STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009443	A. BUILDING: _____ B. WING _____	C 02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-STATE VILLAGE NRSG & RHB	2500 EAST 175TH STREET LANSING, IL 60438

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S 000	Initial Comments Complaint Investigation #2090917/IL119846	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.3240 a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is	S9999	Attachment A Statement of Licensure Violations	

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unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based upon observation, interview, and record

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review, the facility failed to provide adequate supervision in the dining room, failed to ensure that staff are aware of fall prevention interventions, and failed to implement fall prevention interventions for two of three residents (R1, R2) in the sample. These failures resulted in R1's fall with injuries including hematoma and laceration requiring adhesive repair.
Based upon record review and interview the facility failed to document a descriptive summary of resident injuries in the progress notes, and failed to notify IDPH (Illinois Department of Public Health) of serious injury for one of three residents (R1) reviewed for falls.

Findings include;

1.) R1's diagnoses include dementia, epilepsy, weakness, unsteadiness on feet, and history of falling.

R1's (3/5/19) care plan includes risk for falls, preventive interventions include, but not limited to; assist resident to stay in common areas during waking hours.

R1's progress notes include; (2/3/20) 9:50am, upon entering resident's room observed resident lying face down on floor at the foot of her bed. Upon assessment writer observed blood coming from (R1's) forehead.

R1's (2/3/20) head CT (Computed Tomography) includes small right frontal scalp hematoma.

R1's (2/3/20) history & physical states patient was found to have a laceration on the front of her head which was repaired. Repair method: tissue adhesive.

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On 2/24/20 at 11:15am, V4 (Certified Nursing Assistant) affirmed she was aware that R1 recently fell in her room. Surveyor inquired about R1's fall prevention interventions. V4 responded "As I know of, she doesn't have any. No side rails and no floor mats cause she can move." Surveyor inquired again about R1's fall prevention interventions. V5 (Certified Nursing Assistant Supervisor) inspected R1's care card and affirmed she requires staff assistance with ADL (Activities of Daily Living) care, however, fall prevention interventions (chair/bed alarm, floor mats, bed bolsters) were not inclusive and/or verbally stated.

On 2/26/20 at 1:57pm, surveyor inquired about the potential harm to a dependent resident found lying face down on the floor. V19 (Medical Director) stated, "A small abrasion to a bone fracture anything can happen."

2.) R2's diagnoses include legal blindness (left eye), dementia, hemiplegia, hemiparesis and repeated falls.

The (9/1/19-2/24/20) fall log affirms R2 fell on the following dates: 9/7/19, 12/19/19 and 2/15/20.

R2's (9/7/19) charge nurse fall investigation states resident was "In dining room unattended."

R2's (1/31/16) care plan includes potential for falls, preventive interventions include but not limited to; keep frequently used items in reach and for staff to answer light promptly.

On 2/24/20 at 10:45am, R2 was in the dining room with 34 additional residents. V6 (Activities) was the only staff providing supervision.

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On 2/24/20 at 10:47am, V5 (Certified Nursing Assistant) placed R2 in the middle of her room (via wheelchair) and then left the room. R2's call light was observed on top of her bed not within reach. At approximately 10:56am, V2 (Director of Nursing) entered R2's room. Surveyor inquired about the location of R2's call light. V2 stated, "It still was on the bed. The call light is not in reach."

On 2/24/20 at 12:48pm, V7 (Family) voiced concerns regarding lack of staff in the dining room and resident falls. V7 stated she's witnessed a resident on the floor and staff were unaware.

On 2/25/20 at 11:29am, R2 was in the dining room with 36 additional residents. V6 was again the only staff providing supervision. V6 stated, "I'm pretty much here by myself." Surveyor inquired if all residents currently in the dining room could be seen while standing in one location. V6 responded "No." Surveyor inquired if any residents have fallen while supervising the dining room. V6 replied, "Not recently but it has happened."

The fall prevention program (revised 08/08) states it is the policy to have a fall prevention program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary.

On 2/25/20 at 11:20am, surveyor inquired about the regulatory requirements for serious injury. V2 (Director of Nursing) stated, "We report it to the State ASAP (As Soon As Possible) of you

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knowing." Surveyor inquired if R1's (2/3/20) laceration was reported to IDPH. V2 stated, "They (facility staff) told me there was no sutures no stitches" and affirmed it was not.

The (02/14) accident/incident and unusual occurrence policy states in part; accident/incident reports shall include falls. All medically relevant facts shall be accurately and completely recorded in the resident's clinical record in the event of a resident accident/incident, including appropriate clinical assessments. Each incident/accident investigation will include but not be limited to: notification of State and local authorities as appropriate.

(B)