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	07/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow their policy and procedure for fall prevention by not ensuring the fall intervention of providing two-person assistance for transfers was implemented while providing care for a resident who is totally dependent on staff for transfers. This failure applies to one of four residents (R3) reviewed for falls. Findings include: R3 is an [AGE] year-old male with a diagnoses history of Rhabdomyolysis, Polyneuropathy, Presence of Left Artificial Knee Joint, History of Falling, and Generalized Arthritis who was admitted to the facility 06/07/2023. On 07/23/2025 at 11:34 AM Observed R3 in his room lying in his bead, R3 confirmed he had a fall on 07/18/2025, R3 stated he was being brought back to his room from a shower, the nursing aide placed the shower table next to his bed, and when a nursing aide was sliding him from the shower table to his bed he slid down to the floor. R3 stated he received a cat scan while at the hospital and he has bruising on his lower back. R3 stated he told them not to take him to the shower in that manner and that he preferred a bed bath, he is afraid of falling again that way, and he has asked them not to transfer him that way again. R3 stated the incident has caused him a little anxiety feeling that this may happen again. R3's Current care plan documents he is totally dependent on staff for assistance with activities of daily living, requires mechanical lift with two-person assistance for transfers, is at risk for falls and injury related to falls due to history of fall resulting in a fracture. R3's progress note dated 7/18/2025 at 3:51 PM documents he was observed on the floor next to his bed lying on his back, the nurse practitioner (NP) was notified promptly and per the NP's order, the resident was transferred to the hospital; at 8:44 PM it was noted R3 returned to the facility from the Hospital via stretcher, he complained of mild aches and lower back pain and discomfort, and was diagnosed with acute lower back pain. R3's Fall Incident Report dated 07/18/2025 at 12:00 PM documents he was observed on the floor in his room next to his bed and reported he slid off the shower bed when he was transferred from the shower chair to the bed, he was transferred to the hospital for a fall. R3's Hospital Discharge summary dated [DATE] documents he was seen for a fall and his discharge diagnosis included acute midline lower back pain. R3's physician progress note dated 7/23/2025 documents patient presents following a recent fall incident, Physical examination reveals minor bruising, the patient's musculoskeletal system review confirms the presence of bruising related to the fall. On 07/24/2025 at 1:40 PM V13 (Certified Nursing Assistant) stated on 07/18/2025 she was giving R3 a shower by herself, she asked somebody for help, and she thinks the young lady who was working with her on that unit went on break, then her nurse V5 (Licensed Practical Nurse) told her to ask her for help if she didn't find anyone, and she forgot to ask V5 for help. V13 stated she placed the shower bed towards the R3's bed and locked it, she usually takes a sheet and pulls it so she can transfer R3 to the bed and she guesses she didn't do it correctly, so she had to come around the other side of the bed to make sure R3 didn't fall. V13 stated she broke R3's fall a little but not entirely, R3 still complains about his back pain and she feels bad, V2 did speak with her about R3's fall and she was suspended for it and she was educated by V2 and moving forward she must have two person assistance for transfers, when she was preparing to transfer R3 the aide was on break the nurse was passing medications, and she didn't find any other aides around. On 07/24/2025 at 1:50 PM V2 (Director of Nursing) confirmed there should have been two-person assistance with transferring R3 on 07/18/2025 and that he did suspend V13 (Certified Nursing Assistant) for not asking for assistance with transferring R3. The facility's Fall Policies received 07/28/2025 states: The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident. Fall Prevention is achieved through an IDT (Interdisciplinary Team) approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls.Systems Approach - Tips for Compliance includes: Fall Management (Determination of risk)Develop and implement interventions.