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	11/07/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40066 Based on interviews and records reviewed the facility failed to prevent resident to resident inappropriate touching. This affected two of three residents (R3 and R4) reviewed for abuse. This failure resulted in R4 inappropriately touching R3 in the dining room. Findings include: Facility final investigation of incident on 10/9/24 report submitted to the State Agency states per police report R4 touched R3's crotch area. R3's diagnoses include, but are not limited to Polyarthritis, Hypertensive Heart Disease, Vascular Dementia, Schizophrenia, Major Depressive Disorder, and Anxiety. R3's cognitive pattern score on 9/30/24 is a 5 out of 15, impaired. R4's diagnoses include but are not limited to Metabolic Encephalopathy and Hemiplegia/Hemiparesis following Cerebral Infarction. R4's cognitive pattern score on 9/5/24 is a 15 out of 15, intact. R4's care plan documents given my cognitive, emotional, and behavioral impairment; I have lost several social skills. I have demonstrated symptoms of socially inappropriate behavior. On 10/31/24 R3 and R4 were both observed in the dining room sitting at separate tables. R3 did not verbally respond to the surveyor, only made eye contact. R4 looked at the surveyor and turned away when the surveyor asked him a question. R4 able to maneuver his wheelchair independently as he turned away. On 10/31/24 at 11:32AM V1, Licensed Practical Nurse (LPN), stated on 10/9/24 I was by the nurses' station and heard residents in the dining area, a bunch of commotion. V1 stated I was told by the residents R4 was touching R3 in her private area. V1 stated I did not see it happen. V1 stated R3 and R4 were sitting near each other and in wheelchairs. V1 stated R3 and R4 were in arm's length of each other. V1 stated I reported it but I did not see what happened. V1 said there was no other staff in the dining room at the time. V1 said it was a little before 7:00AM we were getting ready for breakfast. V1 said R3 was sitting there calm, not upset or agitated. V1 said I needed to report this because it is inappropriate. V1 said it happened in the front of the dining room. V1 said R3 and R4 are not a couple. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's station does not have a view of the front of the dining room. On 11/1/24 at 1:27PM V12, Social Services, said staff reported R4's behavior and he went out for an evaluation. V12 said R3's cognitive ability is she understands but she is easily distracted and does not stay on topic. On 11/1/24 at 2:33PM V7, Administrator, said I was made aware about R3 and R4 after I came into the building in the morning on 10/9/24. V7 said I was told the residents said they saw R4 touch R3 inappropriately. V7 said I submitted a reportable and called the police. V7 said R4 was sent to the hospital. V7 said I was with the police officer for an hour. V7 said I went thru camera footage with the officer, and he interviewed staff and residents. V7 said when we spoke with R3 and R4, they didn't remember anything. V7 said in the camera footage R4 put his hands over R3's crotch. V7 said in the morning the Rehab aids will be in the dining rooms and the activity aids will take over. V7 said around 7:00AM staff starts putting people in the dining. V7 said the hospital sent R4 back right away. V7 said in situations like this, we always send them out for evaluation. V7 said the findings of the investigation is it was substantiated that R4 touched R3. V7 said it was seen on camera that R4 jumped and then staff came in right away. V7 said R4 looked like he was caught in the act. Police report documents on 10/9/24 officer was advised R4 placed his hand inside R3's pants in the dining room. V7 provided video footage of the incident. I (officer) observed R4 groped R3's crotch area, over the clothes. Staff witness statements reviewed, none witnessed the incident between R3 and R4. Statements say that staff was informed by the residents. Facility final investigation report submitted to the State Agency states per police report R4 touched R3's crotch area. The facility's undated Abuse Prevention Policy states this facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to develop a baseline plan of care for monitoring and assessing a resident diagnosed with acute respiratory failure, obesity hypoventilation, shortness of breath that required a bipap machine when sleeping. This affects one of three residents reviewed for baseline plan of care. Findings include: R's face sheet shows R1 has diagnoses of acute respiratory failure, obesity hypoventilation syndrome, shortness of breath. R1's respiratory progress note dated 10/3/24 at 7:00pm denotes in-part respiratory care note: [AGE] year-old female admitted to this facility on 10/3/24 from hospital. Admitting Diagnoses: acute hypercapnic /hypoxemic respiratory failure, obesity hypoventilation syndrome and NSTEMI. Patient intubated 9/23 with subsequent extubated 9/25. Patient used BIPAP QHS (every night) during hospitalization . Patient seen resting in bed. Moderate accessory muscle use noted. Respirations rapid and shallow. She is currently on 4.5 liters supplemental O2. Patient does not have home oxygen. SPO2 91-92%, HR-86, RR-28. Patient c/o SOB (shortness of breath) and states her breathing is heavy and worsening. Nursing notified. Patient sent out 911 for further evaluation. 30 min. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 10:21am V8 (Director of Nursing) stated R1 did not have a baseline plan of care in place at the facility. V8 stated she cannot find any documentation of vital sign assessments for R1 upon readmission to the facility on [DATE]. V8 stated the nurse was aware that R1 was a readmission. V8 stated her expectation for the Nurse is to assess and document the assessment for a newly admitted or readmitted resident. V8 stated the nurse should gather information from the resident during the assessment if the resident can communicate. V8 stated the nurse should notify the physician of the admission, review the medication, and obtain orders, V8 stated the Nurse should notify the physician of any findings observed during the full body assessment. V8 stated the Nurse should ensure that the resident get a meal, and the Nurse should check on the resident intermittently, V8 stated the Nurse should inform the aide of the admission to provide care. V8 stated vital sign assessment should be completed upon admission and every shift for 72 hours. V8 stated depending on the situation or the condition of the resident, the Nurse should be completing vital sign assessment as needed. V8 stated R1 should have had a head-to-toe assessment completed upon admission on 10/3/24 and on readmission on 10/4/24. V8 stated R1 should have had vital sign assessment competed upon readmission on 10/4/24. V8 stated her expectation is that vital sign assessment should be completed every shift for the first 72 hours. V8 stated the Nurse should complete a skin assessment and document the findings upon the admission and or readmission. V8 stated she was aware of R1 admission on 10/3/24, V8 stated she discovered that R1 used a bipap machine in the hospital and needed a bipap at night. V8 did not respond as too when she discovered this information. V8 stated she notice yesterday (10/31/24) that the nurse did not document any vital signs on R1 upon readmission and that the staff needs coaching. V8 did not give respond regarding developing base line care plan for R1. V8 stated she reviewed the physician orders, and she did not see an order for bipap machine, nor did she see an order for oxygen administration. V8 did not respond when asked how the nurse knew how much oxygen to administer to R1?. V8 continues to repeat if the Nurse made a mistake, there will be education provided. 11/7/24 at 10:31am during a follow up interview V8, V8 stated she doesn't know how much oxygen was administered to R1 upon readmission, and she doesn't know how much oxygen was administered to R1 when using the bipap when sleeping. V8 stated the Nurse should have notified the physician and obtained orders for oxygen administration for R1. 11/7/24 at 12:18pm V8 stated she does not know what bipap 50% means. V8 stated the diagnosis of short of breath must have come from the hospital upon readmission. V8 stated the hospital sent the bipap settings on 10/4/24 for the facility to review when ordering R1's bipap. On 10/31/24 at 11:47am V6 (LPN) stated she was the Nurse for R1 on 10/4/24 upon R1's readmission to the facility. V6 stated R1 was admitted the day prior and was sent back to the hospital for trouble breathing. V6 stated she did not document the vital signs for R1 upon readmission, V6 stated she don't recall what R1 vitals were, it was a while ago. V6 stated she should have assessed and document R1 vital signs, V6 stated the vital signs assessment is important because it help with assessing when there's a change in condition. V6 stated she doesn't know how much oxygen she administered to R1 when connecting R1 to the bipap machine that night (10/4/24). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 2:18pm V19 (LPN) stated he was R1's Nurse on the night shift of 10/4/24. V19 stated he did not assess R1's vital signs, nor did he assess R1's oxygen levels until he observed R1 mottled at or around 4:30am-5:00am, V19 stated that's when he observed R1 with no pulse and no respiration. V19 stated vital signs are not that important and that the vital signs and oxygen levels can be assessed at the end of the shift. V19 stated he was aware that R1 was admitted to the facility on [DATE] and sent back to the hospital due to breathing difficulty, and returned to the facility on [DATE]. V19 stated he don't recall how much oxygen was being administered to R1 that night via bipap. V19 stated he documented everything in the progress notes. V19 did not respond when asked about the plan for monitoring and assessing R1, a resident with diagnosis of acute respiratory failure, hypoventilation, and shortness of breath. On 11/1/24 at 11:34am V20 (Respiratory Therapist) stated she observed R1 on 10/3/24 with breathing difficulty, R1 was sent back to the hospital. V20 stated she gave the facility the settings to give to the medical supply company for R1 bipap machine, V20 stated the settings was 12 over 5 expiratory and inspiratory pressure. V20 stated the settings was generic and that she was planning to see R1 on Saturday for a respiratory assessment and to change the settings for the bipap machine if needed. Review of V19 progress notes for R1 does not denote how much oxygen was being delivered to R1. Facility 24-hour report sheet dated 10/4/24 (3-11) denotes R1 name, returned, Dx (diagnosis) SOB (short of breath), bipap at 50%, and 11-7am Dx (diagnosis) SOB (short of breath). Facility failed to present a baseline care plan for R1 during this survey. Facility failed to present orders for Oxygen administration for R1 during this survey. Review of R1 physician order sheet, there is no orders noted for bipap machine. There are no orders for oxygen administration.