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 08/11/2024

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: 2495189/IL175095	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.1210 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		

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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.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to develop an effective plan with interventions to prevent or reduce the risk of falling for a resident diagnosed with Dementia, wandering behaviors and identify as a high fall risk with balance problems while standing. This affected one of three residents reviewed for falls and fall prevention. This failure resulted in R2 having eight falls, seven of which were unwitnessed and one fall resulting in right periorbital soft tissue swelling and right scalp hematoma with contusion of face and scalp.

Findings Include:

R2 was diagnosed with Dementia, lack of coordination and need for assistance with personal care.

R2's Fall risk observation dated 4/10/24 documents: disoriented times three (person, place, and time) and balance problems while standing, high risk.

R2's Care Plan dated 4/12/24 documents: R2

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presents with wandering behaviors. Wandering with or without a purpose. R2 was risk for falling related to Dementia, weakness, and history of falls.

On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 had a fall in the dining room on 4/19/24. V2 stated, she watched the facility video and saw R2 fall face forward while tying her shoestrings.

On 8/11/24 at 3:20pm, V7 (nurse) stated, she was getting off duty for on 4/19/24 when she was notified of R2's swelling around eye. V7 stated, she does not recall what happened. R2 takes baby steps. R2 has a shuffled gait. Any time, R2 attempts to get up, R2 is trying to toilet self. R2 is Japanese. R2 can answer yes or no questions. R2 can ambulate by herself but it's not safe.

Event report dated 4/19/24 documents: Resident (R2) noted with swelling/bruising to right brow area from unknown origin. Fall risk observation dated 4/19/24 documents: balance problems while walking. Nursing note dated 4/19/2024 documents: Observed mild swelling to resident's upper right brow with tinge redness above brow and cheek area. R2 will be admitted for observation unwitnessed fall. Hospital paperwork dated 4/19/24 documents: Syncope and Collapse. Nursing note dated 4/22/24 documents: Post fall observation for right eye orbital swellings and contusion. Nurse Practitioner note dated 4/23/2024 documents: R2 presented to emergency department due to a fall. R2 was noted with contusion of face and scalp. CT (computed tomography) of sinus facial bones showed right periorbital soft tissue swelling and right scalp hematoma.

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On 8/10/24 at 1:57pm, V4 (nurse supervisor) stated, R2 was seen on the floor at breakfast time in the dining room on 4/24/24. R2 was kept in the dining room for monitoring. R2 wheelchair was locked and behind R2. R2 looked like she pushed the table away from her and slid from her wheelchair. R2 has a shuffling gait and requires one-person physical assist for ambulation. R2 can ambulate by herself but is not safe.

On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 had an unwitnessed fall in the dining room on 4/24/24. V2 stated we determined that R2 shoes was too big.

V4 witness statement dated 4/24/24 documents: observed R2 on the floor in dining room near wheelchair at breakfast time fully dressed with shoes off at the table and grip socks on. Nursing note dated 4/24/24 documents: R2 stated, she hit her head. Fall event dated 4/24/24 documents: Sent to emergency room - Intervention and immediate measures taken increased supervision and monitoring. Care plan approach dated 4/24/24 documents: R2 required shoes that fit with no laces.

On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 had an unwitnessed fall in the dining room on 4/28/24. R2 was used to going to the bathroom on her own. R2 will stand up and fall. V2 stated, she does not recall if R2 was wet/soiled. Intervention keep R2 in the dining room/high traffic area for monitoring.

Nursing note dated 4/28/24 document: R2 had a fall in the dining room. Accident/incident IDT form dated 4/28/24 documents: R2 was last seen eating. Unwitnessed fall -offer toileting and distractions.

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S9999	Continued From page 4 On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 had an unwitnessed fall in the dining room on 4/29/24. R2 was impulsive, R2 was able to push self-back in her wheelchair and stand up. R2 was quick. Intervention: frequent toilet. Nursing note dated 4/29/24 documents: R2 had a fall in dining room near wheelchair. R2 was not able to verbalize what happened. Fall event dated 4/29/24 documents: mental status prior to fall: confused. Writer (V2) called previous Restorative Director at another facility who stated, resident (R2) has a history of trying to escape. V2 stated R2 keeps falling because R2 wants to escape. V2 stated it took a few months for her to become familiar and stop trying to escape. On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 leaned forward and repositioned self in wheelchair and slid out on 5/12/24. R2 was given a non-slip pad. Nursing note dated 5/12/24 documents: R2 had an unwitnessed fall in the dining room. Accident/Incident IDT form dated 5/13/24 documents; fell leaning forward, repositioning, slid out of wheelchair. Intervention: nonslip pad and cushion to wheelchair. On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, she watched the video footage and saw R2 fall on 5/23/24 by R2 leaned back in her wheelchair. R2 fell backward. R2 was given anti-tipsters. Nursing note dated 5/23/2024 documents: R2 fell in dining room witnessed by CNA. R2 hit her head. Small lump is noted in back of head. Fall event dated 5/23/24 documents: R2 was found on	S9999		

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the floor in dining room witnessed by cna that R2 hit her head. V5 (activity aide) witness statement dated 5/23/24 documents: R2 was seating in her wheelchair pushing back on the table when she fell backwards. Hospital paperwork dated 5/23/24 documents: Fall. Contusion to face.

On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 got up out of bed on 7/25/24. R2 was seen sitting on the floor mat. R2 is impulsive and will attempt to get out of bed if awoke.

Fall event dated 7/25/24 document: Unwitnessed. R2 was observed on floor sitting on the mat. Intervention get up upon awaking.

On 8/10/24 at 2:07pm, V2 (restorative nurse) stated, R2 attempted to self-transfer out of bed without using the call light on 8/5/24.

On 8/11/24 at 3:20pm, V7 (nurse) stated, she does not recall the incident on 8/5/24 of R2's incident. R2 takes baby steps, R2 has a shuffled gait. Any time, R2 attempts to get up, R2 is trying to toilet self. R2 is Japanese. R2 can ambulate by herself but it's not safe.

Nursing note dated 8/5/24 documents: R2's roommate informed staff that R2 was on the floor in her room. R2 noted at foot of bed lying in supine position. R2 complained of right shoulder discomfort. Fall event dated 8/5/24 documents: unwitnessed fall, unsteady gait, assist when up, otherwise in wheelchair.

Fall Reduction Program no documents: Intent is to assist clinical staff in determining the need of each resident through the use of standard assessment, the identification of each resident's individual risk and the implementation of

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S9999	Continued From page 6 appropriate interventions, supervision and or assistive device deemed appropriate. (B)	S9999		