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	01/04/2026

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an environment free of accidental hazards, failed to provide an appropriate level of supervision, and failed to ensure the availability and use of an assistive device required for safe mobility for one (R1) of four residents reviewed for falls in a sample of four. This failure resulted in R1 sustaining a fractured hip, which required hospitalization and surgical intervention.Findings include:R1 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Unspecified Dementia, Unspecified Severity with other Behavioral Disturbance; Anemia; Peripheral Vascular Disease; Essential (Primary) Hypertension; Abnormalities of Gait and Mobility; Anxiety Disorder; Bilateral Primary Osteoarthritis of Hip; Vitamin B12 Deficiency Anemia; and Vitamin D Deficiency.According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section C, R1 has BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment.According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section GG, R1's Sit-to-stand and Chair/bed-to-chair transfer ability requires partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort); R1 requires manual wheelchair as a mobility device.R1's risk fall assessment dated [DATE] shows score of 13 indicating R1 is at high risk for fall. R1's care plan initiated on 3/15/2024 reads in part, Resident requires restorative walking program due to her limitation in walking due to impaired balance r/t (related to) dementia and age-related osteoporosis. Interventions: Provide adaptive equipment as needed, (e.g. wheelchair, walker, rolling walker, gait belt, cane, quad cane); Provide appropriate footwear; Provide staff assist with ambulation at level resident requires, (e.g. set up, oversight, encouragement, cueing, physical assistance); Remind resident to not ambulate without assistance. On 1/2/2026 11:07 AM Surveyor observed R1's room. Bed in the low position, in locked position, fall mat on the left side of the bed, room free of clutter, call light attached to the headboard, no mobility devices present. R1 observed sitting in the chair, in the day room, watching TV. R1 clean and dressed appropriately; however, not wearing shoes, wearing regular socks. Surveyor did not observe R1's mobility device within R1's immediate vicinity. R1 said, I remember that I fell. I don't remember how it happened. I hurt myself. R1 pointed to her left leg and grimaced. R1 unable to answer clarifying questions, appears disoriented and forgetful. On 1/3/2026 at 9:41 AM Surveyor observed R1 watching TV in the day room wearing regular sock on her right foot and having her left foot bare. Surveyor did not observe R1's mobility device within R1's immediate vicinity. On 1/2/2026 at 11:16 AM V3 (Certified Nurse Assistant/CNA) said, I am regularly assigned to take care of R1. I was not here when R1 fell (on 9/20/2025). R1's mood varies, she's forgetful, but physically strong for her age. R1 is able to walk independently, without assistive devices. R1 freely walks around the unit. R1 requires total assistance with ADLs (Activities of Daily Living) though. Total assistance means 1-person assist and sometimes (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 - Actual harm Residents Affected - Few	2-person assist if R1 gets agitated. We don't really use a fall mat for R1, it was brought by the hospice staff, but R1 doesn't really need it. R1 is compliant for the most part but she will try to get up or get out of bed unassisted. I often hear in the hand off report, that R1 was getting out of bed at night. R1 is not a fall risk resident; however, we provide additional monitoring after R1's fall. There are no additional fall prevention interventions for R1. R1 had couple of instances of balance loss after her fall, so it looks like she's still recovering from the fall.On 1/2/2026 at 11:28 AM V8 (Registered Nurse/RN) said, On 9/20/2025, between 2:00 PM and 2:30 PM, I was at the desk when V4 (CNA) called me for help. V4 (CNA) was in the bathroom assisting R1's roommate (R3). I think R1 was walking into the room, and she fell to the floor. I think it had to do with an unlocked bed, but I don't know, I wasn't in the room. When V4 (CNA) heard R1, she came out of the bathroom and saw R1 sitting on the floor. I came right when V4 called me. I think I saw R1 sitting on the floor with her back against the bathroom door, it's been long time ago, so I don't remember all the details. I assessed R1, checked her vital signs and range of motion, and she seemed fine. We helped R1 to the wheelchair and placed her in the day room. R1 denied any pain. I notified V2 (Director of Nursing), V9 (Medical Doctor), and R1's family. R1 doesn't listen to anybody, she stands up whenever she wants, but R1 is safe to walk around without assistance. R1 wants to move around constantly. R1 is a fall risk resident, but I'm not sure if she's at high risk for fall. We keep R1's bed in the lowest position and encourage her to use a call light to prevent potential falls, but R1 is not compliant. R1 is mean and curses people out. You can't make R1 do anything. When surveyor asked why R1 is not wearing appropriate footwear, V8 (RN) didn't directly answer; however, asked V3 (CNA) the same question, and V3 (CNA) headed to R1's room to look for R1's shoes.On 1/2/2026 at 12:09 PM V4 (CNA) said, I have been working in the facility for 10 years. I normally work in the memory unit, so I'm very familiar with R1. R1 was assigned to me on 9/20/2025. After lunch, I was doing my rounds. I was assisting R1's roommate and R1 followed me into the room. I was in the bathroom with doors closed, and that's when I heard R1 make a noise like Ouch. I am not sure if she was trying to sit on the bed and missed it or what happened, I'm not sure, I was in the bathroom, I didn't see it. When I opened the bathroom door, I noticed R1's roommate's bed was shifted and R1 was sitting with her back against it. That's how I realized the bed was not in a locked position. I don't know who left the bed unlocked and for what reason, but it wasn't me. I yelled for V8 (RN) for help. V8 (RN) came in and assessed R1, R1 seemed ok. We then lifted her up, R1 was able to walk, I didn't see any issues while R1 was walking to the dining room. R1 wasn't complaining nor grimacing, just being her normal self. R1 sat in the chair until the end of my shift (3:00 PM). R1 is not a fall risk resident. R1 walks all day long, doesn't use any assistive devices. After R1 fell, we started using a fall mat and wedges. We place wedges on both sides of the bed. There is a fall mat on the left side only, because that's where R1 likes to lean towards. There is nothing else we do for her as far as preventative measures. R1 is not compliant, she does what she wants to do anyway.On 1/2/2026 at 2:24 PM V7 (Licensed Practical Nurse/LPN) said, I worked in the afternoon on 9/20/2025. R1 didn't want to eat dinner that evening. I tried to ask R1 what was wrong. R1 said that her legs were hurting. I was made aware that R1 fell on the morning shift but that there was nothing wrong with R1. I gave R1 pain medication and called hospice. When we were trying to put R1 into bed, R1 couldn't stand up and that's not normal for R1. Once R1 was in bed, I performed assessment, I didn't see any swelling or asymmetry but R1 was in a lot of pain. I actually gave R1 pain medication twice on my shift but there was not much relief. I called hospice to give them an update. The hospice nurse came in and performed their own assessment and suggested that we should send out R1 to the hospital. I called the transport ambulance to send R1 to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hospital. I didn't call 911 because it was not life or death, or emergency situation. The family and V9 (Medical Doctor) where notified. I called the hospital a little later and got an update that R1 had a fractured hip. R1 was not a fall risk resident before the fall but she is now. R1 walks fine, she doesn't use assistive devices. I believe now, CNAs make sure R1's bed is locked because that was the cause of her fall, and the bed is in the lowest position, R1 also has a fall mat on the side of her bed.On 1/3/2026 at 10:43 AM V2 (Director of Nursing/Fall Coordinator) said, I got a call from V8 (RN) on 9/20/2026, stating that R1 was found on floor in her room. I was told that R1 attempted to sit on the bed, but bed was not in a locked position, moved away from R1, and she fell to the floor. At first, R1 didn't display any pain and did not show an abnormal assessment but later, during the afternoon shift, R1 started exhibiting sings of pain and discomfort, and was sent out to the hospital where she was diagnosed with a fractured hip. After the incident, the interdisciplinary team met and established that all beds have to be locked. We also updated R1's care plan and we provided additional supervision to R1. It is hard because R1 does what she wants to do, for example does not want to wear shoes.On 1/3/3026 at 11:14 AM V9 (Medical Doctor) said, I believe I was notified about R1's fall on 9/20/2025. R1 is considered a high risk fall resident. If a bed was unlocked, it should definitely be in a locked position and R1 should be wearing non-slip footwear. R1's fracture appears to be fall related. I don't believe this fall will result in R1's long-term issues or decline in her level of assistance.R1's progress note dated 9/20/2025 10:11 PM written by V7 (LPN) reads in part, Received resident (R1) in dining room in wheelchair post fall. Resident started to c/o (complain of) pain after dinner. Resident stated that pain was in both legs. Hospice came for a visit and recommended that resident is to be sent to the ER for evaluation. Pain medication administered. Family made aware. (Ambulance) transport is transporting resident to (local) hospital.R1's neurological assessment dated [DATE] 2:30 PM shows R1's vital signs and neurological assessment were within normal range. R1's pain assessment dated [DATE] 4:38 PM shows R1 having no pain upon assessment.R1's hospital record dated 9/21/2025 shows, R1 was diagnosed with A subcapital fracture is seen in the right femoral neck with slight impaction. R1's right hip fracture followed by right hip ORIF (Open Reduction & Internal Fixation) procedure.The facility Falls and Fall Risk, Managing (no date) reads in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with input of the attending physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. Examples of initial approaches might include exercise and balance training or a rearrangement of room furniture.