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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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 2295441/IL148918 2296351/IL150029 Investigation of Facility Reported Incident of 09-16-2022/IL151442	S 000		
S9999	Final Observations Statement of Licensure Violation 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)5)6) 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	S9999	Attachment A Statement of Licensure Violations	

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 10/05/2022

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

(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	S9999		

manifest decubitus ulcers or a weight loss or gain of five 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

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:

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

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 10/05/2022

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

(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 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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. These Regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to follow the prevention of pressure wounds policy and complete daily skin checks for 3 of 3 residents (R1, R7, R9) reviewed for pressure ulcer prevention. This failure resulted in R7 having an unidentified new wound requiring wound debridement revealing a stage 4 pressure ulcer, and R1 having 3 unidentified wounds, requiring debridement revealing a stage 3 pressure ulcer. Findings include: 1. R7s face sheet shows R7 has diagnoses of Hemiplegia and Hemiparesis, Cerebral Vascular Accident, Peripheral Vascular Disease affecting right dominant side, Congestive Heart Failure, Diabetes Mellitus, Morbid Obesity, Major Depressive Disorder. R7s Braden scale with score dated 5/13/2022 shows score of 12, high risk. R7s plan of care dated 5/12/22 with last review dated of 7/14/22 shows R7 has alteration in skin integrity as evidenced by pressure ulcers R/T (related to) decreased mobility, decreased	S9999		

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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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	S9999		
	cognition, choosing choices that are inconsistent with plan of care, malnutrition. Wound healing may be hindered by refusal of care, Peripheral Vascular disease, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease, Diabetes, incontinence of bowel and bladder, Chronic combined systolic (congestive) and diastolic (congestive) heart failure, Morbid (severe) obesity. Positioning devices, low air loss mattress, and offload boots are in place to assist in healing. R7 has also been provided with a U-shape pillow to assist with comfort. Ulcer will show improvement (e.g., decrease in size, increase in granulation tissue, or decrease in necrotic tissue) by next review date unless co-morbidities/resident choices cause an unavoidable decline. Braden scale per protocol to assess risk factors. Review clinical condition to determine further risk factors for breakdown. Complete skin check and observe for complications such as pain, odor, changes in exudate characteristics, increase in necrotic tissue, infection, cellulitis, osteomyelitis. Notify physician immediately if observed. Dietary Consultation as needed to evaluate nutritional needs. Educate resident regarding risk factors and compliance with care plan interventions. Encourage/assist with turning/repositioning every 2 hours and PRN (as needed). Keep clean and dry as possible. Minimize skin exposure to moisture. Provide/Assist with continence care as needed. Keep linens dry and wrinkle free to prevent further pressure forces. Maintain head of bed at/or below 30 degrees or at lowest degree of elevation consistent with the resident's medical condition to prevent sliding and shear-related injury that may prohibit wound healing and/or cause further wound development. Measure and document wound characteristics observations weekly. Minimize pain by assessing and			

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 10/05/2022

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

(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 administering pain medication as ordered by physician. If pain medication is ineffective, notify physician for possible changes to pain regimen. Obtain labs as ordered and report results to physician. Provide diet, nutritional supplements, vitamins, and minerals as ordered to aid wound healing. Reduce friction and/or shearing to prevent wound from declining and further wound development (e.g., utilize lift/turning sheets, trapeze bar, mechanical devices, lubricants, positioning devices. May use transparent film or hydrocolloid to bony prominence to reduce mechanical injury from friction). Treatment (application of ointment/medication and/or dressings) to site per physician order. Use positioning devices (such as a pillow or foam wedge, off-loading boots, bath blanket, etc.) to avoid further pressure on the affected area and to prevent further ulcer development to other bony prominences. Utilize incontinence briefs to prevent trapping moisture against the skin. Utilize incontinent skin barriers such as creams, ointment, pastes, and film-forming skin protectants as needed to protect and prevent further skin breakdown. Utilize pressure redistribution surfaces on bed and when up in chair to redistribute pressure of affected area and prevent further pressure ulcers. Observe for proper function/use of support surfaces as well as effectiveness. Wound physician consult per physician order. On 9/28/22 at 3:59pm V22 (Nurse) stated he was working with R7 on 6/15/22 on the evening shift when he was summons to R7s room to assist with care, and he noticed R7s toes were blue, V22 stated that's when he took R7s heel protector boot off and observed R7 with purplish blue discoloration to the right heel, right lateral foot and right inner foot. V22 stated he did not	S9999		

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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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		

see anything on R7's left foot when he looked at R7s left foot. V22 stated he worked with R7 on 6/14/22 from 2pm until 7am (2 shifts) and he did not conduct a skin check on R7. V22 stated he was not aware that R7 needed daily skin checks due to being a high risk for skin break down. V22 stated he was aware that R7 was at risk for skin breakdown. V22 stated he does skin checks on R7 when the aides give R7 showers, but he has never checked R7 feet. V22 stated R7 returned from the hospital with the heel boots on, V22 stated he has never removed R7s heel boots when working with R7 to check her feet. V22 stated he reported R7s new skin issue immediately to the nurse practitioner and V13 (wound treatment nurse). V22 reviewed R7s TAR (Treatment Administration Record) for the daily skin checks, V22 stated that is not his initials for 6/14/22 and 6/15/22 when he worked with R7.

V22 stated he did not see any new skin issue to R7s left foot on 6/15/22, however when R7 was seen by the wound physician on 6/15/22 the wound physician observed new skin issue to R7s left foot that required wound debriding due to necrotic tissue.

Review of R7 TAR (Treatment Administration Record) dated June 2022 shows daily skin checks. There are initials in the boxes dated 6/11/22, 6/12/22, 6/13/22, 6/14/22 and 6/15/22.

On 9/28/22 at 12:04pm V23 (Nurse) stated she worked with R7 on 6/11/22 and she stated she signed the TAR, and she did not see any skin issues when she checked R7s skin on 6/11/22. V23 stated she did not work one of her scheduled days because it was her husband's birthday. V23 stated she did not work on 6/13/22 and she did not sign R7s TAR on 6/13/22, V23 stated she

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 10/05/2022

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

(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		

does not work on Mondays.

Review of V23s timecard, it is documented that V23 worked on 6/11/22 and 6/12/22. V23 initials are not noted on R7s TAR for completing a daily skin check on R7 on 6/11/22 or 6/12/22.

Facility schedule and timecard shows V23 was assigned to work the morning on 6/11/22 and not the evening when R7s daily skin check is ordered.

On 9/28/22 at 10:50pm V18 (ADON-Assistance Director Nursing) review of R7s TAR with V18, V18 stated she did not know who that nurse is that signed out the TAR for R7s daily skin checks on 6/11/22, 6/12/22, 6/13/22, 6/14/22 and 6/15/22. At 12:50pm V18 presented signatures key and the signatures/ initials noted on R7s TAR are not identified on the facility nurse signature key.

On 9/28/22 at 1:00pm V5 (Administrator) was made aware that there are unidentified initials on R7 TAR and V18 does not know who the nurses are.

Review of facility nurse signature log, surveyor was not able to identify who the initials belonged to, there were no nurse's name that matched up with the initials identified on R7s TAR for the dates for 6/11/22, 6/12/22, 6/14/ 22, 6/15/22. During this survey the facility did not identify who the nurses were that initialed R7s TAR for the daily skin checks on 6/11/22, 6/12/22, 6/13/22, 6/14/22, and 6/15/22.

On 9/28/22 at 1:15pm V19(nurse) was identified as a nurse with the last name initials of "W", V19 stated he did not sign R7s TAR on 6/14/22 and

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 10/05/2022

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

(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 7	S9999		

6/15/22, V19 stated he did not check R7s skin on 6/14/22, and 6/15/22.

Upon exiting this survey, the facility failed to identify who the nurse was that signed their initials for providing R7s daily skin checks on 6/11/22, 6/12/22, 6/13/22, 6/14/22, 6/15/22.

On 9/28/22 at 4:01pm V13(wound treatment nurse) stated R7 is at risk for skin breakdown and should have daily skin checks for wound prevention this is to identify any skin issue. V13 stated V22 should have completed the daily skin check for R7 on 6/14/22. V13 stated she does not know who initialed that there was a completed skin check for R7 on 6/11/22, 6/12/22, 6/13/22, 6/14/22 and 6/15/22. V13 stated she did not complete the skin checks for R7 on 6/12/22, 6/13/22, 6/14/22 or 6/15/22. V13 stated she did rounds with the wound doctor on 6/15/22 when the wound doctor saw R7 for the new skin issue. V13 stated the nurses are responsible to do the daily skin checks for R7. V13 stated when conducting a daily skin check the nurse should remove anything and or clothing that would prevent them from observing the skin, the nurse should be looking for any changes in the skin.

R7s skin integrity condition dated 6/15/22 with completion date of 6/23/22 shows right lateral ankle date of onset 6/15/22, acquired condition, pressure, stage 4, 5.6x 3.3x und cm, no tunneling, yellow and black in color, wound bed-slough and necrotic 70%, 30% slough, moderate drainage, serous in color, no odor, wound edges attached, surrounding tissue intact, no pain, continue current care plan, signed by V13 (wound nurse).

R7s skin integrity condition dated 6/15/22 with

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 10/05/2022

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

(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 8	S9999		

completion date of 6/23/22 shows right lateral foot date of onset 6/15/22, acquired condition, DTI (deep tissue injury), 6.9x 4.5x und cm, no tunneling, black in color, no exudate, no odor, wound edges attached, surrounding tissue intact, no pain, no referrals necessary, continue current care plan, signed by V13 (wound nurse).

R7s skin integrity condition dated 6/15/22 with completion date of 6/23/22 shows right lateral heel date of onset 6/15/22, acquired condition, pressure, stage 4, 2.0 x 2.0 x und cm, no tunneling, yellow and black in color, wound bed-slough and necrotic 50%, 50% slough, moderate drainage, serous in color, no odor, wound edges attached, surrounding tissue intact, no pain, continue current care plan, no referrals needed, signed by V13 (wound nurse).

R7s skin integrity condition dated 6/15/22 with completion date of 6/23/22 shows left posterior heel, date of onset 6/15/22, acquired condition, pressure, stage 4, 3.0x2.0xx und cm, no tunneling, color of wound bed - yellow and red , wound bed- granulation and slough, 80% granulation, 20% slough, moderate drainage, serous in color, no odor, wound edges attached, surrounding tissue intact, no pain, continue current care plan, no referrals needed, signed by V13 (wound nurse).

R7s wound evaluation and management summary dated 6/15/22 with signature time stamp of 12:25p.m completed by V20 (wound physician) shows in part, this patient has multiple wounds, past medical history-cerebral vascular disease, diabetes mellitus, and obesity. Focused wound site4- stage 4 pressure wound of right, lateral ankle full thickness, etiology -pressure, stage -4, duration- greater than 1 days, objective

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
	IL6009443	A. BUILDING: ___ B. WING ___	C 10/05/2022

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

(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 9 healing, wound size 5.6x3.3x not measurable cm, surface area-18.48cm (squared) , exudate- moderate serous, thick adherent devitalized necrotic tissue- 70%, slough 30%. Surgical excisional debridement procedure- indication for procedure, remove necrotic tissue and establish the margins of viable tissue, the wound was cleaned with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique 15 blade was used to surgically excise 18.48 cm (squared) devitalized tissue and necrotic muscle and surrounding fascial fibers along with slough and biofilm were removed at a depth of 1.3cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented. Focused wound site 6- stage 4 pressure wound of right, lateral ankle full thickness, etiology -pressure, stage -4, duration- greater than 1 days, objective healing, wound size 2.0x2.0 x not measurable cm, surface area-4.00cm (squared) , exudate- moderate serous, thick adherent devitalized necrotic tissue- 50%, slough 50%. Surgical excisional debridement procedure- indication for procedure, remove necrotic tissue and establish the margins of viable tissue, the wound was cleaned with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique 15 blade was used to surgically excise 4.00 cm (squared) devitalized tissue and necrotic muscle and surrounding fascial fibers along with slough and biofilm were removed at a depth of 0.3cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented. Focused wound site 7- stage 3 pressure wound of left, posterior heel full thickness, etiology	S9999		

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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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 10	S9999		

-pressure, stage -3, duration- greater than 1 days, objective healing, wound size 3.0x2.0 x not measurable cm, surface area-6.00cm (squared) , exudate- none, slough 20%, granulation tissue 80%. Surgical excisional debridement procedure-indication for procedure, remove necrotic tissue and establish the margins of viable tissue, the wound was cleaned with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique 15 blade was used to surgically excise 1.20 cm (squared) devitalized tissue including slough, biofilm and non-viable subcutaneous fat and surrounding connective were removed at a depth of 0.1 cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented. Focused wound site5- pressure wound of left, lateral foot full thickness, etiology -pressure, stage -unstageable DTI with intact skin, duration- greater than 1 days, objective healing, wound size 6.9x4.5 x not measurable cm, surface area-31.05cm (squared), exudate- none, recommendations off load wound, reposition per facility protocol, sponge boot.

On 9/28/22 at 2:15pm V20 (wound physician) stated she saw R7 on 6/15/22, R7 had multiple wounds, R7s wound was observed with necrotic tissue, and it is her job to remove as much dead tissue as possible during each visit. V20 stated she debrided the wound due to dead tissue and a stage 4 pressure ulcer was revealed, V20 stated surveyor would have to speak to the facility regarding their practice for daily skin checks. V20 stated she cannot speak to what contributed to the development of R7 wounds. V20 stated she does expect the facility to carry out orders and treatment when they are given. V20 stated a

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 10/05/2022

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

(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 11 pressure ulcer can develop within hours. V20 stated R7 had diabetes and history of stroke, V20 would not give comments on prevention of pressure ulcers or what could have contributed to R7 skin break down and a stage 4 being revealed. V20 stated the wound evaluation shows 1 day duration because that was the first time, she saw that wound. 2. On 9/22/22 at 2:57pm with assistance from V22 (Nurse) R9 was observed to have a wound treatment dressing on his right ischium, dated 9/20/22, this was observed by V22 (Nurse) also. Review of R9s TAR, it is documented that R9 received wound treatment on 9/19/22 and 9/21/22. Review of R9s TAR with V13 on 9/30/22 at 10:27a.m, V13 (wound treatment Nurse) stated she changed R9s wound treatment on 9/21/22 and dated it for 9/21/22. V14 was made aware that surveyor observed R9s treatment dressing with V22 and it was dated for 9/20/22 and not 9/21/22. V13 stated treatment orders should be completed as ordered by the physician and should be documented when the treatment is completed, V13 stated the treatment dressing should be dated for the date they the treatment was completed. R9s POS shows orders for cleanse right ischium with normal saline or wound cleanser. Pat peri area wound dry. Apply alginate calcium and cover with dry dressing, once a day and PRN(as needed) of soiled or dislodged. Review of R9s TAR for daily skin assessment, there are no initials noted for carrying out the order from 9/27/22 to 9/29/22. Facility policy titled prevention of pressure wounds dated January 2017 shows in-part, the purpose of this procedures is to provide	S9999		

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 10/05/2022

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

(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 12	S9999		

information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident care plan to assess for any special needs of the residents. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family an addressed. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.

Facility intervention/ prevention measures- skin inspection and care dated 02/2013 shows in part, documentation of daily head to toe skin assessment by licensed nurse in the resident chart or on a facility approved form- high risk Braden 10-12 and severe risk Braden score 9 or less.

Facility policy titled care plans dated 4/2015 shows in part an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident medical, nursing, mental and psychosocial needs is developed for each resident. Each resident comprehensive care plan has been designed to incorporated identified problems areas, incorporate risk factors associated with identified problems, reflect treatment goals and objectives in measurable outcomes, aide in preventing or reducing declines in the resident functional status and or functional levels. Care plans are revised

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 10/05/2022

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

(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 13	S9999		

as changes in the resident condition dictates.

3. R1 is a 78 years old with diagnoses including but not limited to Spinal Stenosis, type 2 Diabetes Anemia, Hyperlipidemia, Essential Hypertension, Atrial Fibrillation, Benign Prostatic Hyperplasia, Osteoarthritis, Repeated Falls, Mild Cognitive Impairments, and Pressure Ulcer of Left heel, Stage 4.

On 9/22/2 at 12:47PM V9, Certified Nursing Assistant, stated while she was providing care to R1 he was complaining of pain on his buttock and when she turned him over, he had an open wound. V9 stated R1's buttock wound was open. V9 stated she reported to V19, Licensed Practical Nurse, and V13, Wound Nurse. V9 stated R1's buttock dressing was not being changed on 9/2 and 9/5/22.

On 9/22/22 at 2:25PM V13 stated R1 developed a facility acquired pressure ulcer on the right ischium and sacrum. V13 stated R1 had a left ischial wound that was hospital acquired. V13 stated R1 was receiving a wound treatment of Santyl on his sacrum. The surveyor reviewed R1's treatment administration record with V13. The surveyor asked why the treatment for R1's sacrum is signed off after his facility discharge on 9/11/22. V13 stated "I don't have an excuse for that."

On 9/27/22 at 10:36AM V13 stated skin assessments for residents are done on shower days and daily for the first month following admission. V13 stated after the first month, then skin checks are done weekly. V13 stated if a resident refuses showers, the nurse should still do a skin check. V13 stated if there is a skin impairment the nurse should document it. V13

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 10/05/2022

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

(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 14 stated if a resident has an open area, then they should be on daily skin assessments. V13 stated the nurses are responsible for daily skin checks. V13 stated the purpose of doing skin checks daily on residents with skin impairments is because they may be prone to skin changes. On 9/28/22 at 9:47AM V19, LPN, stated he was not aware of R1 having a buttock wound until 9/11 when he sent R1 to the hospital. On 9/28/22 at 10:52AM V13 stated Prostat and Sugar Free (SF) Prostat are used to promote wound healing. V13 stated if a resident has an order for Prostat then the resident should be receiving it. V13 stated the nurses would administer Prostat. V13 reviewed R1's Medication Administration Record for September 2022 with the surveyor and stated Prostat is not on there. V13 stated we cannot substantiate Prostat was given to R1. V13 reviewed R1's care plan with the surveyor. V13 stated she updates the care plan to include wounds. V13 stated she did not update R1's care plan for sacral and ischial wounds. V13 stated she was the first nurse to assess R1's sacral wound. V13 stated she does not have other documentation to support that R1's skin was being checked daily. On 9/28/22 at 1:22PM V4, Director of Nursing, stated I expect the nurses to follow physician orders. V4 stated the purpose of signing the medication and treatment administration records is to show the care was rendered. On 9/28/22 at 2:57PM V20, Wound Doctor, stated Prostat is a protein supplement used for wound healing. V20 stated necrosis is the death of tissue.	S9999		

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 10/05/2022

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

(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 15	S9999		

Continued From page 15

On 9/30/22 at 12:20PM V13, Wound Nurse, stated R1 is incontinent of urine. V13 stated V13 completes the Braden Assessments. V13 stated in regard to the Assessments "always" is not the same as "rarely" V13 stated this was an error on my end for R1's 7/21/22 Braden Assessment. V13 stated the assessment score will change based on the response and this change would increase R1's risk for skin breakdown.

On 9/6/22 V20 documented R1's sacral wound measures 9.4 x 5.9 cm and the depth is not measurable. 50% is necrotic tissue, 10% slough; and 40% granulation tissue. R1's treatment is to apply Santyl once daily and alginate calcium dressing and cover with gauze island once daily. R1's Left ischium stage 3 measures 2.5 x 1.8 x 0.1cm with 100% granulation tissue. R1's right Ischium stage 3 measures 1.3 x 1.8 x 0.2 cm with 100% granulation. Both left and right ischium treatment are to apply alginate calcium with silver and cover with gauze island dressing daily. R1's physician note from the same date notes surgical excisional debridement procedure was performed. 33.28 cm2 of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissues along with slough and biofilm were removed.

R1's Bath and Skin Report Sheet on 9/5/22 has feet/heel areas circled on CNA section. No wound documentation in the nurse section, except for date and signature. On 9/8/22 the nurse section has the date and nurse signature. Skin condition is not documented by the nurse. On 9/8/22 the CNA section has a circle around the buttocks.

R1's MDS section H dated 7/21/22 notes he is always incontinent of bowel and bladder.

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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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 16	S9999		

R1's Braden Scale Assessment dated 7/21/22 notes section 1 R1 is "rarely moist."
Pressure Ulcer care plan for R1 does not include his sacral or ischial wounds. Interventions include complete skin check and observe for complications. No interventions have been added to the care plan since 3/23/22.

Treatment Flowsheets dated 8/1/22 - 8/31/22 notes skin assessment daily, but no daily signatures.

Treatment Flowsheets dated 9/1/22 -9/30/22 do not have daily skin assessment.

Physician Orders Report start date 8/11/22 Sugar Free Prostat liquid 30ml: wound healing twice a day. Review of Medication Flowsheet does not list Prostat.

Physician Orders Report start date 12/30/21 skin assessment daily. End dated 1/30/22.

The facility policy for Prevention of Pressure Wounds policy effective date January 2017 states, in part:
9.Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.
10. Immediately report any signs of a developing pressure injury.
1.Dietician will assess nutrition and hydration and make recommendation based on the individual resident's assessment.
3. Monitor laboratory values.
6. Administer vitamins, minerals and protein supplements in accordance with physician orders and dietitian recommendations.

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 10/05/2022

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

(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 17	S9999		

(A)

Statement of Licensure Violation 2 of 2:
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210d)6)

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 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.

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 10/05/2022

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

(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 18	S9999		

Continued From page 18

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. (Section 3-202.2a of the Act)

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 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

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 10/05/2022

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

(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 19	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on interviews, observations, and records reviewed the facility failed to ensure a resident's (R2) arms were placed properly before lifting her from a chair using a mechanical lift, this failure resulted in R2 suffering a fracture to her right 4th and 5th fingers. The facility also failed to follow the fall preventions and reevaluate fall preventions for a cognitively impaired resident with high risk for falls (R6), R6 suffered 2 falls from bed after climbing over the boaster cushions, R6 sustained a bump to the forehead and small cut to the nose. This failure affects 2 of 3 residents reviewed for accidents/ incidents/ falls.

Findings Include:

R6 face sheet shows diagnoses of Generalized Arthritis, Dementia without behavior disturbance, Urinary Tract Infection, COPD, Hypertensive Heart Disease with Heart failure.

On 9/29/22 at 5:15pm V26 (R6 family) stated the facility does not have fall interventions in place for R6, there's no floor mats in place and the bed boasters are ripped. V26 stated R6 has sun downing behaviors and the facility should monitor her more frequently.

R6s MDS dated 6/22/22 section C shows BIMS score of 3 (cognitive impairments).

R6s fall occurrence dated 9/3/22 shows writer heard a fall sound from the nursing station, on arrival to the resident's room, writer found

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 10/05/2022

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

(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 20	S9999		

resident on the floor laying on her left side, upon assessing the resident writer noted a bump on the resident's forehead and a small cut on the resident's nose. writer immediately applied ice pack to the forehead to stop the swelling and applied pressure on the nose. Writer assessed LOC (level of consciousness) and resident was conscious and able to engage eye contact with the writer. Writer immediately called for help. R6s fall occurrence dated 8/6/22 shows in-part CNA on duty stated she was moving around in the bed, and I entered the room, she was trying to get out of bed, so I assisted her to the floor mat and called the nurse.

On 9/23/22 at 1:00pm V14 (MDS coordinator) stated she conducts the facility fall investigations, and she conducted R6s fall investigation for 9/3/22, V14 stated the root cause analysis was that R6 sustained a fall due to altered mental status related to a Urinary Infection. V14 stated R6 had a fall on 8/6/22 due to trying to get out of bed due to altered mental status related to a Urinary Infection. V14 stated she implemented the bed boasters in December 2021 so that R6 could identify the bed boundaries and not get out of bed or go further than the bed boasters. V14 said R6 has cognitive deficits, but she thinks R6 understand not to go beyond the boundaries of the boasters. R6 BIMs score reviewed with V14; R6 BIMs score dated 6/22/22 shows a score of 3 (cognitive impairments). V14 stated she did not reevaluate the use of the boasters, she did not reevaluate R6 cognition of understanding of the bed boasters and her boundaries when the boasters are in place. V14 stated she feels like the bed boasters are effective although R6 was not able to identify the bed boundaries when the boasters are in place and continued to climb out the bed over the bed boasters and around the

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 10/05/2022

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

(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 21	S9999		

boasters. V14 stated the fall from the bed is higher when the boasters are in place. On 9/30/22 at 4:50pm V14 stated she has been talking with the IDT team about R6, since the surveyor was inquiring about R6 (during this complaint investigation), V14 was asked what the plan was prior to the surveyor inquiring about R6, V14 continued to say V14 has been communicating with the IDT team recently about R6 falls.

On 9/23/22 at 3:20pm R6 was observed lying in bed, V32 (CNA-Certified Nursing Assistant) assisted with observation of bed position/height, R6s bed was not observed in the lowest position. V32 had to lower R6s bed to the lowest position.

Review of R6s care plan for falls with problem start date of 9/7/2017 and long-term goal date of 9/23/22 shows R6 is at high risk for fall related injury- R/T (related/to) dementia with poor judgement and decreased safety awareness, decreased transfers and mobility, weakness, and impaired balance, and new environment. R6 will remain free from severe fall related injury through next review, antibiotic for UTI (urinary tract infection), ER transfer, antibiotic for uti, ua/cs (urine analysis, culture sensitivity), provide repositioning device and staff to ensure that they are in place while in bed to help the resident define the bed boundaries, staff to ensure that R6 is in the center of the bed and position properly while in the bed to aide in fall prevention, non-slip pad to wheelchair, two staff assist for transfer, encourage, and assist with maintaining a safe environment, frequent safety checks, cues, and reminders, keep bed in lowest position when care is not being provided, keep call light in reach and answer promptly, keep frequently used items in reach.

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 10/05/2022

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

(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 22	S9999		

R6s progress notes dated 9/3/22 at 10:56pm shows writer heard a fall sound from the nurse station, on arrival to the resident room, writer found resident on the floor laying on her left side, upon assessing the resident writer noted a bump on the resident forehead and a small cut on the resident nose. Writer immediately applied ice pack to the forehead to stop the swelling and apply pressure on the nose. Writer assessed LOC and resident was conscious and able to engage in eye contact with the writer. Writer immediately called for help and informed the NP of the resident situation and was instructed to send the resident to the hospital. Writer called 911 and then call the family member to be aware of the resident condition and the hospital she is being transferred to for evaluation. Resident left in stable condition.

Facility policy Titled Care plans, dated 4/2015, shows in part an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident medical, nursing, mental and psychological need is developed for each resident.

Facility policy Titled Managing Falls and Fall Risk dated 8/2008 shows in-part based on previous evaluations and current data, the staff will identify interventions related to the resident specifics risks and causes to try to prevent the resident from falling and 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 systemic evaluation of a resident fall risk identifies several possible interventions the staff may choose to prioritize interventions (to try one or a few at a time, rather than many at once). If falling reoccurs despite

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 10/05/2022

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

(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 23	S9999		

initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The staff will monitor and document each resident response to interventions intended to reduce falling or the risk of falling. If the resident continues to fall, staff will re-evaluate the situation an whether it is appropriate to continue or change current interventions. As needed the attending physician will help the staff reconsider possible causes that may not previously have been identified.

Review of R6s care plan there are no documented re-evaluation of R6 current fall interventions/preventions, Review of R6s progress notes dated 8/3/22 to 9/15/22 there are no documented re-evaluations of R6s current fall interventions/preventions.

R2 is an 84-year-old with diagnoses including but not limited to Hemiplegia and Hemiparesis following Cerebral Vascular Disease affecting Right Dominant side, Dementia without Behavioral Disturbances, Essential Hypertension, Convulsions, Osteoporosis, and Contracture of Muscle. R2's cognitive assessment dated 7/1/22 notes R2 is severely impaired.

On 9/22/22 at 9:59AM V4, Director of Nursing, stated regarding R2's injury, V7, Certified Nursing Assistant (CNA) was preparing to give R2 a shower. V4 stated she was the assigned nurse on 9/15/22 for R2. V4 stated based on her investigation R2's hand was in the space below the arm rest and the along the seat in her reclining chair. V4 stated R2's hands should have been inside the sling during the transfer. V4 stated the night shift reported bruising on R2's hand on 9/16/22.

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 10/05/2022

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

(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 24	S9999		

On 9/22/22 at 10:25AM the surveyor observed R2 sitting in a reclining chair without side panels under the armrest and seat. A cushioned device was present under the armrest. R2 alert but responses are nonsensical.

On 9/22/22 at 11:35AM V7, CNA, stated on 9/15/22 she went to give R2 a shower. V7 stated R2 was sitting in the reclining chair with a transfer sling under her. V7 stated using the mechanical lift she raised R2 into the air to move R2 into the shower bed. V7 stated during the transfer she noticed R2's right arm was hanging out of the sling. V7 stated R2's right arm was kind of dangling outside of the sling and wedged under the arm rest. V7 stated she stopped and placed R2's arm back inside the transfer sling. V7 stated the next day R2's right hand was bruised.

On 9/22/22 at 11:52AM V8, CNA, stated she was asked to assist V7 on 9/15/22 in transferring R2 with the mechanical lift. V8 stated R2 was being transferred from her reclining chair into the shower chair with the mechanical lift. V8 stated she was maneuvering the controls on the machine. V8 stated during the transfer she saw R2's hand was not in the sling. V8 stated R2 requires cues to keep her hands in the sling during transfers.

On 9/22/22 at 2:00PM R2 observed sitting in the reclining chair with her right hand wrapped in white kerlix.

On 9/23/22 at 1:28PM V4 stated we had the doctor come see R2 following her injury. V4 provided the surveyor with R2's progress notes on 9/23, including the doctors note from 9/20/22. On 9/28/22 at 1:22PM the surveyor asked V4 if her investigation shows R2's injury occurred

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 10/05/2022

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

(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 25	S9999		

during the mechanical lift transfer, why did the doctor document the injury is likely form cleaning R2's hand. V4 stated I don't know why he wrote that.

On 9/29/22 at 10:45AM V24, Doctor, stated the only way that R2's fracture happened is to have opened the hand. V24 stated R2's bones are very fragile and when staff try to open the hand to clean it, this could have caused the fractures. V24 stated I have a history with R2, I have seen her before, her right hand was contracted. V24 stated R2's injury is known as "boxer fingers," as if someone hit her hand against something. V24 stated this injury is deep in R2's hand, her 4th and 5th phalanges are fractured. V24 stated in the X-ray you can see the base has ripped. V24 stated with a deep injury the bruising develops in hours or later on. V24 stated R2's injury did not likely occur during the mechanical lift transfer.

Skin Integrity event dated 9/16/22 1:55AM for R2 notes right hand with purplish bruising and swelling. Bruising of unknown origin.

R2's Physician Order Report notes start date 9/16/22 Radiology Right hands/fingers.

R2's Progress Notes dated 9/18/22 9:00AM states X-Ray order relayed to Nurse Practitioner gave order for R2 to be sent out to hospital for further evaluation related to results.

Physician note dated 9/20/22 notes R2's right hand is contracted with frozen joints of the fingers. She has tenderness over the fourth and fifth proximal phalanges noted by grimacing of her face. Fracture like this with her significant osteoporosis, I would think it is from trial of cleaning her hand. I doubt any injury would do

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
	IL6009443	A. BUILDING: ______ B. WING ______	C 10/05/2022

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

(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 26	S9999		

this fracture more than they try to open the hand.

R2's initial report to IDPH dated 9/18/22 notes R2 noted with purple bluish discoloration to the right hand, x-ray ordered and resulted with acute fracture of two fingers.

R2's Functional status notes on 7/1/22 R2 requires total assistance from 2 persons for transfers.

R2's ADL Skills Analysis Assessment completed on 7/4/22 notes R2 requires a mechanical lift for transfers.

R2's X-ray dated 9/16/22 Impression states There are fractures of the proximal phalanges of the 4th and 5th digits of the right hand.

The facility final investigation report for R2 notes on 9/16/22 R2 was noted with bruising and swelling to the right hand. The investigation notes staff reported seeing R2's hand resting under the arm rest of the chair in between the seat and the armrest.

The investigation notes the probable cause of the right fourth and fifth finger is due to R2's hand caught in between the arm rest of the chair.

The facility policy revised August 2008 for Lifting Machine notes prior to transfer h. Instruct the resident to fold both arms across his or her chest, if possible.

(B)