STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145608	A. Building B. Wing	04/22/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews the facility failed to ensure resident rooms were clean and free of clutter, trash, dust, food particles, soiled linens, substances, and chemical buildup. This failure applied to four of four residents (R1, R2, R3, and R4) reviewed for environment. Findings include: 1. R1 is an [AGE] year-old male with a diagnoses history of Dementia, Parkinson's Disease without Dyskinesia, Traumatic Brain Injury, Chronic Kidney Disease, Urine Retention, Urinary Tract Infections, Dysphagia, Disorder of Muscle, and Blindness in Right Eye who was admitted to the facility 04/16/2025. On 04/21/2025 at 10:19 AM V9 (Family Member of R1) stated yesterday she observed food particles in R1's bed and she observed red stains that looked like blood and the nursing aide told her it was Jello. On 04/21/2025 at 10:34 AM, R1 is in his room sitting on his bed. Observed R1's room floors to be sticky and with some trash on it, several red particles on his bed sheet, and a gown left on his bed. R1's bedside table is sitting in front of him with a sticky substance on most of it. A clean brief is seen sitting in the chair in R1's room, a small cup with a thick cream like substance and a clean brief left sitting on a nightstand near his room window, and a gown and linens left sitting on a taller nightstand near his window. R1's Current Care Plan initiated 04/17/2025 documents he has multiple diagnoses that impede his ability to perform activities of daily living at his prior level of functioning. R1's Current Care Plan initiated 04/18/2025 documents has an ADL (Activities of Daily Living) self-care performance deficit related to a decrease in functional mobility, decreased coordination, decrease in strength, falls/fall risk, increased need for assistance from others and functional limitation with ambulation. 2. R2 is an [AGE] year-old male with a diagnoses history of Encephalopathy, Lung and Brain Cancer, Disorder of Muscle, and Cognitive Communication Deficit who was admitted to the facility 02/20/2025. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/2025 at 11:34 AM, R2 is observed in his room lying in his bed. R2's blanket is on his bed stained, the nightstand near R2's bed has a pair of latex gloves, multiple greeting cards, a clean brief, a plastic bag, and box of tissue sitting on it. Observed a chair near R2's bed with clothes sitting on the back of it along with multiple heel booties sitting in it. Observed multiple clean briefs sitting on a bedside table against the wall between R2's room closet and his bed. Observed a chair near R2's closet with two wedge pillows sitting in it. Observed a rolled mattress with a foot splint sitting on it in front of R2's room closet. R2's Current Care Plan initiated 02/21/2025 documents he has an ADL (Activities of Daily Living) self-care performance deficit related to impaired sitting balance, impaired standing balance, impaired endurance; impaired functional use, impaired strength, and impaired range of motion of left upper extremity; Impaired cognition, decreased safety awareness, and hospice care. 3. R3 is a [AGE] year-old female with a diagnoses history of Partial Paralysis Following a Stroke, Dysphagia, Breast and Brain Cancer, and Stage 2 Chronic Kidney Disease who was admitted to the facility 03/17/2025. On 04/21/2025 at 11:03 AM, R3 is observed in her room sitting up in her bed unable to speak. Observed a pillow sitting in a chair near R3's bed, a bag of clothes with clothes on top of it sitting in a chair near R3's window, her room floor sticky, food in her hair, on her gown, and on her bed, a hair cover and house shoes on the night stand next to her bed, a clean brief sitting out on a night stand near her bed, and a light urine odor near her. R3's Current Care Plan initiated 03/18/2025 documents she has limited physical mobility Related to a Contracture of her right hand, fingers, and wrist. R3's Current Care Plan initiated 03/21/2025 documents she has an ADL (Activities of Daily Living) self-care performance deficit related to Confusion, Impaired balance, Limited Mobility, and Stroke. 4. R4 is a [AGE] year-old female with a diagnoses history of Dementia, Partial Paralysis following a stroke, Adult Failure to Thrive, Dysphagia, Disorder of Muscle, and Polyneuropathy who was admitted to the facility 01/31/2025 and was readmitted [DATE]. On 04/21/2025 at 10:54 AM, R4 is observed in her room lying in her bed asleep. Observed trash on various parts of the floor around R4's bed, a pair of non-skid socks strewn across the floor, unfolded clothes sitting on top of a basin on the nightstand near her bed, and a dead fly and dust on her window seal. R4's Current Care Plan initiated 03/06/2025 documents she has an ADL (Activities of Daily Living) self-care performance deficit related to impaired mobility, and cognitive deficit. On 04/21/2025 at 11:13 AM V5 (Housekeeper) stated the floors are sticky and the stickiness is from a chemical used to treat the floors. V5 stated warm water is used to mop to help remove the stickiness of the floors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/2025 at 3:33 PM V2 (Director of Nursing) stated he instructs the nursing staff to ensure the residents have linens such as blankets during rounds and to observe when resident's need their linens changed. V2 stated nursing staff should remove food particles from resident's beds if they eat in their room. V2 stated there should not be any trash found on the floor in resident's rooms and on the resident's shower days aides are also instructed to clean the resident's room which includes putting clothes away and clearing the bedside tables and nightstands. V2 stated there should not be cluttered items in the residents rooms, in their chairs, or on their nightstands. V2 stated clean briefs should not be left on the resident's nightstands and should be put away. V2 stated this is especially true for residents such as R2, R3, and R4 who depend on staff to clean their rooms for them. On 04/22/2025 at 12:36 PM V1 (Administrator) informed per V8 (Housekeeping Supervisor) if there is stickiness on the floors, they hot mop the floor and then put it on the strip /wax schedule. The facility's Laundry Services Policy received 04/21/2025 states: [NAME] Responsibility belongs to Laundry and Nursing Personnel. Soiled linen will be placed in labeled, nonporous containers and transported to the soiled linen area for laundry. The facility's Housekeeping Services Policy received 04/21/2025 states: It is the policy of this facility to maintain a clean, odor free, comfortable and orderly environment in all healthcare and public areas, which meet the sanitation needs of the facility and residents' rights for a safe, clean, comfortable home-like environment. Policy Specifications are To ensure that the facility, equipment, furnishings and resident rooms are maintained in a sanitary manner; to provide a comfortable environment, and to prevent the development and transmission of infection. The department shall routinely clean the environment of care to keep the facility fee from offensive odors, the accumulation of dust, rubbish, dirt and hazards.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews, the facility failed to provide assistance for residents assessed to need assistance with activities of daily living and failed to provide assistance and/or supervision with feeding. These failures applied to three of three residents (R1, R3, and R4) reviewed for activities of daily living. Findings include: 1. R1 is an [AGE] year-old male with a diagnoses history of Dementia, Parkinson's Disease without Dyskinesia, Traumatic Brain Injury, Chronic Kidney Disease, Urine Retention, Urinary Tract Infections, Dysphagia, Disorder of Muscle, and Blindness in Right Eye who was admitted to the facility 04/16/2025. R1's Current Care Plan initiated 04/17/2025 documents he has multiple diagnoses that impede his ability to perform activities of daily living at his prior level of functioning with interventions including assist with eating as needed. R1's Current Care Plan initiated 04/18/2025 documents has an ADL (Activities of Daily Living) self-care performance deficit related to a decrease in functional mobility, decreased coordination, decrease in strength, increased need for assistance from others and functional limitation with ambulation with interventions including requiring supervision assistance by staff to eat. On 04/21/2025 at 12:30 PM, R1 is observed in his room eating his lunch with no staff present. On 04/21/2025 at 12:38 PM, R1 has finished his lunch meal without staff assistance or supervision and with a brownie still on his meal tray to his right. When asked by surveyor if R1 was going to eat his brownie R1 asked what brownie and surveyor observed him to be unable to see the brownie or locate it with his hands. Observed R1 to locate the brownie with his hands when verbally guided by the surveyor. Observed R1 pick up the brownie and begin eating it. R1's Point of Care Eating Reports from 04/16/2025 - 04/21/2025 document he ate multiple meals independently and multiple meals with set up or clean up assistance only. 2. R3 is a [AGE] year-old female with a diagnoses history of Partial Paralysis Following a Stroke, Dysphagia, Breast and Brain Cancer, and Stage 2 Chronic Kidney Disease who was admitted to the facility 03/17/2025. On 04/21/2025 at 11:03 AM, R3 is observed in her room sitting up in her bed with her breakfast meal sitting on the bedside table in front of her and her breakfast barely eaten and no staff assisting her with eating. Observed food particles in R3's hair, on her gown, and on her bed. On 04/21/2025 at 11:50 AM, R3 is observed sitting in her bed with food particles in her hair and on her bed and her barely touched breakfast tray sitting on a table near the wall away from R3. On 04/21/2025 at 12:56 PM V3 (Certified Nursing Assistant/CNA) stated R3 doesn't eat sometimes but will eat everything if you feed her. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Admission Minimum Data Set Functional Abilities Section assessment dated [DATE] documents she requires supervision or touching assistance when eating. R3's Current Care Plan initiated 03/18/2025 documents she has limited physical mobility Related to a Contracture of her right hand, fingers, and wrist. R3's Current Care Plan initiated 03/19/2025 documents she has a potential nutritional problem related to a mini nutrition assessment score of 9 and is at risk for malnutrition with interventions including Monitor/document/report as needed any symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. R3's Current Care Plan initiated 03/21/2025 originally reviewed by surveyor 04/21/2025 documents she has an ADL (Activities of Daily Living) self-care performance deficit related to Confusion, Impaired balance, Limited Mobility, and Stroke with interventions including requiring supervision assistance by staff to eat which was revised upon receipt from facility on 04/22/2025 to one to one feeder. R3's dietary progress note dated 4/9/2025 documents her current body weight 94.2 pounds with a Body Mass Index of 17.2 indicating she is underweight; Presents with significant weight loss of -5.5% in 7 days from 99.7 pounds 03/26/2025 and -6.2% from 100.4 pounds 03/17/2025; Her weight loss is undesired and unplanned. Noted resident is a one-to-one feeder. R3's current physician orders document an order effective 04/09/2025 for one-on-one feeding assistance. R3's Point of Care Eating Reports from 04/01/2025 - 04/21/2025 document she receives setup or cleanup assistance only for most of her meals. 3. R4 is a [AGE] year-old female with a diagnoses history of Dementia, Partial Paralysis following a stroke, Adult Failure to Thrive, Dysphagia, Disorder of Muscle, and Polyneuropathy who was admitted to the facility 01/31/2025 and was readmitted [DATE]. On 04/21/2025 at 12:33 PM, R4 is observed left alone with her lunch tray, leaned over in her bed struggling to grab her milk and food. Observed R4's hands and arms to be trembling when attempting to grab items from her tray. On 04/21/2025 at 12:40 PM, R4 is observed alone in her room with her lunch meal barely touched. R4 stated she needs a little bit of help but she'll do it on her own. On 04/21/2025 at 12:48 PM, R4 is observed alone in her room with her lunch meal barely touched. R4 stated they help her eat sometimes, it is hard to grab things and if they don't help her there is nothing she can do. On 04/21/2025 at 12:51 PM, observed V4 (CNA) in the hall near R4's room and when asked if she was available V4 stated she was about to respond to another resident's call light and collect some trash. V4 responded thank you when the surveyor informed her that R4 needed some help with eating. Observed V4 approach R4's room. R4's Admission Minimum Data Set Functional Abilities Assessment 03/10/2025 documents she requires supervision or touching assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Current Care Plan initiated 03/06/2025 documents she has an ADL (Activities of Daily Living) self-care performance deficit related to impaired mobility and cognitive deficit, wounds with interventions including requiring supervision assistance by staff to eat. R4's Current Care Plan initiated 03/07/2025 documents she has a nutritional problem related to her mini nutrition assessment score indicating malnutrition; she was recently discharged from this facility 2/22 and significantly deconditioned while home & now presenting with significant weight loss from previous admission with interventions including Monitor/document/report as needed any signs and symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. R4's Point of Care Amount of Food Eaten Reports from 04/01/2025 - 04/21/2025 document she ate independently multiple times and eats with setup or cleanup assistance only for most of her meals. R4's dietary progress note dated 4/16/2025 at 11:30 AM documents staff reports she continues to eat poorly, and needs significant encouragement to eat; was seen by the registered dietitian 4/9/2025 for weight loss, her current body weight is 126.3 pounds as of 04/09/2025 with a Body Mass Index of 20.4 which is within normal limits but less than desirable for age. 04/21/2025 3:33 PM V2 (Director of Nursing) stated eating supervision includes setup and cueing if needed and monitoring because the staff have to record how much is eaten. V2 stated R1 can feed himself although he may need some cueing or someone observing him while he's eating and may be more suitable for eating in the dining room when he's up. V2 stated supervision during eating for R1 would include dining room eating or someone coming back and forth and checking him to make sure he's feeding himself. V2 stated staff should make sure R1 is clean after he eats meals. V2 stated R3 became a feeder due to weight loss and staff should be feeding her. V2 stated R3 normally eats in the dining room and should be fed. V2 stated it's best that residents eat in the dining room to prevent food from being left in their room area and for supervision and assistance. V2 stated it's difficult to supervise residents when they are in their rooms eating. V2 stated R4 needs a lot of encouragement to eat and sometimes refuses feeding assistance. V2 stated R4 should have supervision and cueing to eat and should be up and in the dining room eating. Guidelines for feeding assistance provided on 04/21/2025 in response to surveyors request for Feeding Assistance Policies states: A patient who can't self-feed is susceptible to malnutrition. Feeding a patient improves nutritional intake and clinical outcomes. Various disabilities and conditions may prevent a patient from self-feeding, including cognitive deficits, neuromuscular disease, cancer, obstructive lung disease, and traumatic brain injury. Position a chair next to the patient's bed so you can sit comfortably if you need to feed the patient. To help a blind or visually impaired patient feed, describe the placement of various foods on the plate in relation to the hours on a clock face. Provide verbal encouragement to participate in eating by talking about the food's taste and smell and providing verbal prompts to chew and swallow. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the patient is a risk for aspiration, monitor closely. When the patient finishes eating, remove the tray. If necessary, clean up spills and change the bed linens. The facility's Activities of Daily Living Policy received 04/22/2025 states: In accordance with the comprehensive assessment, together with respect for individual needs and choices, our facility provides care and services for the following activities: Dining - Eating including meals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedures for catheter care by not ensuring residents catheters were positioned properly to prevent contamination. This failure applies to two of three residents (R1 and R5) reviewed for catheter care. Findings include: 1. R1 is an [AGE] year-old male with a diagnoses history of Dementia, Parkinson's Disease without Dyskinesia, Traumatic Brain Injury, Chronic Kidney Disease, Urine Retention, Urinary Tract Infections, Dysphagia, Disorder of Muscle, and Blindness in Right Eye who was admitted to the facility 04/16/2025. R1's Current Care Plan initiated 04/17/2025 documents he has an Indwelling Catheter related to obstructive Uropathy with interventions including check tubing for kinks each shift. On 04/21/2025 at 10:34 AM, R1 is observed in his room sitting on his bed on top of his catheter tubing, his catheter tubing and bag is sitting directly on the floor in front of his bed, and R1's catheter bag is without a privacy cover on it. On 04/21/2025 at 12:30 PM, R1 is observed sitting on his catheter tubing. 2. R5 is a [AGE] year-old male with a diagnoses history of Dementia, Partial Paralysis due to Stroke, and Urinary Tract Infection 04/09/2025 who was admitted to the facility 05/04/2023. R1's Current Care Plan initiated 05/28/2024 documents he is at risk for developing a Urinary Tract Infection; R1's Current Care Plan Initiated 04/16/2025 documents he has an Indwelling Suprapubic Catheter related to Obstructive Uropathy. On 04/21/2025 at 3:23 PM, R5 is observed ambulating in his wheelchair near the nurses station on the unit where his room is located with his catheter tubing rubbing directly across the floor and half of his catheter bag out of the privacy bag rubbing directly across the floor. R5 stated he had pain in his groin area from his catheter yesterday and this morning and the pain is now gone after they adjusted it. 04/21/2025 3:33 PM V2 (Director of Nursing) stated ideally catheter bags and tubes should not be on the floor. V2 stated R5 is in a chair and moves around frequently and depending on how he moves the chair his catheter bag may move, and he just received his catheter a week ago. V2 stated he has ordered a protective bag that will seal and cover the catheter. V2 stated the catheter tubing needs to be hooked appropriately to prevent it from being dragged across the floor. V2 stated sitting on catheter tubing could cause kinks and prevent free flow and draining and nursing staff should examine the tubing to ensure there are no kinks. V2 stated if the staff position R1 correctly, he shouldn't be able to sit on his catheter tubing because it's in front of him. V2 stated R1 sitting on his catheter tubing could cause urine backflow and this would be an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Catheter Care, Urinary Policy received 04/21/2025 states: Check the resident frequently to be sure he or she is no lying on the catheter and to keep the catheter and tubing free of kinks. Be sure that catheter tubing and drainage bag are kept off the floor.