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	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

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41758 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 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. (continued on next page)

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
	145879	A. Building B. Wing	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

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 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. (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	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

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 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 appropriate interventions, supervision and or assistive device deemed appropriate.