Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ______ B. WING ______	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #2393857 / IL159657 #22910311 / IL154766	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b 300.1210d)2)5) 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.	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ______ B. WING ______	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement interventions to prevent pressure ulcer/pressure injury (PU/PI) development for residents who were admitted without PU/PIs and totally dependent on staff for care and assessed to be at increased risk for PU/PI development; the facility also failed to provide ongoing skin assessments for these residents. This failure affected three (R4, R5 and R7) of four residents reviewed for pressure ulcers and resulted in R4 developing a stage 4 facility acquired wound to the right buttock, R5 developed a stage 3 facility acquired wound to the coccyx, and R7 developed a stage 3 facility acquired wound to the sacrum.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ______ B. WING ______	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 2	S9999		

Findings include:

R4 is an 86-year-old male who was admitted to the facility August 4, 2022 with diagnoses that include malignant neoplasm of the prostate pressure ulcer of right lower back stage for retention of urine other core compression, secondary malignant neoplasm of bone, atherosclerotic, heart disease, paraplegia, spinal stenosis, hyperlipidemia, history of falling, anemia, neuromuscular dysfunction of the bladder gastroesophageal, reflux disease, essential, hypertension, osteoarthritis, and weakness. MDS (minimum data set) dated March 8, 2023, indicates R4 requires extensive two person staff assist with bed mobility and toileting, extensive one person staff assist with dressing and personal hygiene.

5/17/23 3:36 PM R4 stated, "I got a bedsore on my butt, and it healed about this month, the last month I got it while I was here. I think they weren't cleaning me properly. The staff doesn't come and reposition me when they come to change me. That's the only time I get repositioned and that's only about two or three times a day because I have the catheter". Braden score assessment dated 8/5/2022 scored R4 as 12.0 high risk, initial skin assessment dated 8/4/2022 documented no skin issues.

5/22/23 3:24 PM V19 (RN Wound Care) said that R4 was admitted in August he will sit up in his chair for long periods of time. He did have a chair cushion, but he can't feel anything from the waist down. The woman started as a deep tissue injury. He was already at risk for pressure ulcer development because, he is paralyzed a DT high is considered a pressure injury and he developed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ____ B. WING ____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 3 it about a month after he was admitted every once in a while I spot check residence just to make sure their skin is OK I'm the one who discovered the wounds according to my notes, it was 90% read 10% scan with some bleeding it was identified September 5, 2022 and we marked it as an unstageable wound November 28th, 2022 the wound opened and it was stage IV. It was covered with yellow or gray slough. DTIs can sometimes heal without opening and sometimes it will soften up, and the tissue will slowly deteriorate meaning the necrotic tissue starts to come off and granulation tissue forms. Granulation tissue is beefy red, healthy tissue, and is an indication of healing if there were other increases of redness surrounding the wound and increased tissue necrosis would mean that the wound is deteriorating. This wound eventually healed and it was a very slow process. I can't explain why the wound developed if we had interventions put in place to prevent this. Whenever they were changing him, they should have been repositioning to take off pressure. He also had a skin tear on the tip of his penis where the catheter laid up against the skin, and when we saw that we told the nurses that they have to make sure that the anchor is in place so that it is not causing pressure he's still at risk for developing pressure ulcers even though the side has healed right now, he has a protective dressing on the sacrum and Ischium, where the scar is The doctor said the strength of the tissue is never going to be 100% so he can re-open quite easily residence with pressure. Ulcers are susceptible to more pain in the open wound and makes the resident at risk for infection. I would expect the nurses and CNA's to conduct daily skin checks, regular repositioning, air mattress and heel protectors to remain in place as interventions. I checked his skin this morning and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ____ B. WING ____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 4	S9999		

he didn't have his heel protectors on, but I didn't notice any new openings.

R5 is a an 85-year-old female who was admitted to the facility on 1/20/2023 with medical history including, but not limited to Unspecified dementia, unspecified severity with other behavioral disturbance, hypertensive heart disease without heart failure, weakness, fibromyalgia, anxiety disorder, hyperlipidemia, history of falling, etc.

5/17/2023 at 9:30AM, R5 was observed in her room, awake and alert with some confusion. Resident was noted with lots of redness and bruising on her legs and arms, staff is not sure if resident is on a blood thinner. At 9:38AM, observed wound care for resident with V6 (LPN/Wound care) and noted a quarter size opening on the resident's sacrum, V6 stated that the wound is facility acquired, and has been documented as stage 3, they always stage wounds as stage 3 until it is healed.

Admission progress note dated 1/21/2023 documented the following skin issues; Skin tear to Rt forearm 0.5x1.5cm, 100% red, small amt. bleeding, no odor, peri wound intact. Skin tear to Rt lateral shin, 2.0x2.0cm, 100% red, small amt. bleeding, no odor serous drainage and intact. Braden score dated 1/20/2023 coded R5 as 16, mild risk for skin breakdown.

R5 has an active order for Skin assessment daily, turn and reposition q 2hrs, q shift, & PRN, and was assessed as requiring staff assistance for all Activities of daily living (ADLs). Review of shower sheets for the month of May for R5 did not show any documentation of resident receiving a shower, and no documented skin assessments. Wound management report for R5 documented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ____ B. WING ____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 5	S9999		

facility acquired pressure ulcer to the coccyx, identified on 3/21/2023, measuring 0.6x0.6 with a depth of 0.1, moderate serous exudate, and was described as a stage 3.

R7 is a 69-year-old female who have resided at the facility since 2018, with past medical history of type 2 diabetes mellitus with diabetic neuropathy, unspecified psychosis not due to a substance or known physiological condition, sepsis, gastritis, dementia, dysphagia oral phase, anxiety, etc.

Review of resident's record showed a Braden score assessment dated 7/23/2022 with a score of 11, high risk for alteration in skin impairment, skin assessment dated 7/23/2023 documented no bruises and no open areas. R7 also has an order for daily skin assessment and to be turned and repositioned every 2 hours and as needed. Review of shower sheet for the month of May did not show a documentation of any showers given or skin assessment done as ordered.

5/17/2023 at 9:38AM during wound care observation, V5 (LPN/Wound care) was asked if she has any wound treatment for R7 and she said that the resident just got a pressure ulcer to her right buttocks that was identified last night. At 9:55AM, surveyor did a skin check for R7 with V5 and noted with a nickel size open area to her sacrum, V5 said that she classified it as a stage 3 pressure ulcer with slough in the wound bed. V5 added that the wound doctor will see resident on Friday, when asked if resident gets out of bed, V5 said that she does not know, she is not familiar with the resident.

R7's care plan dated 8/17/2019 states Resident is at risk for further skin breakdown R/T impaired mobility, incontinence, potential problem for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: ______ B. WING ______	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 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) COMPLETE DATE
S9999	Continued From page 6	S9999		

friction and shear, Hx. (history) healed wound, interventions include Avoid shearing resident's skin during positioning, transferring, and turning, Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences, Provide incontinence care after each incontinent episode, etc.

5/17/2023 at 2:47PM, V3 (RN Supervisor) said that skin assessment should be done during showers, everyone has a scheduled shower date, showers should be documented in the shower sheets. If a shower sheet is empty and nothing is documented, then it is not done. If residents do get their scheduled showers, they will not be clean and that will be an indication of poor hygiene and could lead to skin breakdown.

(B)