STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145879	A. Building B. Wing	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri-State Village Nrsg & Rhb	2500 East 175th Street Lansing, IL 60438

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for dementia/behavior care planning by not ensuring a care plan for a resident who exhibits physically aggressive behavior towards staff included comprehensive personalized interventions for behaviors. This failure applied to one (R3) of six residents reviewed for care planning. Findings include: R3 is an [AGE] year-old female with diagnoses history of Dementia without Behavioral Disturbance, Chronic Diastolic Heart Failure, Stage 3 Chronic Kidney Disease, COPD, and Syncope/Collapse who was admitted to the facility 06/22/2023. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's current care plan initiated 10/16/23 documents she demonstrates mood distress & anxiety related to: A diagnosis of Pseudobulbar affect. Problems/needs are manifested by: Uncontrollable episodes of crying that are disproportionate to the situation at hand with interventions including Use behavior management techniques to promote & shape the desired behavior such as: Controlling the environment to the degree possible to moderate stress. Reduce noise, over-stimulation, commotion, movement, crowds, close contact; Provide reassurance to me and remind me that I am in a safe and secure environment with dedicated and caring persons; Provide opportunities for the resident to have space and fresh air; Utilize psychiatric management to monitor psycho-active medications, provide support & enhance structure. R3's current care plan initiated 06/24/23 documents she demonstrates behavioral distress related to: Ineffective coping mechanisms., Poor verbal skills & inability to express self-more appropriately. Being an adult living with medical and mental health diagnoses., having several medical comorbidities., Given her cognitive, emotional, and behavioral impairment, she has lost several social skills, and is frustrated by any delay in gratification and being dependent upon others., She may display behavioral symptoms out of anger, confusion, and fear., she has demonstrated behavior symptoms including physical aggression such as hitting, biting, and swinging at care givers, and socially inappropriate behavior, she is having trouble with emotional and behavioral self-regulation., she is having trouble understanding how this behavior is detrimental to her personally., and she does not understand the risks she would face if she were to leave with interventions including: If the resident becomes verbally or physically abusive attempt to calm the resident by explaining that ladies & gentlemen do not talk/behave this way. We do not touch other people.; Resident will demonstrate an improvement or reduction in distressing behavioral symptoms in response to behavior management interventions as evidenced by no attempts to hit staff; Look proactively at the behavior; Identify causal factors and work to reduce, minimize and/or treat the causal factors. This stresses prevention; If talking to the resident is not successful in stopping the behavior, try to walk with the resident to a quiet area, away from other individuals. R3's care plan does not include specific causal factors or potential triggers for her physically aggressive behavior and does not include personalized interventions to address these behaviors. R3's progress note dated 11/05/2023 6:30 PM documents notified by CNA (Certified Nursing Assistant) that R3 was being combative with CNA while providing incontinent care. R3's Abuse Investigation Report dated 11/10/2023 documents: a family member of another resident called police reporting she witnessed V6 (Certified Nursing Assistant) being verbally discourteous to R3, push her down and strike her. Police were notified and observed R3 with no signs of injury. R3 was unable to provide a narrative due to confusion due to diagnoses of Dementia. R3 has a diagnosis of Pseudobulbar affect, a disorder that causes a person to experience uncontrollable episodes of crying, laughing, or other emotional displays that are out of context in their social interactions. Staff that were interviewed reported that R3 can be physically aggressive toward staff during care at times. V6 was interviewed on 11/05/23 at approximately 9PM by phone and reported that R3 punched and pushed at her as she was assisting her to transfer to the bed and that she did have her hands up to block her strikes; she was asking R3 to remain calm and let her know it was bedtime; On 11/05/23 at approximately 9:15 PM V4 (Licensed Practical Nurse) was interviewed and reported R3 strikes the staff at times related to her confusion when attempting to provide ADL (Activities of Daily Living) care and/or assist her to bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/23 V11 (Family Member) met with V1 (Administrator) and V3 (Director of Nursing) and acknowledged that R3 can fight and be physically aggressive to staff, and could understand how anyone attempting to redirect or provide for safety might be misperceived by someone who did not know her mother, V11 verbalized agreement with new interventions to be implemented to ease waking and bedtime routines for R3. On 11/05/2023 at approximately 9:45 PM V8 (Certified Nursing Assistant/Staffing Coordinator) was interviewed and reported R3 often exhibits tearfulness during mundane interactions and that staff attempt to provide reassurance at these times. V8 reported that at times R3 can seem agreeable to an activity then during the activity she may unexpectedly strike out. On 11/09/23 at approximately 12:30 PM V9 (Certified Nursing Assistant) was interviewed and reported R3 regularly becomes tearful during normal conversation and/or care activities. V9 stated R3 can be physically aggressive toward staff at times and sometimes during care without warning. V9 stated R3 can strike her at times but she usually responds to gentle redirection (guiding hands away from striking) and reassurance. On 12/04/2023 at 1:15 PM V6 (Certified Nursing Assistant) stated R3 is very abusive and a batterer. V6 stated on 11/05/2023 when she was taking R3 to her room a family member saw R3 was fighting her. On 12/05/2023 at 12:46 PM V6 (Certified Nursing Assistant) stated on 11/05/2023 she was getting everything set up and was providing patient care and in the midst of her trying to take R3's clothes off she was kicking and swinging as she normally does. V6 stated she had brought R3 to her room, transferred her from her wheelchair to her bed. V6 stated R3 then laid down and when she began taking R3's pants off, she started kicking and screaming. V6 stated when residents become combative it should instantly be reported to the supervisor and try to go get help. V6 stated she normally doesn't work with R3 but has heard she is combative. On 12/05/2023 at 1:52 PM V3 (Director of Nursing) sated if a resident becomes combative or resistant to care while receiving care from a CNA (Certified Nursing Assistant), the CNA should report this to the nurse, and as a team we would try to determine if the issue is behavioral or physical in order to know how to address it. V3 stated the facility sort of has a care plan in place on how they've been handling resistance to care. V3 stated she was not aware of when R3 began exhibiting physically combative behavior during care until the incident of her exhibiting this behavior occurred on 11/05/2023. V3 stated interventions for when residents become physically combative or resistant to care is based on the resident and will be different for each resident. On 12/06/2023 at 10:14 AM V3 (Director of Nursing) stated when it was first identified that R3 was becoming physically aggressive with staff the nursing staff should inform social services, and immediately an IDT (Interdisciplinary Team) meeting would be conducted. V3 stated after the IDT meeting takes place R3's care plan would be updated with interventions to address the behavior. 12/06/2023 10:39 AM V1 (Administrator) and V3 (Director of Nursing) stated it is challenging to pinpoint what triggers or precedes R3's physical aggression due to occurring sporadically and in different situations; however, R3's care plan could include more personalized interventions for her behavior. The facility's Dementia Care Policy reviewed 12/05/2023 states: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Objective: To develop and implement individualized plan of care for each resident with dementia. Identify diversional activities and techniques to reduce agitation. Analyze behaviors which are symptomatic of dementia and how the behavior reflects the individual resident's dementia losses and anticipate potential triggers which may precipitate behavior reactions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews, the facility: 1. failed to follow their policy and procedures for dementia care/behavior management by not ensuring a certified nursing assistant discontinued providing care and at a later time reapproached a resident (R3) with dementia who became physically aggressive while receiving care; 2. failed to follow facility policy and immediately assess and notify a physician for one resident (R2) who experienced head pain after having an unwitnessed fall; and 3. failed to follow their Medication Administration Policy by preparing mediations in advance for several residents at the same time. These failures applied to 17 (R2, R3, R7-R21) of 17 residents reviewed for nursing care. Findings include: R3 is an [AGE] year-old female with diagnoses history of Dementia without Behavioral Disturbance, Chronic Diastolic Heart Failure, Stage 3 Chronic Kidney Disease, COPD, and Syncope/Collapse who was admitted to the facility 06/22/2023. R3's current care plan initiated 10/16/23 documents she demonstrates mood distress & anxiety related to: A diagnosis Pseudobulbar affect. Problems/needs are manifested by: Uncontrollable episodes of crying that are disproportionate to the situation at hand with interventions including Use behavior management techniques to promote & shape the desired behavior such as: Controlling the environment to the degree possible to moderate stress. Reduce noise, over-stimulation, commotion, movement, crowds, close contact; Provide reassurance to me and remind me that I am in a safe and secure environment with dedicated and caring persons; Provide opportunities for the resident to have space and fresh air; Utilize psychiatric management to monitor psycho-active medications, provide support & enhance structure. R3's current care plan initiated 06/24/23 documents she demonstrates behavioral distress related to: Ineffective coping mechanisms., Poor verbal skills & inability to express self-more appropriately. Being an adult living with medical and mental health diagnoses., having several medical comorbidities., Given her cognitive, emotional, and behavioral impairment, she has lost several social skills, and is frustrated by any delay in gratification and being dependent upon others., She may display behavioral symptoms out of anger, confusion, and fear., she has demonstrated behavior symptoms including physical aggression such as hitting, biting, and swinging at care givers, and socially inappropriate behavior, she is having trouble with emotional and behavioral self-regulation., she is having trouble understanding how this behavior is detrimental to her personally., and she does not understand the risks she would face if she were to leave with interventions including: If the resident becomes verbally or physically abusive attempt to calm the resident by explaining that ladies & gentlemen do not talk/behave this way. We do not touch other people.; Resident will demonstrate an improvement or reduction in distressing behavioral symptoms in response to behavior management interventions as evidenced by no attempts to hit staff; Look proactively at the behavior; Identify causal factors and work to reduce, minimize and/or treat the causal factors. This stresses prevention; If talking to the resident is not successful in stopping the behavior, try to walk with the resident to a quiet area, away from other individuals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's progress note dated 11/05/2023 06:30 PM documents notified by CNA (Certified Nursing Assistant) that R3 was being combative with CNA while providing incontinent care. Family member from another patient stated CNA pushed resident. CNA stated to writer that she did not push resident that resident was resisting care and was trying to transfer her into the bed to provide incontinent care. R3's Abuse Investigation Report dated 11/10/2023 documents: a family member of another resident called police reporting she witnessed V6 (Certified Nursing Assistant) being verbally discourteous to R3, push her down and strike her. Police were notified and observed R3 with no signs of injury. R3 was unable to provide a narrative due to confusion due to diagnoses of dementia. R3 has a diagnosis of Pseudobulbar affect, a disorder that causes a person to experience uncontrollable episodes of crying, laughing, or other emotional displays that are out of context in their social interactions. Staff that were interviewed reported that R3 can be physically aggressive toward staff during care at times. V6 was interviewed on 11/05/23 at approximately 9PM by phone and reported that R3 punched and pushed at her as she was assisting her to transfer to the bed and that she did have her hands up to block her strikes; she was asking R3 to remain calm and let her know it was bedtime. On 11/05/23 at approximately 9:15 PM V4 (Licensed Practical Nurse) was interviewed and reported R3 strikes the staff at times related to her confusion when attempting to provide ADL (Activities of Daily Living) care and/or assist her to bed. On 11/07/23 V11 (Family Member) met with V1 (Administrator) and V3 (Director of Nursing) and acknowledged that R3 can fight and be physically aggressive to staff, and could understand how anyone attempting to redirect or provide for safety might be misperceived by someone who did not know her mother, V11 verbalized agreement with new interventions to be implemented to ease waking and bedtime routines for R3. On 11/05/2023 at approximately 9:45 PM V8 (Certified Nursing Assistant/Staffing Coordinator) was interviewed and reported R3 often exhibits tearfulness during mundane interactions and that staff attempt to provide reassurance at these times. V8 reported that at times R3 can seem agreeable to an activity then during the activity she may unexpectedly strike out. On 11/09/23 at approximately 12:30 PM V9 (Certified Nursing Assistant) was interviewed and reported R3 regularly becomes tearful during normal conversation and/or care activities. V9 stated R3 can be physically aggressive toward staff at times and sometimes during care without warning. V9 stated R3 can strike her at times but she usually responds to gentle redirection (guiding hands away from striking) and reassurance. On 12/04/2023 at 1:15 PM V6 (Certified Nursing Assistant) stated R3 is very abusive and a batterer. V6 stated on 11/05/2023 when she was taking R3 to her room a family member saw R3 was fighting her. V6 stated what the family member said about her fighting R3 wasn't true and R3 was fighting her while she was trying to take R3's clothes off and get her dressed for bed. On 12/05/2023 at 12:46 PM V6 (Certified Nursing Assistant) stated on 11/05/2023 while getting everything set up and providing patient care, in the midst of her trying to take R3's clothes off she was kicking and swinging as she normally does. V6 stated she had brought R3 to her room, transferred her from her wheelchair to her bed. V6 stated R3 then laid down and when she began taking R3's pants off, she started kicking and screaming. V6 stated she then began to try to unbutton R3's pants, and in the midst of trying to take her pants off she heard a visitor scream at the door. V6 stated when residents become combative it should instantly be reported to the supervisor and try to go get help. V6 stated when R3 began doing all the movement, she didn't have a chance to ask anyone for help before the lady started hollering at the door. V6 stated she normally doesn't work with R3 but has heard she is combative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2023 at 1:52 PM V3 (Director of Nursing) sated if a resident becomes combative or resistant to care while receiving care from a CNA (Certified Nursing Assistant), the CNA should report this to the nurse, and as a team we would try to determine if the issue is behavioral or physical in order to know how to address it. V3 stated the facility sort of has a care plan in place on how they've been handling resistance to care. V3 stated she was not aware of when R3 began exhibiting physically combative behavior during care until the incident of her exhibiting this behavior occurred on 11/05/2023. V3 stated interventions for when residents become physically combative or resistant to care is based on the resident and will be different for each resident. V3 stated if R3 began to kick V6 (Certified Nursing Assistant) on 11/05/2023 while attempting to provide care to R3, once R3 began kicking if it becomes excessive the CNA should get the nurse to assess the behavior. V3 stated when a resident becomes physically combative or resistant while receiving care the CNA should stop engaging in the care activity, stay with resident to keep them safe, ask for help, and have the nurse come to assess the behavior. V3 stated if the resident becomes physically combative or resistant to care the while being assessed by the nurse, the nurse should attempt to calm the resident down and call doctor and family, because sometimes the doctor will give an order, or the family may calm them down. The facility's Dementia Care Policy reviewed 12/05/2023 states: Identify diversional activities and techniques to reduce agitation. Analyze behaviors which are symptomatic of dementia and how the behavior reflects the individual resident's dementia losses and anticipate potential triggers which may precipitate behavior reactions. 46344 R2 is a [AGE] year-old female with multiple diagnoses including but not limited to the following: rheumatoid arthritis, mild protein calorie malnutrition, cerebral infarction, depression, syncope. Per progress note dated 11/29/23 and 11:50PM states in part but not limited to the following: R2 fell at 10:40pm and complained that she hit her head on the end of the table in her room. At this time, R2 is at the nursing station and has history of falling. Due to her condition and since she was not sent out for possible head injury, 911 was called. On 12/4/23 at 12:00PM, R2 was interviewed regarding incident on 11/29/23. R2 said I was in bed, and I needed some water. I put my call light on and was getting aggravated because it was taking so long for someone to come. I then attempted to get out of bed and fell . R2 said on the way down I hit the front of my head on my nightstand. I did have a headache after the fall. R2 said a CNA found me on the floor and they sent me to the hospital. R2 said I came right back to the facility and did not have any injuries. 12/4/23 at 12:15PM, V16 (Restorative Nurse) was interviewed regarding expectations for staff when a resident falls. V16 said when a resident hits their head during a fall, they should notify the physician and be sent out to the hospital right away to be assessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/4/23 at 1:08PM, V6 (Certified Nurse Assistant) was interviewed regarding incident with R2 on 11/29/23. V6 said I was the nurse on duty when R2 fell . I walked into the room due to the call light being on and found R2 on the floor. I reported this to the nurse on duty at the time, V13 (Licensed Practical Nurse). V17 (Licensed Practical Nurse) was not on duty at the time of this resident falling. V6 said I do not understand how she fell , I just found her and let the nurseV13 know she was on the floor. V6 became verbally upset with this surveyor when attempting to ask more questions about this incident and the conversation was ended. Daily Staffing Schedule for 11/29/23 shows that V17 was scheduled to be assigned to R2 from 10:00PM-6:30AM. Timecard Report shows that on 11/29/23, V17 clocked in at 11:27PM. Time Care Report also shows that on 11/29/23 between 10:33PM to 11:27PM, V13 was the only nurse on duty. It is to be noted that when R2 fell on [DATE] at 10:40PM, V13 was the only floor nurse on duty. At 2:20PM, V18 (Registered Nurse) was interviewed regarding 11/29/23. V18 said I was the nurse for the afternoon shift on this day. When I left that day, I do not believe V17 was there yet, but I did give report to V13. At 1:39PM, V13 (Licensed Practical Nurse) was interviewed regarding incident on 11/29/23. V13 said I was not R2's nurse at the time of the fall but the CNA notified me of the fall since V17 was not around at the time. I did a head-to-toe assessment and we put her back in bed. I wrote this information on a piece of paper and left it at the nursing station for when V17 returned. I then returned to my side of the building. I did not complete the fall report, I believe V17 did this. V13 said when a resident falls and hits their head, we should be sending them out for evaluation immediately. On 12/5/23 at 11:01AM, V17 was interviewed regarding R2 and incident on 11/29/23. V17 said on 11/29/23, I was late to arrive and got to the facility a little after 11:30PM. I was not present when R2 fell but V13 let me know what had happened. However, all V13 told me was that R2 fell by climbing over the bed and that she is always falling. I did not have much information. V17 said I did my assessment and interviewed R2 who said she hit her head on the end table and has a headache. I decided to call 911 and then notify the doctor after to be safe. It is to be noted that the physician and 911 was called approximately one hour after R2 fell . V17 said I feel as if V13 could have handled the situation differently. V13 was the only nurse in the building when R2 fell . I felt as if V13 thought that it wasn't her problem, and she would just wait for me to arrive. 12/5/23 at 2:10PM, V2 (Director of Nursing) was interviewed regarding fall protocol. V2 said when a resident falls and believed to have hit their head, my expectation would be that the nurse on duty assesses the resident, initiates neuro checks, and contacts the doctor and family. The nurse should be following the fall binder that is located at both nursing stations. We require a stat (immediate) x-ray. However, if a resident falls at night, they should be sent to the hospital because we do not have a portable x-ray machine available. When the nurse calls the doctor, they will tell them to send them to the hospital immediately. The nurse that is on duty at the time of the fall should be the one doing the assessment and sending the resident out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Change in a Resident's Condition or Status with revision date of 05/2017 states in part but not limited to the following: Objective: Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. Procedure: The nurse will notify the resident's attending physician when the resident is involved in any accident or incident that residents an in injury. 44570 On 12/04/23 at 4:15PM V20 LPN was observed standing at the medication cart preparing medications. Several medication cups were on the medication cart with names on the cup. V20 was seen putting medications in the different cups and writing in the Medication Administration Record. When surveyor asked V20 what he was doing, V20 said, Why are you bothering me ma'am? On 12/5/23 at 10:45AM V20 was interviewed over the phone. V20 said that they had just begun working in the facility in October on the evening (2PM-10PM) shift, but had been practicing as an LPN for [AGE] years. V20 acknowledge the events that had been observed by the surveyor on the previous day and explained that during the interaction, they were preparing medication for several residents at the same time. When V20 was asked which residents they were preparing medication for, V20 said all of them. V20 said that normally, they were responsible for about 30 or so residents and in order to ensure the medications are given on time, they are prepared and placed in the medication cart to be passed. V20 acknowledged that this practice was not taught to them by anyone and that all of the nurses do it and that it was not in alignment with professional nursing standards. V20 said, the proper and nice way to pass medications was to practice the 5 Rights of medication administration; right resident, right medication, right dosage, right time, and right route), however the process takes time, and they want to make sure everyone gets the medications timely. On 12/05/23 at 2:09PM V3 Director of Nursing said, the nurses are expected to assess the resident and practice the 5 Rights. This ensures that they are giving the correct medications to the correct resident at the correct time. Deviating against this standard, has the potential to create a medication error. I would expect for all nurses to know this because it is the standard. Physician Order Sheets were reviewed. Of the 24 residents V20 was assigned to on 12/4/23 evening shift, 13 residents were scheduled to receive medications between the hours of 4PM and 5PM. Facility policy titled; Administration of Drugs revised 5/20 states in part; Objective: 1. Medications shall be administered as prescribed by the attending physician. 5. Identification of the resident must be made prior to administering medication to the resident. (Note: Persons administering the resident his/her medications should check the photo identification card or other means of identifying the resident). 7. Medications may not be set up in advance and must be administered within one (1) hour before or after their prescribed time. (Note: Before and/or after meal orders must be administered as ordered.)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on observation, interview, and record review, the facility failed to honor a resident's request to obtain assistance in obtaining the legal and/or social services necessary to have his guardianship status legally re-evaluated and maintain his highest practical well-being. This failure affected one (R1) of one resident reviewed for resident rights and has resulted in R1 suffering psychosocial harm as a result of not being able to leave the facility on pass status and having his phone taken away; this was further exhibited by R1 calling the police due to feelings of imprisonment. Findings include: R1 is a [AGE] year-old male who originally admitted to the facility on [DATE] with multiple diagnoses including but not limited to the following: hemiplegia, CHF, seizures, HTN, and CAD. Minimum Data Set (MDS) assessment dated [DATE] from admission shows that R1 had a Brief Interview of Mental State (BIMS) of a 14, indicating resident was cognitively intact. Most recent MDS assessment dated [DATE], shows R1 has a BIMS of 15, and also indicating resident is cognitively intact. On 1/20/23, R1 was granted a temporary guardian, V25 (Family Member) due to R1 being in a medical induced coma and was unable to make decisions. On 5/2/23, V25 was granted permanent guardianship of resident. Progress note written by V14 (Social Service Director) states in part but not limited to the following: R1 shared their preference for community access. V14 reached out to V25 - legal resident guardian responsible for R1. V25 expressed her disagreement with the resident having community access. Progress note dated 10/20/23 states in part but not limited to the following: Police department on the unit stating that they were called by R1 with complaint that he was being held against his will. Made police officers aware that V25 is currently not giving R1 permission to leave the facility without her consent. Progress note written on 10/21/23 states in part but not limited to the following: R1 was observed trying to exit the facility to go to the grocery store. R1 informed that V25 denied resident request for community access. R1 stated Police stated he could leave and comeback. R1 said I am going to call the police again. On 12/4/23 at 12:00PM, R1 was interviewed regarding community pass and guardianship. R1 stated he is frustrated and upset because V25 is not letting him leave the building. R1 said I do not feel as if V25 is looking out for my best interest. R1 said we do not get along and did not get along prior to the guardianship. She turned off my phone and will not let me leave the building. R1 said they won't even let me go to Walmart which is in the same parking lot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145879	A. Building B. Wing	12/06/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Actual harm Residents Affected - Few	R1 said I have talked to V14 (Social Service Director) in the past to let her know that I do not want V25 (Family Member) as my guardian and nothing is being done to help assist me. R1 said, I feel as if I do not need a guardian at this time, as I am not in the same state when it was originally put into place .When the guardian was assigned initially, I was in a medically induced coma and could not make decisions for myself at that time .Obviously that is not the case currently. 12/4/23 at 12:55PM, V14 was interviewed regarding community pass access for R1. V14 said when R1 was in the hospital, he was non-decisional and V25 was elected to be his guardian. Sometimes R1 and V25 are on good terms and sometimes they are not. V14 said that R1 has expressed concern to her in the past, saying that he does not want her (V25) to be his guardian anymore. I instructed him that he could contact the ombudsman and/or legal aid for assistance. This surveyor requested documentation that V14 provided R1 with contact information to both the ombudsman and legal aid. It is to be noted that V14 documented that the contact information was given to R1 on 12/4/23 at 1:15PM, after this interview was conducted; no documentation prior to this date that R1 was being provided with assistance from the facility to dispute his guardianship status. 12/4/23 at 2:45PM, R1 said, I never received any contact information from V14 for legal aid or the ombudsman. I have not heard anything from V14 after expressing my concerns. On 12/6/23 at 11:50AM, V23 (Previous Nurse Practitioner) was interviewed regarding R1. V23 said, I did not participate in collecting data for his permanent guardianship. It is to be noted that V23 was R1's nurse practitioner at the time when the permanent guardianship was put into place on 5/2/23. 12/4/23 at 2:10PM, V24 (Attorney) was interviewed regarding the process of guardianship. V24 said that at some point when the guardianship was instated, a judge had to declare the resident to be disabled. If a resident desires to terminate the guardianship, they would have to go through the process of filing a motion and potentially hiring an attorney to assist. It is to be noted that resident concern forms dated September 2023-present were reviewed. No concerns noted regarding community pass or guardianship from R1 were identified. Facility policy titled Resident's Rights with revision date of 10/2017 states in part but not limited to the following: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include but not limited to the resident's right to: voice grievances and have the facility respond to those grievances. Residents are entitled to exercise their rights and privileges to the fullest extent possible.