's current physician orders document an active order effective [DATE] for Physical Therapy to Evaluate and Treat. R4's current restorative care plan initiated [DATE] documents she is limited in her ability to transfer herself-related to decreased strength/balance and requires a restorative transfer program with interventions including Refer to PT (Physical Therapy) as needed and R4's current care plan initiated [DATE] documents she was admitted to the facility for short term rehab with a target goal of returning home upon completion of therapy. R4's progress note dated [DATE] at 2:56 PM created by V5 (Social Services Worker) documents the Director of Social Services met with R4 in regard to her crying and she stated she felt depressed on [DATE]. R4 stated that she made an appointment with an outsider Chiropractor to get a better result within her care due to the fact she no was no longer on the therapy or a restorative program. Treatment Authorization Report dated [DATE] regarding therapy coverage dates from [DATE] - [DATE] documents R4 was preauthorized for coverage by her insurance provider for 6 sessions from [DATE] - [DATE] and for 15 sessions from [DATE] - [DATE] which have since expired with 9 of 15 sessions remaining for the period of [DATE] - [DATE] On [DATE] at 4:49 PM V2 (Assistant Director of Nursing) stated R4 has been in the facility since [DATE]. V2 stated R4 is cognitively intact, has not seen her stand up and walk however, feels she could live independently at home. On [DATE] at 11:00 AM V10 (Director of Rehab) stated R4's insurance authorization received [DATE] covered one PT (Physical Therapy) evaluation and 15 sessions. V10 stated R4 already received a PT evaluation [DATE] and would require a reevaluation prior to resuming physical therapy. On [DATE] at 11:30 AM V11 (Physical Therapy Director) stated there is no specific policy for PT services. On [DATE] at 11:45 AM V2 (Assistant Director of Nursing) stated if R4's insurance company authorizes more PT (Physical Therapy), she should have received more PT. On [DATE] at 2:48 PM V11 (Physical Therapist) stated she worked with R4 during her time with PT (Physical Therapy) services. V11 stated R4's physical therapy goal is to walk. V11 stated R4 could use physical therapy. V11 stated there is no reason R4 could not resume PT. V11 stated since May of last year R4 has never walked. V11 stated R4 is very motivated and would wheel herself to the therapy room. V11 stated R4 never missed a physical therapy session. V11 stated R4 was added for physical therapy services because of a decline in her mobility. V11 stated she believes R4 informed the nurse she wanted therapy which was reported to therapy and R4's insurance. It was then verified whether her insurance would cover the services. V11 stated when she asked R4 why she wanted therapy she responded because she was just in the bed and wanted to get up. V11 stated R4 suffers from episodes of pain in her back and knees but there was never a time where R4 could not get through a therapy session due to pain. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:31 PM V1 (Administrator) stated the facility was aware of the type of insurance benefits R4 had and agreed based on her insurance coverage there was a likelihood of her being approved for PT (Physical Therapy). V1 could not explain why the PT department couldn't wait for a response from the insurance company before discharging R4 from PT in February. V1 stated today the facility reached out to their contracted Physical Therapy Company to ask how they could confirm that the facility's former Director of Rehab received R4's insurance authorization when it was generated back in February. V1 advised she cannot confirm or deny whether the facility's former director of rehab did receive R4's authorization for PT in February. V1 stated once the insurance authorization was received for R4's PT services the PT department should have resumed her services. V1 stated she does not know why this was not done. The facility could not provide a policy for therapy services as requested during the survey.