STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Certification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Facility failed to report allegations of abuse immediately to the Administrator and the Department for two residents (R22, R23) in the supplemental sample. Findings Include: 1. The Untitled Form, dated 08/22/2014, documents that E2, Director of Nursing, received a call from E15, Social Service Designee, on 08/18/2014. E15 stated Z1 reported R22 was accusing E14, Occupational Therapist, of being rude and bossy towards (R22). The form also documents the investigation began on 08/18/2014, but the Illinois Department of Public health (IDPH) was left a voicemail on 08/19/2014 per E2 requesting how to handle this allegation of abuse. E1, Administrator, was not notified per this form. E2 called the Department on 08/19/2014, one day after the allegation was made. 2. The Untitled Form, dated 09/02/2014, documents the on 09/01/2014 at 10:00 PM, (R23) reported to E16, Nurse, a tall thin blond girl dropped her on the toilet, and left her sitting crooked on the toilet. E16 notified E2, not E1. The form documents the tall blond was identified as E17. The form also documents E 17 transferred R 23 without a gait belt, and E 17 admitted the transfer was unsafe, but was not trying to hurt R 23. The form does not document E1. The form documents the Department was not notified of the allegation until 09/02/2014.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 225	Continued From page 2 In an interview, on 12/11/2014 at 10:55 AM E3, Assistant Director of Nursing stated "All allegations of abuse should be reported to the (Department) immediately."	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the Facility failed to develop an abuse policy regarding reporting allegations of abuse immediately to the Administrator and the Department. This has the potential to affect all of the 65 residents living in the facility. Findings include: 1. The Facility's Resident Abuse Prevention Program Policy, dated 01/2013, documents the facility should implement systems to investigate all reports and allegations of mistreatment promptly and aggressively. The facility must also file accurate and timely investigative reports. The Facility Policy entitled Abuse Investigation Procedure dated 01/2013 documents (in part) when the incident or alleged abuse is suspected it will be reported to the administrator. These policy did not document that all allegations should be immediately reported to the Administrator and	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 226	Continued From page 3	F 226		

Department.

2. The Untitled Form dated 09/22/2014 documents that E2, Director of Nursing, received a call from E15 Social Service Designee on 08/18/2014. E15 stated Z1 reported R22 was accusing E14 Occupational Therapist of being rude and bossy towards (R22). The form also documents the investigation began on 08/18/2014, but the Department was left a voicemail on 08/19/2014 per E2 requesting how to handle this allegation of abuse. This form did not document E1, Administrator was notified. was not notified per this form. E2 notified the Department on 08/19/2014.

3. The Untitled Form dated 09/02/2014 documents the on 09/01/2014 at 10:00 PM, R23 reported to E16, Nurse, a tall thin blond girl dropped her on the toilet, and left her sitting crooked on the toilet.
E16 notified E2. The form does not document E 1was notified. The facility notified the Department on 9/2/2014.

In an interview, on 12/11/2014 at 10:55 AM E3 Assistant Director of Nursing stated "All allegations of abuse should be reported to the Department immediately."

B. Based on interview and record review the Facility to obtain background checks in a timely manner to determine if employees had a prior criminal history, which would disqualify them for employment for 4 of five employees (E19, E20, E21, E22) reviewed for pre-employment screening. This had the potential to effect all of the 65 residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 226	Continued From page 4 Finding Include: 1. On 12/11/2014, Employee files were reviewed for E19-E22. The Untitled Health Care Worker Background Check packets do not document when the background checks were initiated. The Facility Policy titled" Regarding Hiring Nurse Aides To Provide Direct Patient Care" documents "The background check will be submitted within the first week of employment. The employment will be probationary until a qualifying background check is received." 2. The Resident Census and Conditions of Residents, CMS 672, dated 12/09/2014, documents that the facility has 65 residents living in the facility.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Facility failed to provided residents' dignity by answering call lights in a timely manner and providing privacy during physicians visits for 2 of 15 residents (R3 and R7) reviewed for dignity in the sample of 15 and two residents (R16 and R17) in the supplemental sample.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 241	Continued From page 5	F 241		

Findings Include:

1. Resident Council Meeting Minutes dated 3/4/2014 document the members of the council readdressed a previous concern from January, about staff members members coming into resident rooms, and silencing the call light. Once the call light is silenced the residents needs are not met,and the employee does not return. A resident also gave the example of being up to 4:00 AM to get the roommates needs met, since she is dependent on the staff. The call light was not answered, and rounds were not made.

During the Group Interview on 12/10/2014 at 11:00 AM R3, R7, R16, and R17 all stated there is a long wait for call lights to be answered. They also stated the problem of call lights not being answered is worse on the evening and night shifts. R7 stated the staff are always on their cell phones, and the wait can for care can be up to 45 minutes.

In an interview on 12/11/2014 at 10:55AM, E3 Assistant Director of Nursing stated she expects the call lights to be answered within 5 minutes.

2. On 12/11/2014 at 2:00PM, R16 stated Z2, Doctor, makes rounds in the dining room during the evening meal. R16 states she feels uncomfortable talking to Z2 about her personal aliments in front of her table mates. R16 states she does not have an opportunity to visit with Z2 privately.

Resident Council Minutes for 10/7/2014 document, in part, " Issue brought up was when the Dr (Doctor) makes rounds, he talks of their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 241	Continued From page 6 health issues at the dining table or in the hall or etc. (etcetera)." On 12/11/2014 at 2:55PM, in an interview with E13, Licensed Practical Nurse (LPN) and E3, Assistant Director of Nursing (ADON), they confirmed this was Z2 frequent practice of making resident rounds in the Facility. E3 stated the Facility management has requested he not do this but Z2 continues to make resident rounds in the dining room during the evening meal. E3 states Z2 sometimes sees the residents in other areas.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Facility failed to provide individualized psychosocial and activity programming to prevent wandering and aggressive behaviors for 1 of 3 residents (R6) review for Dementia care in the sample of 15. Findings include: On 12/9/2014 at 10:30 AM, during the initial tour of the Facility, R6 was observed to have an alarm on the upper right side of the hallway door into his	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 309	Continued From page 7	F 309		

room. E13, Treatment Nurse, stated R6 wanders a lot, tries to elope. This alarm is to alert staff when he is out of his room. R6 was not in his room during the tour.

R6's Minimum Data Set (MDS) dated 9/18/2014 documents R6 is moderately impaired for cognition, physically independent with walking and transfers but needs supervision during ambulation off the unit. The MDS documents R6's wandering as placing the resident at significant risk of getting to a potentially dangerous place.

On 12/10/2014 at 1:45 PM, E25, MDS Coordinator, explained R6 did not "Exit seek" when he was first admitted. however,at some point, his behavior changed and then he started doing it all the time. E25 stated his family wants to move him to a Dementia Unit in another facility but there are not any openings at this time. E25 explained the staff are supposed to walk after him when he starts Exit seeking and redirect him to a group activity, a sports program on TV. E25 explained if this behavior happens during over night shift, the staff is supposed to redirect R6 to the Nurses Station. E25 explained there does not seem to be any one thing that starts his behaviors.

On 12/11/2014 at 9:40AM E24, Activity Director explained the Facility does not have planned activities specifically for R6. E24 explained they do provide "Low functioning" activities but not specific activities for R6. R6 is not on the 1:1 activity list. Sometimes (E6) helps put up the Activity Boards or helps with Bingo. E24 stated the staff can try blocks, dominos or movies when (R6) behaviors are escalated or during hours

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 309	Continued From page 8	F 309		

when there are not activity programs but R6 does not usually do them.

Behavior Tracking Progress Notes for R6 documents as follows: "11/13/2014 (R6) shoved nurse up against the wall while she was trying to redirect him from going outside." Nurses Note on 11/13/2014 with no documented time of day, documents, "... Out B hall door x 1. (R6) redirected into building wonders facility floors at x's." There was not a Nurse Note entry on 11/13/2014 for interventions prior to or after R6's behavior.

11/14/2014 the Behavior Tracking Progress Notes document, "Resident swung at the nurse when (R6) was asked to stop running and to not go out the door." There was no documentation in the Nurses Notes for 11/14/2014 related to behavior interventions before or after this incident.

11/16/2014 "Nurses Notes for 11/16/2014 at 12:30 PM document, " Res (Resident) restless this shift. Numerous attempts to exit facility. Out doors on B hall, D hall center, and D hall north. Elbowed one CNA while trying to exit B hall. Pushed another CNA while trying to exit D hall center. Attempts to occupy res with activities such as watching TV, Reading a magazine, folding laundry. No activity holds res interest.....2 PM Wife in to visit, res attempting to go into parking lot at this time. CNA intervened. Res punched CNA in the stomach x 2. Other staff out to assist, res back inside followed by wife. Informed wife of resident several attempts to go outside...".

The Facility Behavior Tracking Sheets for November and December 2014 track for:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 309	Continued From page 9 Agitation/Aggression toward staff or wife, Hitting Staff, Delusions and Hallucinations causing anxiety or Distress (unable to reorient), Walking out of his room without clothes on, Difficulty sleeping, Restlessness, Attempt to open outside doors. These behaviors were documented as occurring up to 25 times per shift in November. The Exit seeking behavior continued up to 5 times per shift through the beginning of this survey. R6 Current Care Plan does not document a specific resident centered behavior program according to his hobbies and interests. On 12/10/2014, Z2, R6's attending physician explained he has cared for R6 for several years. Z2 stated R6 did not originally have all these behaviors however, now needs 1:1 care at times. Z2 stated this facility is just not set up that way.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide complete incontinent care for four of seven residents (R1, R2, R5, R9) reviewed for incontinent care in the sample of 15.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 312	Continued From page 10	F 312		

Findings include:

1. The Minimum Data Set (MDS) dated 9/10/2014 documents R2 is severely impaired with cognition, is incontinent of bowel and bladder and requires extensive assistance for personal hygiene.

On 12/09/2014 at 12:22 PM, R2 was in bed with no pants on. R2 had been incontinent of urine and feces. E10, Certified Nurses Aide, (CNA) applied gloves, used a bath towel and wet one end of it. E10 applied perineal soap to the end of the towel. While R2 was positioned on her back, E10 used the end of the wet towel to wipe down the center of R2's vaginal area. Without cleansing R2's inner thighs or labia, E10 turned R2 to the left side, changed the surface area of the wet towel and wiped R2's rectal area to remove the feces. E10 then stated, "I'm going to get more towels. E10 removed her gloves and left R2's room. E10 returned quickly and used a clean towel to wash R2's rectal area, then turned her to the right side. E10 failed to cleanse R2's left buttock that had a dressing on it. E10 failed to dry any area she cleansed on R2's perineal area. E10 put the soiled linens on the floor next to R2's bed, regloved and picked up the soiled linen leaving R2's room. No barrier cream was applied to R2's perineal area.

R2's Care Plan, updated 12/08/2014, documents, in part, "Is incontinent of bladder and bowel. Interventions-Clean peri-area with each incontinence episode with soap and water, apply barrier cream PRN (as needed)."

2. The MDS dated, 11/04/2014, documents R4 is moderately impaired with cognition, is incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 312	Continued From page 11	F 312		

of bowel and bladder and requires extensive assistance with personal hygiene.

On 12/09/2014, at 3:21 PM, E11 and E12, CNA's entered R4's room and asked her if she needed to use the bathroom. E11 and E12 transferred R4 from the wheelchair to the toilet. R4's incontinent brief was wet with urine. R4 had a bowel movement while on the toilet. E11 removed R4's soiled incontinent brief. E11 wet the end of a bath towel, but did not apply soap to the towel. E11 changed the surface area of the wet end of the towel and wiped R4 from the top of the vagina back to the rectal area three times. E11 did not wash R4's labia, inner thighs or buttocks. E11 then used the dry end of the towel to wipe R4's perineal area, then pulled up R4's clean incontinent brief and pants. No barrier cream was applied to R4's perineal area.

R4's Care Plan, revised 11/12/2104, documents, in part, "Has functional bladder incontinence related to no longer recognizing the urge to void. Interventions-Clean peri-area with each incontinence episode with soap and water, apply barrier cream PRN and assess skin condition."

3. On 12/9/14 at 12:15 PM, E6, CNA, wet wash cloths in R1's bathroom sink and applied a small amount of liquid soap from the wall dispenser to the damp cloths. E6 used the damp wash cloths with soap to perform catheter and perineal care for R1. E6 did not rinse or dry R1's perineal area afterward.

4. On 12/10/14 at 10:35 AM, E6, wet wash cloths in R5's sink and applied a small amount of liquid soap from the wall dispenser to the damp cloths. E6 used the damp cloths with soap to perform incontinent care for R5. E6 did not rinse or dry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 312	Continued From page 12 R5's perineal area afterward. During R5's incontinent care, E6 stated it was a no rinse soap in the dispenser that she used. On 12/10/14 at 10:58 AM, E8, Housekeeping Manager, displayed a bottle of Antimicrobial Soap with the directions, "Apply and rinse thoroughly." E8 stated, "This is what we fill the soap dispensers with. It needs to be rinsed." On 12/11/14 at 1:45 PM, E3, Assistant Director of Nursing (ADON), stated , "We have no rinse periwash. When using any regular soap, I expect them to rinse and dry." The Facility's Procedure for giving perineal care to the incontinent Resident, dated 10/14/02, documents (in part), "If incontinent of urine: Female: b. Wash upper thigh with soapy cloth and fold. c. Wash the vaginal area downward from the pubic area making sure the labia and vaginal area are completely clean. d. Rinse the areas the same with new clean cloth. e. Dry completely." After washing the anal area, "Rinse and dry."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 314	Continued From page 13	F 314		

This REQUIREMENT is not met as evidenced by:
Based on Record review and interview the Facility failed to prevent a facility acquired pressure ulcers and failed to provide turning and repositiong to prevent pressure ulcers for 2 of 7 residents (R3 and R4) reviewed for pressure ulcers in a sample of 15.

Findings include:

1. R3's Nurse's Notes documented R3 sustained a fracture to her left femur on 3/28/2014 requiring an immobilizer to be applied for support and healing. The Nurse's Notes document R3 did not have any documented skin issues on her legs prior to the fracture.

4/2/2014 Nurse's Notes document new order for knee immobilizer to be removed only while flat in bed for skin care only.

On 2/28/2014 R3's Braden Scale score R3 at "High Risk" for pressure areas.

R3's current Care Plan documents she is Diabetic, immobile and at risk for skin breakdown. The Care Plan directs staff to, in part, " Keep immobilizer in place WOOB (when out of bed). Monitor skin at (left) leg and (right) inner thigh for irritation." The Care Plan does not direct staff how often to remove the immobilizer and provide skin care.

Nurse's Notes from 4/14/2014 through 4/18/2014 document the knee immobilizer was in place as ordered but did not document if the immobilizer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 314	Continued From page 14	F 314		

was removed for skin care and/or the condition of R3's skin under the immobilizer.

On 4/19/2014 at 6:30 AM the Nurse's Notes document, "Found decubitus (left, lower, posterior) outer leg 1.5 centimeters (cm) x 3.5cm and dark eschar in the center...."

Wound Care Skin integrity Report from the Wound Consultants, dated 4/29/2014, documents the wound as: "Facility acquired and stageable."

On 4/30/2014, Z2, Attending Physician, Doctor's Progress Notes' document, in part, "Patient has current issue with pressure ulcer underneath her leg immobilizer for a recent lower leg fracture.....pressure ulcer secondary to leg immobilizer."

On 12/11/2014 at 12:10PM, E3, Assist Director of Nursing (ADON) stated R3 did develop a pressure ulcer under the knee immobilizer.

2: The Physician's Order Sheet, (POS) for 12/2014 documents R4 has the diagnoses, in part, as "Dementia and Alzheimer's Disease." The Minimum Data Set (MDS) dated 9/10/2014, documents R4 is severely impaired with cognition, is incontinent of bowel and bladder and requires extensive assistance for bed mobility and personal hygiene. The Braden Scale, dated 9/10/2014 documents R4 is a high risk for the development of pressure ulcers.

On 12/09/2014, at 12:05 PM, R4 was in bed laying on her left side. A pillow was between R4's knees, but her feet were directly on the mattress. On 12/09/2014 at 12:22 PM, E10, Certified Nurses Aide, (CNA) provided incontinent care for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 314	Continued From page 15	F 314		

R4. R4's left outer ankle and left ischium (hip joint)was red, but blancheable. R4 had a dressing dated 12/09 to the left buttock. After completing care, E10 positioned R4 on the right side in bed at 12:30 PM.

On 12/09/2014, at 12:58 PM, 2:00 PM, 2:45 PM, 3:15 PM and 3:40 PM, R4 remained in bed on the right side with her feet and heels directly on the mattress without repositioning (over 3.5 hours).

On 12/10/2014, at 10:30 AM, E10 and E13, Treatment placed R4 in bed to do the treatment to provide care, and then transferred back to the wheelchair. R4 was up in the wheelchair propelling herself throughout the facility with her feet at 11:05 AM, 11:25 AM, 11:35 AM, 11:48 AM, 12:07 PM, 12:15 PM, 12:45 PM, 12:55 PM, 1:00 PM and 1:15 PM (2 hours and 45 minutes).

On 12/10/2014 at 1:18 PM, E10 and E13 transferred R4 from the wheelchair to the bed to do a skin assessment. R4 had two scabbed areas to the right upper hip. At that time, E13 reported the 2 areas to R4's right hip were from shearing. R4 had gauze wrapped between the first and second toe. R4 first great toe was positioned over the second toe. A pinpoint dark area was on the second toe. The bunion area to R4's left foot was red, but blancheable. The outer ball of the left foot was red, but blancheable. A small unblancheable, red area was on the left heel.

On 12/10/2014, at 1:30 PM, E13 was asked why R4 had developed skin breakdown. E13 replied, "It could be her poor appetite. I would say (R4) needs to be turned or repositioned every 1 to 2 hours or if needed, more often. (R4) needs a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 314	Continued From page 16	F 314		

pillow between her knees and ankles." When asked what pressure relief was being provided for R4's feet/heels, E13 stated, "We could float her heels while in bed. To my knowledge there is no breakdown to her ankles or heels."

The Monthly Weights for R4 documented a weight of 104.6 pounds in January 2014, and a current weight for December 2014 of 102.8 pounds (a 1.8 pound loss in 11 months. The Laboratory Reports for R4 for 2014 only document electrolytes completed since 12/31/2013, but no documentation of albumin or protein levels.

The Pressure Ulcer Log for December 2014 documents R4 has a facility acquired pressure ulcer, SDTI (suspected deep tissue injury) to the left heel measuring, 1.7 cm (centimeter) X 2/7 cm, a facility acquired unstageable pressure ulcer to the left buttock, measuring 0.5 cm X 0.3 cm and a facility acquired in 11/2014 ulcer to the right second toe, measuring 0.2 cm X 0.2 cm.

The Incident Details Report for R4 dated 12/01/2014 at 6:00 AM, documents, in part, "0.5 cm X 0.3 cm unstageable area to left buttock with 100 percent yellow slough wound bed. Notified wound specialist, notified MD (medical doctor), new treatment, Decub (decubitus) I diet. Staff directed to reposition (R4) often to prevent further breakdown."

R4's Treatment Record for 12/2014 documents, "12/08/2014, 0.6 X 0.4 and 0.2 X 0.3 cm superficial abrasions to right buttock, 0.4 X 0.3 cm scab to left buttock."

R4's Care Plan, updated 12/08/2014, documents,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 314	Continued From page 17 in part, "Is at risk for skin breakdown, bruise and skin tears due to poor appetite, dry skin, thin fragile skin, sitting majority of the time. Right great toe crosses over second toe, unstageable left buttock. Interventions-Turn and reposition every 2 hours, during care and PRN (as needed)." There is no intervention to address pressure relief for R4's feet in the Care Plan except for gauze between the toes of the right great toe and second toe.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 322	Continued From page 18 review, the Facility failed to check the placement of the gastrostomy tube (G-tube) prior to use for one of one residents (R5) reviewed for G-tube feedings in the sample of fifteen. Findings include: On 12/10/14 at 12:25 PM, E9 Licensed Practical Nurse (LPN), did not check R5's G-tube placement prior to flushing the G-tube before and after medication administration of Vancomycin, and starting R5's tube feeding of Jevity 1.5 cal. On 12/10/14 at 12:45 PM, E9 stated, "I should have checked the G-tube for placement with stethoscope prior to any of that. I was nervous with being observed and forgot." The Facility's Feeding Systems Policy, revised 1/5/99, documents, "Miscellaneous: 3. Proper placement of the tube must be assessed by observation and auscultation before the instillation of any liquid into it. 22. Placement to be checked for gastrostomy tube feedings by instilling 30 cc (cubic centimeters) air into gastrostomy tube and auscultate for sound of air rushing by placing stethoscope above stomach, prior to administration or flushings as ordered."	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 19	F 323		

This REQUIREMENT is not met as evidenced by:
A. Based on observation, record review and interview, the facility failed to implement safety measures and progressive interventions to prevent falls, and provide safe transfer techniques for 5 of seven residents (R1, R3, R4, R5, R10) reviewed for falls in the sample of 15. This resulted in staff failing to transfer R3 safely and R3 sustained a fractured femur.

Findings include:

1. The Physician's Order Sheet for R4 documents, diagnoses, in part, as "Altered Mental Status, Post Radiation Dementia and Neuropathy." The Minimum Data Set (MDS) dated 11/04/2014, documents R4 is moderately impaired with cognition, has unsteady sitting and standing balance, with limited range of motion to the lower extremities, and requires extensive assistance for transfers.

On 12/09/2014, at 10:01 AM, R4 was in bed on her right side. A fall mat was on the floor next to R4's bed and the bed was in low position. A soft foam lap top cushion was next to the bed. At that time, E2, Director of Nursing (DON) stated, "(R4) leans really bad."

On 12/09/2014 at 12:05 PM, R4 was in the wheelchair with a soft foam lap cushion attached to the wheelchair, and a personal body alarm (PBA) with a long string attached by a clip to R4's shirt. On 12/09/2014 at 12:13 PM, E10 and E18, Certified Nurses Aides (CNA) applied a gait belt to R4 after removing the soft foam lap cushion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 20	F 323		

Without locking R4's wheelchair, E10 and E18 attempted to transfer R4 to the bed. R4 was holding onto the arms of the wheelchair to steady herself and the wheelchair began to roll backward. R4 immediately began to sit back down, nearly missing the seat of the wheelchair. Both E10 and E18 left R4 in the wheelchair, left the room without placing the soft foam lap cushion back onto R4's wheelchair. R4 began to propel herself into the hall, leaning over forward. R4 was out in the hall for several minutes, when E10 noticed and reapplied the lap cushion.

On 12/09/2014, at 3:35 PM, E11 and E12 toileted R4 and placed her in bed. E12, CNA attached the clip of the personal body alarm to R4's blouse and placed the base of the alarm next to the pillow, with no attachment to anything. E12 washed her hands and left R4's room.

On 12/10/2014 at 9:20 AM and 10:05 AM, R4 was laying in bed with the base of the personal body alarm not attached to anything, enabling the alarm to sound if R4 begins to leave the bed.

On 12/10/2014 at 12:45 PM, R4 was in the wheelchair by the nurses station leaning forward, with her head resting on the lap cushion. R4 was asleep. The string attached to the PBA and blouse was 22 and 1/2 inches long.

The Incident Detail Report, dated 8/10/2014, at 5:40 AM documents, in part, "(R4) rolled out of bed onto floor. No injury noted at this time, but later on noted bruise to right thumb. Bed was in low position. Comments: Position resident in center of bed to prevent rolling out of bed."

The Nurse's Note, dated 8/10/2014 at 5:30 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 21	F 323		

documents R4 was "found lying on the floor on the right side on mat beside bed, alarm not sounding."

The Safety Risk Data Collection for R4, dated 5/11/2014, documents, in part, "Is at risk for falls due to confusion, poor balance, poor safety awareness, leans forward in wheelchair, unsteady gait, leans back. Pressure alarm in bed, PBA (personal body alarm) in wheelchair, lap (cushion) when in wheelchair." Quarterly Review for R4 dated, 11/04/2014, documents in part, "Pressure alarm and PBA at all times."

R4's Care Plan, revised 11/12/2014, documents, in part, "Is a high risk for falls. Interventions-Apply lap (cushion) when up in wheelchair due to leaning forward, inability to right self consistently. Monitor for proper placement. Keep in high traffic area. Do not leave in bathroom unattended. Remind her not to get up without assist."

2. The POS for 12/2014 documents diagnoses for R10, in part, as "Cerebral Vascular Accident and Dementia." The MDS dated 9/29/2014, documents R10 is moderately impaired with cognition, has poor sitting and standing balance, and requires extensive assistance from staff for transfers, with limited range of motion to the lower extremities.

On 12/09/2014 at 12:37 PM, R10 was sitting at the dining room table, leaning forward, with her chin resting on the table. A long, knotted string was attached with a clip to R10's blouse and to a PBA attached to the wheelchair. E23, CNA instructed R10 to sit up straight.

On 12/10/2014 at 11:00 AM R10 was in a low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 22	F 323		

bed. The base of the PBA was laying next to the pillow by R10's head. The base was not attached to anything. The long string was attached to R10's blouse.

On 12/10/2014 at 11:30 AM R10 was in a wheelchair in her room, leaning far over the bedside table. The string to the PBA was attached to her blouse but was not taut enough to sound. An activity tray to the right of R10's wheelchair was positioned downward. At 11:48 AM, R10 was still in her room in the same position. The string attached to the alarm measured 19 and 1/2 inches in length.

On 12/10/2014 at 1:45 PM, R10 was seated in the wheelchair in her room, leaning forward. Her body was wedged between the left arm rest of the wheelchair and the raised activity tray. Her head was laying on the bed, with the string pulled taut, but not sounding. R10 was awake.

On 12/10/2014, at 2:40 PM, R10 was in bed. The PBA was attached to the wheelchair which was across the room.

The Safety Risk Data Collection for R10, dated 7/05/2014, documents, in part, "At risk for falls due to poor balance, poor posture, leans forward in wheelchair, poor weight bearing, confusion, previous falls. PBA in place when up in wheelchair. half lap tray in place for improved posture. Last fall 6/12/2014."

R10's Care Plan, revised 9/30/2014, documents, in part, "Is high risk for falls related to unaware of safety needs. Interventions-Apply PBA PRN when in bed at night due to increased confusion. Encourage her to sit up when leaning forward,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 23	F 323		

Lay down between meals to prevent leaning forward as often, remind to use call light for assist to transfer and not attempt per self, 1/2 lap tray in place when up in wheelchair for proper positioning. Able to reposition 1/2 tray as she wishes."

On 12/11/2014, at 3:00 PM, E3 Assistant Director of Nursing (ADON) reported the facility has no policy related to the use of the PBA with a clip, or how long the string must be to be effective to alert staff or assist in preventing falls, or where the base of the alarm should be attached to be effective when a resident is in bed.

3. R1's 11/17/14 Incident Report documents "Description: staff was transferring resident (R1) from wheelchair to toilet and resident (R1) tried to sit down before turning, so staff lowered her to the floor. Comments: staff to use gait belt for all transfers."

R1's Care Plan, revised 11/9/14, documents the new interventions as may use mechanical lift, transfer with 2 assist and gait belt on and off toilet or may offer bedpan.

On 12/11/14 at 1:55 PM, E3 stated, regarding R1 incident 11/17/14, "I would assume from the intervention that they didn't use a gait belt."

4. R5's MDS for 6/30/14, 8/29/14, and 11/29/14 document R5 requires extensive assist of one person for transfers. R5's 6/30/14 MDS documents R5's balance is unsteady and can only stabilize with assistance, and has severe cognitive impairment. R5's 8/29/14 MDS documents R5's balance is unsteady, but he can stabilize himself, and has severe cognitive impairment. R5's 11/29/14 MDS documents R5's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 24	F 323		

balance is unsteady for transfers and can only stabilize with assistance, and is cognitively intact.

R5's Incident Reports, dated 7/13/14, 9/2/14, 9/3/14, and 11/23/14, document R5 fell in his room while trying attempting to transfer himself and had no significant injuries. The above Incident Reports continue to document for interventions the comments of remind/encourage resident to use call light to ask for assistance with transfers.

On 12/11/14 at 1:55 PM, E3 also stated, regarding R5's falls, "There weren't really progressive interventions. I would have tried to identify why he (R5) was trying to get up."

The Facility's Fall Protocol, revised 3/2011, documents, "1. On admission and readmission, a Fall Risk Assessment will be completed within 24 hours. 2. Preventative measures will then be implemented for those residents assessed as moderate to high risk. When a fall occurs: 7. Depending on the nature of the fall, preventative measures will be implemented accordingly. 8. Care plans will be updated as appropriate within 3 days of a fall occurrence."
5. On 12/9/2014 at 10:15AM R3 was lying in bed with eyes closed. E13, Treatment Nurse stated R3 has an immobilizer on the left leg from a fracture. E13 stated the injury happened from a fall in-house.

Nurse's Notes on 3/28/2014 at 3:30PM document, "(R3) was lowered to the floor by a CNA due to wheel chair rolled backwards during a transfer...."

Nurse's Notes on 3/30/2014 at 9:00AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 25	F 323		

document, "This nurse notified POA (Power of Attorney) that after speaking to several staff members it was discovered that Friday evening while staff was transferring resident (R3) to wheelchair, the wheelchair moved and staff had to lower resident to the floor....." . This entry was signed by E2, Director of Nursing (DON).

The x-ray report on 3/29/2014 documents, "A comminuted fracture is noted involving the distal third of the femur. Posterior displacement of the distal fracture is noted...."

A comparative x-ray report on 6/19/2014 documents, "Marked displaced healing fracture distal shaft of the femur with approximately 6.9 centimeter (cm) over-riding of the fracture fragments...".

A comparative x-ray report on 8/28/2014 documents, "Subacute supracondylar fracture of the femur with moderate displacement and angulation.....There is no significant interval of change."

On 12/22/2014, E3 Assistant Director of Nursing (ADON) stated, "(R3) was a transfer with 2 assist at the time of the fall on 3/28/2014. I am not sure why the CNA transferred (R3) by herself. We tell them (CNAs) to read the residents' Care Plans. That CNA knew (R3) was a 2 person transfer."

B. Based on observation and record review, the facility failed to ensure that chemicals are stored in areas which are inaccessible to cognitively impaired, mobile residents for two of two residents (R2 and R6) reviewed as mobile and cognitively impaired in the sample of 15 and one resident (R20) in the supplemental sample.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 26	F 323		

Findings include:

1. On 12/10/2014, at 11:34 AM, in the Women's Bath across from Room D6, there was one aerosol can of foam disinfectant cleaner in an unlocked cabinet on the wall. In a plastic bin on top of this cabinet were six four ounce tubes of protective barrier cream. The warning labels on the back of these tubes documented if the cream is swallowed to seek medical help and contact Poison Control.

2. On 12/10/2014, at 11:40 AM, in an unlocked cabinet under the sink in the D-hall kitchenette, there was one aerosol can of foam disinfectant cleaner.

3. On 12/10/2014, at 11:56 AM, in an unlocked cabinet on the wall in the C-Hall Women's Shower/Bath Room, there were two spray bottles of liquid bleach cleaner and one four ounce tube of antifungal cream. The Warning Label on the back of the antifungal cream documented if the cream is swallowed to seek medical help and contact Poison Control.

4. On 12/10/2014, the Material Safety Data Sheet (MSDS) for the aerosol foam disinfectant cleaner was reviewed and documented " Eye Contact: Flush with water for 15 minutes. If irritated, seek medical attention. Skin Contact: Wash with soap and water. If irritated, seek medical attention. Inhalation: Remove to fresh air. Resuscitate if necessary. Get medical attention. Ingestion: DO NOT INDUCE VOMITING. Drink two large glasses of water. Get immediate medical attention."

The MSDS for the liquid bleach cleaner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 323	Continued From page 27 documented "Eye Contact: In case of contact, immediately flush eyes with plenty of water. Remove contact lenses and flush again. Get medical attention if irritation persists. Skin Contact: Rinse with water for a few minutes. Inhalation: If inhaled, remove to fresh air. Get medical attention if irritation persists. Ingestion: Get medical attention if symptoms occur." 5. On 12/11/2014, the facility provided a list of residents who are independently mobile and cognitively impaired which included R2, R6 and R20.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Facility failed to ensure food is stored and prepared in a manner which prevents potential contamination. This has the potential to affect all of the 65 residents in the Facility. Finding include: 1. On 12/9/2014 at 9:45 am, during the intial tour	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 371	Continued From page 28 of the kitchen the hood above the stove contained large amounts of discolored, greasy brown stains, dust and debri on the vents and sides of the hood, as well as spots on the walls surrounding it. On 12/10/14 at 9:55 AM, E4, Dietary Manager, maintance man cleans the vent once a month. E4 reported she had been on vacation recently and apparently the maintenance was behind in schedule. The service sticker on hood documented the last service date was on 07/20/2013. The form entitled, 'KITCHEN EXHAUST SYTSTEM CLEANING QUALITY CONTROL CHECKLIST', documents the last cleaning of the hood was dated 1/20/2014. 2. On 12/10/2014 at 10:09 am the large walk in freezer located outside the Facility contained a large shallow pan on the top shelf. In the shallow pan, frozen solid water with five five inch ice cycles was hanging from the shelf. On that shelf, was a pan of roast beef covered in alumunium foil with a layer of ice on top of it. Next to the roast beef was also a box of frozen food with a layer of ice on top of it as well. At that time, E4, stated "The freezer roof leaks when it rains outside." 3. The Resident Census and Conditions of Residients, CMS 672, dated 12/9/2014, documents that the facility has 65 residents living in the facility.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 441	Continued From page 29	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 441	Continued From page 30	F 441		

Based on observation, interview, and record review, the Facility failed to perform adequate hand hygiene and glove changing during incontinent care and when entering an isolation room for 3 of 15 residents (R2, R4, R5) reviewed for infection control practices in the sample of 15.

Findings include:

1. R5's Care Plan, dated 12/5/14, documents R5 is on contact isolation for Clostridium difficile (C. diff).

On 12/10/14 at 10:58 AM, E8, Housekeeping Manager, entered R5's room to check the soap dispenser. E8 did not don gloves before entering R5's isolation room. E8 washed her hands with soap and water after checking the dispenser. E8 exited the room. E8 stated, "As soon as I saw you putting on gloves, I knew I had forgotten and walked right in the room." E8 donned gloves, and reentered the room to finish with the dispenser.

On 12/10/14 at 11:55 AM, E6 and E7, Certified Nurses Aides (CNA) donned gowns and gloves before entering R5's room. E6 and E7 stood R5 and transferred him with the use of a gait belt to the bedside commode to toilet him. E6 and E7 stood R5 with the gait belt and his walker when he said he was finished. R5 did not have a bowel movement. E7 used a damp wash cloth to wipe R5's rectal area. E7 pulled up R5's incontinent brief and his pants, removed the gait belt and placed it on the dresser before she removed the soiled gloves.

On 12/11/14 at 1:45 PM, E3, Assistant Director of Nursing (ADON), stated, "I expect glove change with handwashing in between when going from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 441	Continued From page 31	F 441		

soiled to clean."

The Facility's undated Universal Precautions Policy documents, "4. Barriers indicated in Universal Precautions are: a. Gloves. These must be worn whenever exposure to the following is planned or anticipated (or to an item contaminated with such): 2. Urine; 3. Feces; f. Handwashing. This is indicated: 1. After contact with blood/body fluids; 3. Before clean procedure; 4. After dirty procedure."

The Facility's Handwashing Policy, revised 9/2009, documents, "It is the policy of this facility that handwashing be regarded as the single most important means of preventing the spread of infections. Procedure: 2. Appropriate ten (10) to fifteen (15) second handwashing must be performed under the following conditions: After having prolonged contact with a resident; After handling used dressings, urinals, bedpans, catheters, contaminated tissues, linens; After offering incontinence care (catheter) care; After contact with blood, urine, feces, oral secretions, mucous membranes, or broken skin; After handling items potentially contaminated with any resident's blood, excretions, or secretions; 4. The use of gloves does not replace handwashing."

The Facility's Guidelines for Clostridium Difficile (C. diff) Policy, revised 5/7/14, documents, "Transmission: C. diff is shed in feces. Any surface, device or material(commodes, bath tubs, rectal thermometers) that came in contact with feces may serve as a reservoir for the C. diff spores. The spores are transferred mainly via the hands of healthcare workers that have touched a contaminated surface or item. Isolation Precautions: Handwashing should be done

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 441	Continued From page 32	F 441		

frequently using soap and water. Gloves should be worn when entering the room."
2. On 12/09/2014 at 12:22 PM, R2 was in bed with no pants on. R2 had been incontinent of urine and feces. E10, Certified Nurses Aide, (CNA) applied gloves, used a bath towel and wet one end of it. E10 applied perineal soap to the end of the towel. While R2 was positioned on her back, E10 used the end of the wet towel to wipe down the center of R2's vaginal area. E10 turned R2 to the left side using soiled gloves to position R2. E10 changed the surface area of the wet towel and wiped R2's rectal area to remove the feces. E10 then stated, "I'm going to get more towels. E10 removed her gloves and left R2's room without washing her hands. E10 returned quickly, applied new gloves and used a clean towel to wash R2's rectal area, removing feces. E10 put the soiled linens on the floor next to R2's bed, changed gloves and picked up the soiled linen from the floor and left R2's room. E10 failed to sanitize or wash her hands before leaving R2's room.

R2's Care Plan, updated 12/08/2014, documents, in part, "Is incontinent of bladder and bowel. Interventions-Clean peri-area with each incontinence episode with soap and water. Monitor/document for signs and symptoms of UTI (urinary tract infection)."

3. The MDS, dated 11/04/2014, documents R4 is moderately impaired with cognition, is incontinent of bowel and bladder and requires extensive assistance with personal hygiene.

On 12/09/2014, at 3:21 PM, E11 and E12, CNA's entered R4's room and asked her if she needed to use the bathroom. E11 and E12 transferred R4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 441	Continued From page 33 from the wheelchair to the toilet. R4's incontinent brief was wet with urine. R4 had a bowel movement while on the toilet. E11 removed R4's soiled incontinent brief. E11 wet the end of a bath towel, but did not apply soap to the towel. E11 changed the surface area of the wet end of the towel and wiped R4 from the top of the vagina back to the rectal area three times. Without changing the soiled gloves, E11 used the dry end of the towel to wipe R4's perineal area. Without removing the soiled gloves, E11 then pulled up R4's clean incontinent brief and pants. E11 assisted E12 to transfer R4 back to the wheelchair, touching the wheelchair with the soiled gloves. E11 removed the soiled gloves and reapplied R4's oxygen tubing to her nose and attached the personal body alarm to R4, touching the base of the alarm and the clip. Then E11 washed her hands. R4's Care Plan, revised 11/12/2104, documents, in part, "Has functional bladder incontinence related to no longer recognizing the urge to void. Interventions-Clean peri-area with each incontinence episode with soap and water."	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide 80 square feet of floor space per resident bed for ten of 15 residents	F 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145497	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE SPRINGS LODGE NURSING HOME, LLC	161 THREE SPRINGS ROAD CHESTER, IL 62233

(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
F 458	Continued From page 34	F 458		

(R1, R2, R4, R6, R8, R10, R11, and R12) in the sample of 15 and 42 residents (R16, R17, R18, R21, R23, R24, R25, R27-R35, R37, R38, R40-R63) in the supplemental sample.

Findings include:

1. The facility has 29 two bed rooms occupied by 1 or 2 residents. According to historical data and room measurements these 29 resident rooms provide only 75 square feet per resident bed. 22 of the rooms are certified for Medicaid. 7 of the rooms on B-hall are certified for Medicare.

R2, R4, R10, R18, R23-R25, R28-R35,R37, R38, and R40-R43 reside in rooms A1-A12 on A-hall. R44-R51reside in rooms B1-B6 and B8 on B-hall. R1, R6, R8, R11, R12, R17 and R52-R61 reside in rooms C1-C8, C10 and C12 on C-hall.

2. The facility has two four bed rooms occupied by 1, 2, 3 or 4 residents. According to historical data and room measurements these two resident rooms only provide 77 square feet per resident bed. These rooms are certified for Medicaid.

R16, R27, R62 and R63 reside in rooms D1 and D4 on D-hall.