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	11/17/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observations, interviews, and record reviews, this facility failed to provide the necessary care and services to prevent a stage 3 sacral pressure ulcer from recurring, assess and document wound conditions, perform weekly wound assessments with measurements for one resident (R1) out of three residents reviewed for pressure ulcers. On 10/1/25 R1's stage 3 sacral pressure ulcer reopened; wound measured 2. 9cm (centimeters) x 0.6cm x 0.1cm. On 11/14/25, R1's wound declined; wound measures 3cm x 4,3cm x 0. 4cm with 50% slough and 50% granulation tissue. Findings include:On 11/17/25 at 8:45 AM, V4 (wound care nurse) stated that she believes R1's sacral pressure ulcer is facility acquired. V4 stated that the nurse is expected to chart in the resident's medical record when dressings changed. V4 stated that resident's family is updated weekly after resident is seen by wound care physician. V4 stated that the resident's family is notified if a new wound identified. V4 stated that wounds are measured weekly during wound care physician rounds. V4 stated that if resident develops a MASD (moisture associated skin damage), the nurse is expected to notify wound care team so resident can be assessed and have wound treatment orders obtained. On 11/17/25 at 11:15 AM, V2 DON (director of nursing) stated that V4 has been in the wound care nurse position for one week. V2 stated that the previous wound care nurse was not doing her job.R1's medical record notes R1 was hospitalized 9/26-9/30/25 and 10/11-10/18.On 9/30/25 at 6:30 PM, V5 LPN (licensed practical nurse) notes R1 is re-admitted after hospitalization. R1 is noted to have two old wounds (scar tissue) to the sacrum and left posterior thigh.R1's full clinical body observation, dated 9/30/25, notes R1's skin color is normal, skin temperature is warm, skin is dry, and skin turgor is normal. R1 is noted with MASD to sacrum and left posterior thigh. No pressure ulcers identified.On 10/1/25 at 12:52 PM, V6 LPN noted R1 is a readmission from hospital. Head-to-toe skin assessment completed. R1 has a 1.5cm x 0.5cm wound on her sacrum. V6 received new orders to clean with normal saline and apply calcium alginate to wound bed on sacrum and posterior thigh and cover with gauze dressing. R1's family notified of new orders.R1's wound care physician's initial note, date 10/7/25, notes R1 with stage 3 sacral pressure ulcer, measuring 2.9cm x 0. 6cm x 0.12cm, 100% granulation tissue. On 10/21, the wound care physician documented R1's sacral pressure ulcer resolved.R1's wound was not monitored by wound care physician 10/22 to 11/13.R1's full clinical body observation, re-admission dated 10/18/25, notes R1's skin color is normal, skin temperature is warm, skin is dry, and skin turgor is normal. R1 is noted with a stage 3 sacral pressure ulcer. R1's POS (physician order sheet), dated 10/1/25, notes an order to cleanse sacrum with normal saline and apply calcium alginate to wound bed and cover with a dry dressing once a day; discontinued on 10/7. 10/7 notes an order to cleanse sacrum with wound cleanser and apply calcium alginate to wound bed and cover with a dry dressing once a day; discontinued on 10/11 (due to hospitalization). 10/18 notes an order to cleanse sacrum with normal saline and apply a dry dressing until wound care evaluates and treats; discontinued on 10/21. 10/26 notes an order to cleanse sacrum with normal saline and apply a foam dressing with zinc.There are no wound care treatment orders from 10/21 until 10/26.R1's TAR (treatment administration record), dated 9/30 to 11/17, was reviewed. There is no documentation R1 received wound care treatment to sacral wound on 10/3, 10/7, 10/8, 10/22, 10/23, 10/24, 10/25, 10/28, 11/4, 11/7, 11/13, or 11/15.R1's wound management documentation, dated 10/2 to 11/4, notes on 10/2 R1's sacral wound measured 2.9cm x 0.6cm x 0.1cm with100% granulation tissue; on 10/7 wound measured 2.9cm x 0.6cm x 0.1cm with100% granulation tissue; on 10/28 wound measured 3.5cm x 1cm with100% granulation tissue; and on 11/4 wound measured 3.5cm x 4cm x 0.2cm with 50% slough (yellow tissue) and 50% granulation tissue.There is no further documentation under wound management after 11/4/25.On 11/14/25, R1's sacral wound was assessed by the new wound care physician. R1's wound measures 3cm x 4,3cm x 0.4cm with 50% slough and 50% granulation tissue.