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 10/26/2021

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 Facility Reported Incident of 10/2/2021-IL138898	S 000		
S9999	Final Observations Statement of Licensure Violation: Section 300.610a) Section 300.1010h) Section 300.1210a) Section 300.1210b) Section 300.1210d)3)6) Section 300.1220b)2)3) Section 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999		

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S9999	Continued From page 2 and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

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S9999	Continued From page 3 indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 requirements were not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a resident's mental change of condition and failed to have effective interventions in place to monitor a resident with a history of suicidal ideation for 1 of 3 residents (R1) reviewed accidents and incidents in a total sample 10. This failure resulted in R1 being found deceased, with a cord around the neck, and hanging from a doorstop. Findings include: The Face Sheet documents that R1 was admitted to the facility on 12/24/20 with a diagnosis of Bipolar Disorder and Major Depression. The Nurse's Notes from April through September of 2021 documents that R1 has a history of suicidal ideation requiring multiple hospitalizations. R1's Suicidal Risk Observation dated 9/17/21 documents that R1 is at moderate risk for committing suicide and the care plan documents that staff will notify the Physician of any increased suicidal ideation. The Incident Report documents that on 10/1/21 at 2:30pm, R1 had suicidal ideation and delusions of being filmed for a reality TV show. Staff suggested to R1 to purchase a "signal jammer"	S9999		

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so the resident will be assured of not being filmed. R1 was on hourly monitoring. At 2:00am, R1 was observed in bed. At 3:00am R1 was not in bed and found hanging from the bathroom door with a cord around the neck. R1 had no vitals, CPR performed, 911 called and medical examiner removed the resident's body from the facility.

On 10/6/21 at 2:05pm V2 (Director of Nursing) stated "When residents have suicidal ideation, we typically send them to the hospital for 1:1 care. R1' suicidal ideations started in August and we would send the resident out. The last few times the hospital sent the resident back. R1 stated that this behavior was for attention. On 10/1/21, I was told by staff that R1 was having suicidal ideation and I started the paperwork to send the resident out. When it was time to send the resident out, R1 denied suicidal ideations and said, "I'm ok". R1 was on hourly monitoring and the resident was fine on second shift. On 3rd shift, R1 was seen lying in bed at 2:00am. At 3:00am, R1 was not in bed and was found hanging from the bathroom door. I did not call the Physician and the Nurse caring for the resident did not call the Physician either."

On 10/6/21 at 2:35pm V3 (Receptionist) stated on that on 10/1/2021, "R1 came around my desk area and I heard the resident say, "I'm ready to do it, I'm going to kill myself." I reported it to social services right away."

On 10/6/21 at 2:40pm, V4 (Social Services) stated "R1 made multiple threats to self-harm. Most of the time, R1 was sent out involuntarily and was sent back to the facility. On 10/1/21 around 2:00pm, staff told me that R1 was having suicidal ideations. R1 admitted to suicidal

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ideation, but denied having a plan. I told V2 and the paperwork was started for involuntary petition to have the resident sent out. I left at 3:00pm, under the impression that R1 would be sent out to the hospital. I found out later that R1 was not sent out. Our usual protocol is to send residents with suicidal ideation out to the hospital. I did not call the Physician. I went right to V2."

On 10/7/21 at 9:30am V5 (Nurse) stated "I work second shift. I assessed the resident after hearing that R1 wanted to self-harm. I asked R1 about suicidal ideation and the resident denied it. R1 was on hourly monitoring. R1 has a history of suicidal ideation and was sent out on my shift once. I did not notify the Physician."

On 10/7/21 at 9:35am V6 (Certified Nurse Assistant) stated "I came in on the night shift. I did my walk through and started making rounds. R1 was sitting on the edge of the bed and was ok. I did rounds at 2:00am and R1 was in bed. At 3:00am, R1 was not in bed and was found hanging, with a cord around the neck. R1 was on hourly monitoring and I would look down the hall to make sure the resident was ok."

On 10/7/21 at 9:40am V7 (Nurse) stated "I got report that R1 was on frequent monitoring for suicidal ideation and elopement. I did my rounds at 10:30pm and R1 appeared to be on a cell phone. I did vitals around 11:30pm. There were no behaviors or nothing going on. At 12:30am I did rounds again. R1 was sitting on the bed, staring into space. R1 didn't really say or do anything. I kept on with my rounds. At 1:30am and 2:00am, R1 was observed lying in bed. At 3:00am, V6 said that R1 was not in bed. I went in the room and the resident was hanging from the bathroom door on a door stopper. R1 had a cord

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wrapped around the neck, twice, that was tied very tight. I called for help. I called 911. The resident was cut down and we started CPR until Police arrived. Residents with suicidal ideations are usually sent out with a Physician order. I have no idea why R1 wasn't sent out on the previous shift. My instructions were to check on the resident hourly."

On 10/7/21 at 2:45pm V1 (Administrator) stated "I spoke to the resident, asking what was going on. R1 admitted to not really wanting to self-harm and said the threat to commit suicide was made so that the resident could go to the hospital. R1 felt that a reality TV show was being filmed at the facility and thought that we had bugged the resident's room. I explained that there was no reality TV show and I offered to buy the resident a signal descrambler, a device that messes with the internet signal in the resident's room. R1 was happy with this solution because the resident did not want to participate in the reality TV show since R1 was not getting paid."

On 10/8/21 at 10:35am V8 (Psychiatric Nurse Practitioner) stated "I started seeing R1 about 2 years ago and the resident was severely depressed. We found the right medications and R1 was pretty stable but would still have suicidal ideation from time to time. R1 would be triggered after talking to family. R1 was being seen monthly and getting weekly therapy sessions. R1 was on hourly monitoring and whenever the resident would have suicidal ideation, staff would send the resident out right away. If R1 was having suicidal ideation, I would expect that staff would contact the Provider and remain with the resident until R1 could be sent out. I was not contacted about suicidal ideation on 10/1/21."

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S9999	Continued From page 7 On 10/8/21 at 3:15pm V9 (Physician) stated "R1 would sometimes make threats and want to go to the hospital. R1 would be sent out to the hospital and sent back to the facility. I was not notified of suicidal ideation on 10/1/21. Residents with suicidal ideation should be assessed for a plan and intent, every single time, and hospitalized with any uneasiness. The hospital is where the resident can be monitored more closely. In my history, anytime a resident has suicidal ideation, they are checked on frequently to make sure that there's no intent. Social Services, Psychiatrists, and Psychologists are all trained in assessing for intent and plan. Nurses should be trained to take it seriously. Even if it happens 1000 times, you must take it seriously every single time. Suicidal ideation can't be ignored." The Facility's Policy on Suicide Threats documents that resident threats of suicide must be reported immediately, and the resident's attending Physician should be notified. Staff will examine the resident and report findings to the attending Physician to seek further medical instruction. Residents maybe temporarily secluded in a safe environment and/or placed on observation by staff when there is a potential for danger. The care plan should be assessed to determine interventions to prevent the recurrence of such threats. (A)	S9999		