STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-STATE VILLAGE NRSG & RHB	**2500 EAST 175TH STREET , LANSING, Illinois, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint investigation: 25910524/2654174	S0000		11/25/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210d)2 300.1620a) Section 300.610 Resident Care Policies a) 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 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification	S9999		11/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These requirements were not met as evidence by: 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. The 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	S9999		

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S9999	Continued from page 2 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	S9999		

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S9999	Continued from page 3 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. "B"	S9999		