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	08/27/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transfer a resident safely and in line with facility protocols, which resulted in R3 falling while staff were transferring R3 from the chair to bed. This failure applied to one (R3) of four residents reviewed for falls.Findings include:R3 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: Paraplegia, Multiple Sclerosis, and morbid obesity.R3's Minimum Data Set (MDS) dated [DATE] section C0500 documents Brief Interview for Mental Status (BIMS) score = 15 which suggests cognition is intact. Section GG0130 documents resident needs set up or clean up assistance for eating. Resident needs partial/moderate assistance for upper body dressing. Resident needs substantial/maximal assistance for oral hygiene, shower/bathe self, lower body dressing, and personal hygiene. Resident is dependent on staff for toileting hygiene and putting on/taking off footwear. On 8/11/2025, at 10:56 AM, R3 stated I did have a fall from the sit to stand (mechanical lift). That was in March this year. V4 Certified Nursing Assistant (CNA) was new. It was just one person (V4) helping me when I fell. She starts at 2pm and works 2nd shift. I told V3 Director of Nursing (DON) what happened. V3 DON did not look at my hip or anything.On 8/11/2025, at 2:16 PM, V4 CNA stated I have worked with R3 before. I do recall moving R3 in a sit to stand (mechanical lift) and R3 had a fall. I called someone to help me get her back up off the floor to the bed. I was using the lift with V19 CNA my coworker. V19 CNA is out of the country on vacation right now. I was new then. This is my first experience as a CNA. We (V19 and I) put the pad on R3's back as we were about to lift her R3 was sort of afraid, so we tried to calm her down. In the process, R3 dropped from the chair to the floor. R3 has a leg problem. R3 normally uses her hand to pull her leg up. I called for someone else to help. It was another CNA. I do not know her name, I don't think she no longer works here. She oriented me. I was new and I did not report to the nurse. I asked R3 if she had any problem at all, and she said no. We helped her back to bed, V19 and myself. The other CNA was just watching us. V19 and I lifted R3 up from the floor with the hoyer (mechanical lift). There was no nurse in the room. I am unaware of any other residents that fell from the lifts. So, after the fall V3 DON and V7 ADON called me to the office and told me to always use the hoyer (mechanical lift) with another person. I think V3 DON and V7 ADON knew R3 had a fall. I was a new CNA, so they were just telling me what to do and what not to do. I am not sure if they knew. If I see a resident on the floor, we let the nurse know right away and get help to assist the resident up after the nurse sees them. The fall with the sit to stand (mechanical lift) with R3 happened somewhere between March 17th this year when I started to April this year. Maybe like 2-3 weeks after I started.On 8/12/2025, at 9:30 AM V3 DON stated we did a fall event for the fall with R3 for yesterday because we were notified yesterday of the event. We interviewed R3 and she said V4 CNA was trying to transfer from chair to sit to stand (mechanical lift) to put her in the bed, but it seemed like the chair was not locked because the chair moved, so she slid to the floor. V4 CNA called for another CNA to come and assist her. V4 CNA was using the sit to stand (mechanical lift) alone. There is always supposed to be 2 staff. V4 CNA did tell us the truth that she did use the sit to stand alone that day. When the other CNA V19 came they asked R3 if she was ok and R3 said she was ok. They both (V4 and V19) transferred her back to bed. I asked V4 CNA if she told the nurse, and V4 CNA said she did not because R3 said she was fine. V4 CNA was ignorant to the fact because she was new here and she was new to this type of job. R3 said this fall happened back in March 2025. When surveyor asked V3 DON if V4 CNA had proper training on lifts prior to this fall V3 stated V4 CNA did not have proper training prior to this. V4 CNA has had training since and we retrained her again yesterday and we are retraining all staff members. Fall event was done, we put an intervention for staff education on use of mechanical lifts.On 8/12/2025, at 10:57 AM, V1 Administrator stated I am now aware of a resident falling out of the lift. I was made aware yesterday. My expectation is that 2 staff should be using the mechanical lifts at all times.On 8/12/2025, at 11:11 AM, V7 Assistant Director of Nursing (ADON) stated I was made aware just yesterday of a resident falling out of a lift. That was the first I had heard of it. There should always be at least 2 staff members to use both mechanical lifts. My expectation of staff after a fall should notify the nurse, nurse should do head to toe assessment, notify doctor, if patient can be moved then the staff would safely transfer the patient back to bed.On 8/12/2025, at 2:09 PM, V3 DON stated I was not aware of R3's fall prior to yesterday. I started in servicing yesterday on timely reporting, and mechanical lift use. Prior to yesterday V4 CAN did not have any formal training on mechanical lifts except for the 3-day training with preceptor. I do not have any documentation of preceptor training for V4 CNA on

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and facility assessment and assure competency of each employee for proper transferring technique to safely transfer residents. This includes gait belt use training for all nursing staff and mechanical lift training for 7 Certified Nursing Assistants. This failure affected one resident R3 and has the ability to affect all 76 residents in the facility.Findings include:R3 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: Paraplegia, Multiple Sclerosis, and morbid obesity.R3's Minimum Data Set (MDS) dated [DATE] section C0500 documents Brief Interview for Mental Status (BIMS) score = 15 which suggests cognition is intact. Section GG0130 documents resident needs set up or clean up assistance for eating. Resident needs partial/moderate assistance for upper body dressing. Resident needs substantial/maximal assistance for oral hygiene, shower/bathe self, lower body dressing, and personal hygiene. Resident is dependent on staff for toileting hygiene and putting on/taking off footwear.On 8/11/2025, at 10:56 AM, R3 stated I did have a fall from the sit to stand (mechanical lift). That was in March this year. V4 Certified Nursing Assistant (CNA) was new. It was just one person (V4) helping me when I fell. She starts at 2pm and works 2nd shift. I told V3 Director of Nursing (DON) what happened. V3 DON did not look at my hip or anything.On 8/11/2025, at 2:16 PM, V4 CNA stated I have worked with R3 before. I do recall moving R3 in a sit to stand (mechanical lift) and R3 had a fall. I called someone to help me get her back up off the floor to the bed. I was using the lift with V19 CNA my coworker. 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