FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6009443 07/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST 175TH STREET TRI-STATE VILLAGE NRSG & RHB LANSING, IL 60438 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation: 2394934/IL160948 S9999 **Final Observations** S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1)3) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the

The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

Section 300.1210 General Requirements for

medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

and dated minutes of the meeting

Nursing and Personal Care

plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 08/04/23

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in a timely manner.

Findings include:

distress related to not receiving pain medication

On 07/10/2023 at 12:47 PM, observed R1 lying in bed who said he had just finished eating lunch.

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Illinois Department of Public Health

heart disease with heart failure, peripheral

toe(s), and difficulty in walking.

vascular disease, acquired absence of other right

R1's care plan last reviewed 07/05/2023 reads in

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: B. WING IL6009443 07/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2500 EAST 175TH STREET** TRI-STATE VILLAGE NRSG & RHB LANSING, IL 60438 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 3 S9999 part, resident is at risk for generalized pain in which he is receiving an opioid pain medication with problem start date of 06/05/2023. Approach showed to administer pain medications as per physicians' orders, evaluate effectiveness of pain management interventions, and use non-medicated pain relief measures. Reviewed R1's current physician orders that showed the following pain medication orders for: acetaminophen 325 milligrams (mg) take 2 tablets by mouth every 6 hours as needed for pain, apply one lidocaine adhesive medicated 4% patch to affected areas once daily. oxycodone-acetaminophen 10-325 mg one tablet by mouth every 12 hours at 10AM and 10PM for optimum performance at therapy and bedtime rest with start date of 06/18/2023; diclofenac sodium 1% topical gel apply 4 grams topically to lower back at bedtime. Reviewed R1's readmission pain observation assessment with completion date of 07/07/2023 at 12:20 AM and noted assessment to be blank and not completed. Reviewed R1's medication administration record for June 2023 that showed R1's daily pain assessments were inadequately documented throughout the month for 1 of 3 shifts; his lidocaine medicated patch administrations were "circled" on the 17th, 18th, and 20th (no documentation that R1 refused meds or it was withheld); acetaminophen and oxycodone were minimally documented as being administered throughout entire month; diclofenac sodium 1% topical gel administration was "circled" on the 8th; acetaminophen 500 milligrams (mg) 2 tablets by mouth every 8 hours as needed for breakthrough

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pain showed no documented administrations (unsure of start and/or stop date, not included in

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Illinois Department of Public Health

On 07/12/2023 at 2:32 PM, V2 (Assistant Director

of Nursing/ADON) said her expectations regarding medication administration are for nursing to follow physician orders, properly assess residents and to administer medications

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pain or at risk for pain; assessments should occur upon admission to facility, at each quarterly review, with any significant change and when pain is suspected; identify the nature and severity of

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Illinois Department of Public Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 000	INITIAL COMMENT	rs	F	000			
F 684 SS=D	Complaint Investig 2394934/IL160948- 2395278/IL161367- 2395390/IL161520 Quality of Care CFR(s): 483.25	F697 cited F684 cited	F 6	684			8/6/23
	§ 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents receivaccordance with propractice, the comprocare plan, and their This REQUIREMENT by: Based on observative review, the facility facare and services for interventions and/or residents (R2, R7) in follow physician's or administration policing R6) residents review services related to refindings include:	fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices. IT is not met as evidenced ions, interviews, and record ailed to provide necessary or residents in need of fall supervision for 2 of 3 reviewed for falls; and failed to reders and/or medication by for 1 (R1) of 3 (R1, R4 and wed for nursing care and medication administration.					
	past medical history arthritis, cerebral infi side), benign neopla (unspecified), unspec	ity on 03/15/2023 and has a not limited to: rheumatoid farction, sciatica (unspecified asm of meninges ecified cataract, iron hypotension, urinary tract			<u>.</u>		
ARORATORY	DIRECTOR'S OR PROVID	 ER/SUPPLIER REPRESENTATIVE'S SIGN	IATI IDE		TITLE		(X6) DATE

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.

Electronically Signed

08/04/2023

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
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F 684		_	F	684			
	R2's progress note reads in part, "Write nursing assistant) to next to her bed. Re reaching for cookie	dated 05/08/2023 5:30 PM er notified by CNA (certified hat resident was on the floor sident stated she was s and slipped out of bed. were in place at time of fall".					
	reads in part, "Write room, noted resider window lying prone Resident has bilate bed in lowest position she was trying to do kept pointing to the	dated 06/12/2023 4:11 AM er summoned to resident's nt on floor next to bed near with head resting on pillow. ral side bolsters in place and on. Resident was asked what to that she got out of bed and window stating she heard Frequent monitoring ongoing.					
	dated 06/24/2023 2 found on the floor b assistant). Resident	review, R2's progress note :11 PM showed, "resident was y CNA (certified nursing t tried to walk her lunch tray to help. Resident fall was					
	showed resident is R2's care plan last i 06/30/2023 reads in to weakness second rheumatoid arthritis	reviewed/revised on part: at risk for falling related					

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	PROVIDER OR SUPPLIER TE VILLAGE NRSG &	RHB		250	REET ADDRESS, CITY, STATE, ZIP CODE DO EAST 175TH STREET .NS!NG, IL 60438	<u>U</u>	1 07710720		
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F 684	and urinary tract inf 05/10/2023. First ap to "keep bed in lowe locked". Problem Si	ection. Problem Start Date: oproach listed but not limited est position with brakes tart Date: 06/25/2023. Care ate whether R2 is in a fall	F 6	84					
	the facility on 06/29, history not limited to without heart failure	ndicated that she admitted to /2023 and has a past medical b: hypertensive heart disease , unspecified dementia, weakness, malaise, and							
	R7's fall assessmer resident is a "high ri	it dated 06/29/2023 showed sk for falls".							
	part that resident is to history of fall and date of 07/03/2023. limited to equip resid	evised 07/06/2023 reads in at high risk for falling related weakness with problem start Approaches listed but not dent with device that monitors dent in a fall prevention 07/03/2023.							
	Practical Nurse/LPN posted on the bulleti station (privacy obse "get-up list/fall risk rustaff try to monitor the make sure they are	11 PM, V5 (Licensed l) showed surveyor a list n board behind south nurse's erved). V5 said this list is a esidents". V5 (LPN) then said nese residents at all times and not left in their rooms R3 are both listed on the "get							
	bed receiving incont	16 PM, observed R2 lying in inent care by certified nursing to be at knee level with no							

LAND PLAN OF CORRECTION I IDENTIFICATION NUMBER		1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	fall precautions obs On 07/11/2023 at 10 bed on her right side and wearing a hosp knee level. At 11:47 back in bed fully dreknee level. No fall pat this time. At 1:34 that was again at knee observed near during these observed on 07/11/2023 at 1: (Licensed Practical facility does fall insadded that there was recall the date. On 07/11/2023 at 3: Nurse) said restoration in a resident's close fall risk. V9 added that are confused in to use alarms but so on fall risks and wair residents could disawedges and booster therapy. V9 added the should always be in consider a bed positheight for fall risks. Vare checked on every be checked more from in the confused in the c	served in place at this time. 0:19 AM, observed R2 lying in the near edge of the mattress obtained by the served R2 lying on the sessed and noted bed to be at the precautions observed in room the PM, observed R2 lying in bed the level position. No staff or R2's room or in the hallway	F 6	684		

NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB (X4) ID PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 4 confused or anxious resident. On 07/12/2023 at 11:39 AM, observed R2 sitting in a wheelchair in her room near foot of her bed facing the window, call light not within reach. At 11:43 AM, observed R2 sittling were observed near R2's room or in the hallway of south unit during these observations. On 07/12/2023 at 12:50 PM, V8 (Certified Nursing Assistant) said she has been employed at the facility for 5 years and has worked on the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
TRI-STATE VILLAGE NRSG & RHB SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID PREFIX TAG CONTINUED FOR SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 4 confused or anxious resident. On 07/12/2023 at 11:39 AM, observed R2 sitting in a wheelchair in her room near foot of her bed facing the window, call light not within reach. At 11:43 AM, observed R2 still in wheelchair resting her head on the frame at foot of bed. No staff were observed near R2's room or in the hallway of south unit during these observations. On 07/12/2023 at 12:50 PM, V8 (Certified Nursing Assistant) said she has been employed at the facility for 5 years and has worked on the		145879			I .		
F 684 Continued From page 4 confused or anxious resident. On 07/12/2023 at 11:39 AM, observed R2 sitting in a wheelchair in her room near foot of her bed facing the window, call light not within reach. At 11:43 AM, observed R2 still in wheelchair resting her head on the frame at foot of bed. No staff were observed near R2's room or in the hallway of south unit during these observations. On 07/12/2023 at 12:50 PM, V8 (Certified Nursing Assistant) said she has been employed at the facility for 5 years and has worked on the		RHB	25 2	2500 EAST 175TH STREET		113/2023	
confused or anxious resident. On 07/12/2023 at 11:39 AM, observed R2 sitting in a wheelchair in her room near foot of her bed facing the window, call light not within reach. At 11:43 AM, observed R2 still in wheelchair resting her head on the frame at foot of bed. No staff were observed near R2's room or in the hallway of south unit during these observations. On 07/12/2023 at 12:50 PM, V8 (Certified Nursing Assistant) said she has been employed at the facility for 5 years and has worked on the	REFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	(X5) COMPLETION DATE	
"south" unit for the past 2 months. V8 then said R2 is confused, requires assist of two with transfers and that R1 hasn't had any falls recently to her knowledge. When asked how staff can identify who the resident's at risk for falls are, V8 (certified nursing assistant) said they would be wearing "a yellow bracelet" and would use "fall mats, bolsters/wedges and non-skid socks. V8 added that all residents are "checked on whenever we're on the hall" and indicated there "should be a list of fall risks hanging up somewhere". When asked when the last fall in-service was, V8 said a few weeks ago but could not recall the exact date. On 07/12/2023 at 12:53 PM, observed R2 sitting in wheelchair in main dining room with multiple other residents. Observed one staff member across the hallway from dining room in a smaller room feeding a resident with her back towards the main dining room. No other staff where present. At 12:58 PM, observed V12 (Activity Aide) walk up to R7 in the dining room and attempt to wheel her away but R7 continued attempting to stand, began grabbing ahold of the table several times all while seated at the edge of	confused or anxio On 07/12/2023 at in a wheelchair in facing the window 11:43 AM, observe her head on the free were observed nere of south unit during. On 07/12/2023 at Nursing Assistant) at the facility for 5 "south" unit for the R2 is confused, retransfers and that to her knowledge, identify who the re(certified nursing a wearing "a yellow mats, bolsters/wed added that all reside whenever we're or "should be a list of somewhere". Whe in-service was, V8 could not recall the On 07/12/2023 at in wheelchair in material of the main dining residents. Of across the hallway room feeding a resident of the main dining resident of the main dinin	1:39 AM, observed R2 sitting er room near foot of her bed call light not within reach. At d R2 still in wheelchair resting me at foot of bed. No staff r R2's room or in the hallway these observations. 2:50 PM, V8 (Certified said she has been employed ears and has worked on the past 2 months. V8 then said juires assist of two with R1 hasn't had any falls recently When asked how staff can ident's at risk for falls are, V8 sistant) said they would be racelet" and would use "fall ges and non-skid socks. V8 ents are "checked on the hall" and indicated there fall risks hanging up in asked when the last fall said a few weeks ago but exact date. 2:53 PM, observed R2 sitting in dining room with multiple served one staff member from dining room in a smaller dent with her back towards in. No other staff where M, observed V12 (Activity in the dining room and in away but R7 continued began grabbing ahold of the	F 684				

		IDENTIFICATION NUMBER:	100		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145879	B. WING	;		1	C / 13/2023
	PROVIDER OR SUPPLIER TE VILLAGE NRSG &	RHB		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST 175TH STREET LANSING, IL 60438	1 07	113/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	wheelchair. At 1:05 another activity aide thinks "she" is on be never told by the far are. R2 was seated at this time and obsher right wrist. V12 knows what the red yellow ones. When in-service was, V12 On 07/12/2023 at 1: table in the main dir to stand up from he present at this time. with R7 while speak English to "sit down don't fall". R7 sat be wheelchair but contherself up. At 12:58 PM, obserup to R7 and attempting ahold of the table set the edge of wheelch the dining room was seated and sit back resident out of dinin (Activity Aide) transf (Certified Nursing Asaid normally he and the dining room but then said he was ne fall risk residents are ones are". No fall prat this time. On 07/12/2023 at 2:	PM, V12 said normally he and a monitor the dining room but reak. V12 then said he was cility who the fall risk residents at a table in the dining room served a "yellow bracelet" to (Activity Aide) said he only bracelets mean and not the asked when the last fall could not recall. 2:54 PM, observed R7 at a ning room near R2 attempting r wheelchair. No staff was A male resident was pleading ting in both Spanish and and wait for help, so you	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		145879	B. WING	<u> </u>	0.7	C / 13/2023
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIF	CODE	11312023
TRI-STA	TE VILLAGE NRSG &	RHB		2500 EAST 175TH STREET LANSING, IL 60438		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OBBECTION	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 6	 F 6	84		
	in place prior but sh implementing a fall previously used cal	of fall prevention program was the "is in the process of prevention program" she had led "falling stars". She added		*		
	door and on the res at risk for falls as w information card wit	ace a star sign on the room ident's wheelchair of residents ell as posting a resident thin their closet that will assistance required. V10 then				
	said a resident with falls in a short periodiagnoses such as unsteady gate woulfalls. V10 (Restoratiget up list is an unohigh fall risks, staff help monitor these frequently monitored	a history of falls or multiple d of time, or with certain weakness, anxiety, and/or d indicate they are at risk for ive Director) said the third shift fficial list of residents who are often utilize group activities to residents and they are d while in their rooms. V10				
	weeks ago where si about implementing between the nurses so that residents at every hour. When a is documented, V10 documented and whether is relying on nurse.	nen she is not at the facility, rsing that they are doing		2		
T.	asked what the yello indicate, V10 said the starting here. V10 (If there seems to be condentification of who which could cause so the reason why she stars program becauseffective in addition including one at the	fall risk residents. When ow plastic band/bracelets lose were in place prior to me Restorative Director) also said onfusion present with the the fall risk residents are supervision issues which is is implementing the falling use she believes it will be to monthly in-services, end of the month and post 0 (Restorative Director) said			8 1	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		145879	B. WING	·	.	C 07/13/2023
	PROVIDER OR SUPPLIER FE VILLAGE NRSG &	RHB		STREET ADDRESS, CITY, STATE, ZIP 2500 EAST 175TH STREET LANSING, IL 60438	CODE	0771372023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	with every fall and sidentify intervention rolled out of bed, the low position and fall knee level height is is a high risk for fall V10 (Restorative D. R3's post fall intervention of freesident because slintervention program resident with a fall view intervention of fall view intervention program resident with a fall view intervention with a fall view int	rventions should be updated she interviews staff post fall to s. She added if a resident e intervention would be bed in a mats. When asked if a bed at appropriate for a resident who s, V10 said "no". At 3:06 PM, irector) said she did not input entions nor has she inputted all prevention program for any ne doesn't currently have an m in place. V10 then said any will be in this fall program and fies for a fall prevention	F6	;84		
	2008 that reads in p to fall despite attem will review the situal contributing causes assessment, the sta pertinent intervention subsequent falls and consequences of factorian to be readily id- try various relevant assessment of the runtil falling reduces identified for its conti- will monitor and doc-	d to address risks of serious lling; if underlying causes entified or corrected, staff will interventions based on eature or category of falling, or stops or until a reason is inuation; staff and physician ument the individual's attions intended to reduce				
,	the facility on 06/05/ on 06/20/2023 then 07/03/2023. Face sh	dicates resident admitted to 2023, went on hospital leave readmitted to the facility on neet also indicates resident history not limited to complex				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION PING	(ХЗ	(X3) DATE SURVEY COMPLETED	
		145879	B. WING			C
	PROVIDER OR SUPPLIER TE VILLAGE NRSG &	RHB		STREET ADDRESS, CITY, STATE, ZIP 2500 EAST 175TH STREET LANSING, IL 60438	CODE	07/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATI	(X5) COMPLETION DATE
	regional pain syndrowith hyperglycemia in left toe(s), unspe toe with damage to peripheral vascular R1's care plan last in part, resident is at in which he is receiving with problem start of showed but not limit medications as per effectiveness of paid. On 07/10/2023 at 1: night, a male nurse pain medication) on take it at 12:00 AM. him due to the floors wouldn't be able to in the correct of the consumeration. On 07/11/2023 at 1: (Licensed Practical not left at the bedsic to ensure the correct medications. On 07/11/2023 at 2:: Nurse) said a few dath is oxycodone at 11 resident if he wanted was an hour early be the med at midnight be buffed that night return until 2:00 to 3 would take the medication (oxycodone).	ome, Type 2 diabetes mellitus and diabetic neuropathy, Pain cified open wound of left great nail, cellulitis of left toe,	F 6	84		

AND PLAN OF CORRECTION INCREDED I		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	T	145879	B. WING		07	C /13/2023
	NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST 175TH STREET LANSING, IL 60438		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
F 684	on his bedside table R1's room to talk to told R1 he was goir said he'd take it at to pill then he left the was approximately has an order to leave "no". At 3:00 PM, V don't leave pills at to and watch the resid then said "we have confused that could we want to ensure to	and didn't know what pill was left and to be a V9 said he went back to him again about the pill and ag to take the pill away but R1 his time. V9 said R1 took the room and indicated the time 11:10 PM. When asked if R1 we meds at bedside, V9 said 9 (Registered Nurse) said "we he bedside at all, staff stay ent take the medication(s)" residents who wander and are lingest the medications, and the correct resident is taking ed med at the correct time as	F 6	384		
	reads in part, "oxycomg one tablet by mound 10 PM for optinand bedtime rest will No current order in medications. On 07/12/2023 at 2 of Nursing/ADON) segarding medication nursing to follow physics are reatments as ordered medications are not completed medication record dated 07/11/2	ent physician orders that odone-acetaminophen 10-325 outh every 12 hours at 10 AM num performance at therapy th start date of 06/18/2023". place for R1 to self-administer 32 PM, V2 (Assistant Director said her expectations on administration are for ysician orders, properly do to administer medications dered. V2 added that to be left at the (Administrator) provided on administration in-service 2023 that reads in part, nister medications according				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		145879	B. WING				1	C / 13/2023
	PROVIDER OR SUPPLIER TE VILLAGE NRSG &	RHB		25	TREET ADDRESS, CITY, STATE, ZIP (500 EAST 175TH STREET ANSING, IL 60438	CODE	1 0	TVIAVEO
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 684	Reviewed "IIA2 Med with effective date of part: when medication mobile cart taken to medications are adopted prepared; the person administration is the dose; residents are medications when sattending physician procedures for self-the resident is alway administration to encompletely ingested On 07/12/2023 at 2	dication Administration policy of 10/25/2014 that reads in tions are administered by the resident's location, ministered at the time they are on who prepares the dose for e person who administers the allowed to self-administer specifically authorized by the and in accordance with administration of medications; by sobserved after insure that the dose was discovered.	F6	84				
F 697 SS=G	of Nursing/ADON) s regarding medication nursing to follow phy administer medication Pain Management	said her expectations on administration are for sysician orders and to ions or treatments as ordered.	F 69	97				8/6/23
	provided to resident consistent with profet the comprehensive and the residents' g This REQUIREMEN by: Based on observati review, the facility fatreat, and manage p pain due to multiple factors; and failed to	issure that pain management is the who require such services, ressional standards of practice, person-centered care plan, poals and preferences. Note is not met as evidenced ailed to effectively assess, pain for a resident at risk for a medical diagnoses and						
		for pain management. R1 was						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
-		145879	B. WING			07	C 07/13/2023	
	PROVIDER OR SUPPLIER	RHB		25	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST 175TH STREET ANSING, IL 60438	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 697	frustrated and expe	eriencing psycho-social not receiving pain medication	F 6	97				
	bed who said he ha R1 reported medical evening shift. R1 said (narcotic pain medical prescribed "as needed get it when needed last dose was this ra AM. R1 reports have and that staff have pain relief measure	2:47 PM, observed R1 lying in ad just finished eating lunch. ation issues at times on the aid he knows the oxycodone cation) is not scheduled and is ded". R1 then said he "should or wanted". R1 added that his morning around 8:00 or 9:00 ring "some pain" at this time never offered non-medicated is and wants to take the 2 hours. Observed R1 to be and emotional.						
	bed who said his cuand doesn't recall to and doesn't recall to pain medication. Rowill get a pain pill at schedule". R1 then frustrating" to not hat Again, observed R1 emotional. At 1:37 I Practical Nurse) sa	:28 PM, observed R1 lying in arrent pain level was "9/10" he last time that he received added that the nurse said he "1:00 PM to get him back on said it is "unbearable and ave his pain under control. It to be visibly distraught and PM, V4 LPN (Licensed at R1 just received a pain pill a received one was at 1:00						
	facility on 06/05/202 06/20/2023 then re- 07/03/2023. Face s has a past medical	cates resident admitted to the 23, went on hospital leave on admitted to the facility on heet also indicates resident history not limited to complex ome, Type 2 diabetes mellitus		~				

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
145879			B. WING	·		C 07/13/2023	
NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB				2	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST 175TH STREET ANSING, IL 60438	1 0.	1072020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	other gram-negative unspecified open w damage to nail, cell heart disease with h	and diabetic neuropathy, e sepsis, pain in left toe(s), ound of left great toe with ulitis of left toe, hypertensive neart failure, peripheral cquired absence of other right	F	697			
	part, resident is at ri which he is receivin with problem start d showed to administ	reviewed 07/05/2023 reads in isk for generalized pain in g an opioid pain medication ate of 06/05/2023. Approach er pain medications as per evaluate effectiveness of pain entions, and use relief measures.					
	showed the followin acetaminophen 325 tablets by mouth every pain, apply one lidot patch to affected are oxycodone-acetamic by mouth every 12 hoptimum performancest with start date of	nophen 10-325 mg one tablet nours at 10AM and 10PM for ce at therapy and bedtime of 06/18/2023; diclofenac nel apply 4 grams topically to					
	assessment with co at 12:20 AM and not and not completed. Reviewed R1's med for June 2023 that s assessments were i throughout the mont	mission pain observation mpletion date of 07/07/2023 ted assessment to be blank ication administration record howed R1's daily pain nadequately documented th for 1 of 3 shifts; his patch administrations were					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA

		IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C		
		145879	B. WING _		07			
NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST 175TH STREET LANSING, IL 60438					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	LD BE COMPLETION		
F 697	documentation that withheld); acetamin minimally document throughout entire model and the topical gel administ acetaminophen 500 mouth every 8 hour pain showed no docunsure of start and active physician's oprovided indicating administrations for active active of 10-325 mg one table at "7/10" and 6/20/22. Reviewed R1's med for July 2023 that should be active of the foliation	n, 18th, and 20th (no R1 refused meds or it was ophen and oxycodone were ted as being administered bonth; diclofenac sodium 1% ration was "circled" on the 8th; milligrams (mg) 2 tablets by as a needed for breakthrough cumented administrations for stop date, not included in refused any medication month of June 2023. N Medications Notes" showed acycodone-acetaminophen et on 6/18/2023 for pain rated 023 for pain rated 18/10". Ilication administration record nowed R1's lidocaine ministrations were "circled" on 1th; acetaminophen and nimally documented as being thout entire month. Irolled drug administration is R1 is to receive nophen 10-325 mg one tablet hours. The record shows R1 on unknown date at 6:00 PM, on 06/10/2023 at 10:00 AM the medication again until cord also shows that R1 106/17/2023 and only one d July 10th.	F 69					
		Administrator) provided June ministration records for R1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	145879 B. WING				C 07/13/2023				
NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST 175TH STREET LANSING, IL 60438						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 697	for 5:00 AM and 5:0 through 06/17/2023 from 06/18/2023 to On 07/12/2023 at 2 of Nursing/ADON) s	stration times for nophen 10-325 mg scheduled 10 PM from 06/16/2023 : at 10:00 AM and 10:00 PM current. :32 PM, V2 (Assistant Director said her expectations	F 6	97					
	nursing to follow phrassess residents are or treatments as ord important to administ ordered by a physic the physician presciresident and implement for the resident. V2 should be administed residents' pain free ability to function the nurses primarily door resident's administrativity their initials and missed administration record and/or progressional mean it was not resident to some could mean it was not residents.	* *				\$** O			
	completed medication record dated 07/11/2 "nurses are to admit to policy IIA2". Reviewed "IIA2 Mediwith effective date of the complete of the	Administrator) provided on administration in-service 2023 that reads is part, nister medications according lication Administration policy f 10/25/2014 that reads in a administered in accordance							

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				(X3) DATE SURVEY COMPLETED	
	145879	B. WING		C				
NAME OF PROVIDER OR SUPPLIER TRI-STATE VILLAGE NRSG & RHB				250	EET ADDRESS, CITY, STATE, ZIP CODE 0 EAST 175TH STREET NSING, IL 60438	_ 1 078	13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 697	with written orders of without unnecessar schedule of routine	of the prescriber, administered y interruptions, and a dose administration times is acility and utilized on the	F	597			4	
	that reads in part: to pain or at risk for paupon admission to freview, with any sign is suspected; identification pain with use of a sappropriate to reside how pain is affecting living, sleep and selwith the input from repain treatment; physically non-pharmacologic to address the indivitation occasional anawill consider changing at least one analges as needed use, increase.	ey last revised August 2008 identify individuals who have in; assessments should occur acility, at each quarterly inficant change and when pain by the nature and severity of tandardized pain assessment ent's cognition level; evaluate a mood, activities of daily ected quality of life measures; esident, establish goals of sician will order appropriate and medication interventions dual's pain; if there are more ligesic requests, the physician ing to regular administration of ic with another medication for easing the standard dose of ic, or switching to another					1350	