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	03/13/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess, monitor and treat residents with multiple pressure ulcers for 2 of 3 residents (R3 and R4) This deficient practice resulted in R3 being hospitalized for necrotizing fasciitis of the wound bed. Findings include: On 3/10/2026 at 2:00pm V14(Certified Nursing Assistant-CNA) said on 10/5/2025 she entered R3 room and V10 said to clean her up she's going out to the hospital the areas on her buttocks were some what dark she did answer me correctly when I told her what I was doing she responded ok. R3 could not turn or reposition herself she was dependent on staff for all care. On 3/10/2026 at 3:00pm V8(Nurse Practitioner-NP) said that a wound can become infected with necrotizing fasciitis leading to sepsis based on three of the five criteria that the hospitals use, tachycardia, fever, increased white cells, infected wounds, disease factors, V8 said she did not observe R3 wound on 10/5/2025 she gave order to send her out because of a new wound onset. On 3/10/026 at 3:10pm V2(Director of Nursing-DON) said the floor nurses and the weekend wound care nurses do not measure resident's wounds only the wound care nurse on the week day does the measurements. On 3/12/2026 at 9:30am, V10 (Wound care Nurse) said she was the nurse for R3 on 10/5/2025, V10 said she observed a new sacral wound on R3 dark in color like a blister, and notified V8 (Nurse Practitioner -NP) of the new wound also that R3 was not responding to questions as usual. V10 said she does not do measurements on the weekend and that is why she cannot recall the size or length of R3 sacral wound, V8 gave orders to send R3 to the hospital for a wound evaluation. On 3/12/2026 at 10:30am V13(Nurse) said upon her start of shift on 10/5/2026 V10 informed me that R3 would be transferring to the local hospital for a wound evaluation, I made sure to call the family and inform V8 again, I never saw R3 wound, I do not assess any wounds I'll turn it over to the wound care nurse whom was the nurse transferring R3 to the local hospital that day. R3 could not turn and reposition herself she was dependent on staff I never entered the room the transfer was in progress at the start of my shift. R3 resident face sheet indicates that R3 has a diagnosis of hemiplegia, hemiparesis, Chronic respiratory failure, obesity, encounter for Palliative care, muscle wasting, peripheral vascular disease. A Braden score of 14 on 5/18/2024 moderate risk, on 9/9/2025 a Braden score of 16 mild risk, no Braden score on 10/5/2025, R3 was admitted on [DATE] with wounds of the left buttocks stage 2, on 2/4/2025 R3 had a skin tear to right posterior thigh, a care plan dated 8/1/2025 for skin checks per protocol report any signs of skin breakdown. On 3/10/2026 at 10:00am this writer observed R4 incontinence care, and observed two pink open areas with scant drainage to the left and right buttocks. On 3/10/2026 at 10:03am V5(Certified Nursing Assistant-CNA) said I don't know if those open areas were on his buttocks this is my first time having R4.On 3/10/2026 at 10:05am V6(Certified Nursing Assistant-CNA) said the wound care nurse should know the wounds are their R4 came from the other side with this barrier cream that V4 said to apply. On 3/10/2026 at 10:08am V8(Nurse Practitioner-NP) said the wounds are new, R4 also has excoriation to the scrotal area, which I'll order an hydrocolloid dressing three times a week and nystatin powder twice daily with barrier cream to buttocks will be ordered. On 3/10/2026 at 10:12am V4(Wound care Nurse) said that she was not informed of R4 open wound on his buttocks and applied a hydrocolloid dressing to the left and right buttocks, nystatin cream to scrotum and barrier (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	cream to the surrounding buttocks.On 3/12/2026 at 12:30pm V4 said , she complete skin assessments twice a month on the entire building, the floor nurses do a weekly skin assessment on non-pressure ulcer residents and the residents with pressure ulcers she complete weekly assessments along with the wound care physician. I expect the wound care nurse on the weekend to assessment measure and notify the nurse practitioner of any wound just as I do on the week day and complete wound care interventions, then on Monday I will complete them. On 3/12/2026 at 11:30am V7(Certified Nursing Assistant-CNA) said she informed V4 of R4 open areas on his buttocks several times a couple of weeks ago she said to apply barrier cream. R4 resident face sheet indicates that R4 has a diagnosis of Hemiplegia, Hemiparesis, osteoporosis, lack of coordination, an weekly skin assessment dated [DATE], a initial Braden score dated 10/20/2025 of 13 indicates moderate risk and on 3/10/2026 a Braden sore of 12 high risk, on 12/10/2025 a care plan that indicates R4 was at risk for skin breakdown, , On 3/10/2026 R4 has a care plan of left buttock pressure area related to incontinent of bowel and bladder, apply dressing per medical doctor, assess the pressure ulcer for stage, size, length , width, and depth conduct systemic skin inspection weekly report any signs of any further skin breakdown. Left buttocks measuring 1.0x1.2 and Right buttocks 1.0x1.0 pink granulating tissue. Facility Policy: dated October 2025Policy: At first observation of any skin condition, the nurse is to describe and document in clinical record. The nurse is to notify the family of new skin alteration and inform physician of new alteration to obtain initial order. Wound care nurse to follow up with staging and measurements and must add to weekly wound round list for NP to follow. Wound Assessment:Identify the type of wound present such as pressure, arterial diabetic, venous and etc. Identify the stage or extent of tissue destruction involved.Pressure Ulcer and Wound Prevention /Management Program: updated 9/30/2025Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown.Responsibility: Director of Nursing, Licensed Nurses, Certified Nursing Assistants, Restorative Nursing, Care plan Coordinator, Dietician, Physician, and Medical Doctor.Policy; To ensure that residents that enter the facility do not develop pressure ulcers unless the individual's clinical condition demonstrates that the pressure ulcers were unavoidable.2. Residents will have a head to toe skin assessment upon admission, readmission, at the time of discharge and transfer and prior to return from a leave of absence by a licensed nurse.

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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. Based on interview and record review the facility failed to ensure a resident with a history of falls was monitored during a transfer for one of three residents (R2) reviewed for falls. Findings Include:On 3/10/2026 at 1:30pm R2 said that on 3/3/2026 , his CNA sat him up on the side of the bed, went to retrieve the mechanical lift he could not hold his balance and slid to the floor. On 3/11/2026 at 12:58pm , V14(Certified Nursing Assistant-CNA) said she sat R2 on the side of the bed and went to retrieve the mechanical lift R2 yelled, she ran over to him and lowered him to the floor then went for assistance. On 3/12/2026 at 11:30am, V12(Restorative Nurse/Fall Coordinator) said R2 is a high risk for falls and should not be left alone on the side of the bed. On 3/12/2026 at 2:00pm, V2(Director of Nursing-DON) said I expect the staff to monitor any resident that is high risk for falls and never leave them alone on the side of the bed. A resident face sheet indicates R2 has a diagnosis of dementia, Parkinson's disease, edema unspecified of BLE-Bilateral lower extremities unspecified abnormalities of gait and mobility. A fall , and root cause analysis indicates R2 had a fall on 12/21/2025 rolled out of bed no injuries unwitnessed, a fall, and root cause analysis on 1/23/2026 R2 was trying to take himself to the bathroom, and a fall and root cause analysis , on 3/3/202 R2 started sliding and was lowered to the floor during a transfer. A care plan dated 2/13/2026 indicates R2 problem requires a sit to stand mechanical lift for transfers related to decreased lower extremity strength and endurance, a intervention maintain body in functional alignment during transfer, ensure safe placement of extremities during transfers Facility Policy: Falls-Clinical Protocol 1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk for subsequent falling.3. A risk factor for subsequent falling include lightheadedness, or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders.