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 _____	10/22/2015

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

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation #1545182/IL80273 No Deficiency	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report an incident resulting in injury for 1 of 15 residents (R11) reviewed for physician notification in the sample of 15. Findings include: The 08/04/15 1:30 PM Nurse's Notes state that a Certified Nurse Aide, (CNA), was assisting R11 to bed and R11 became resistive, jerked back away, and fell into the wall hitting her head on the wall. R11 asked the CNA not to tell the nurse, because it would mess up her hair. The record states that E3, (Licensed Practical Nurse), went to look at R11, but she was not cooperative. The Nurse's Note documents, "No bruising noted upon looking quickly." The Nurse's Note that addresses the fall is dated 08/05/15 at 12:00PM, and states that R11 was found to have a 3.0 centimeter hematoma on the back of her head, on the right side, and the area was slightly tender upon touch. A Neurological Assessment Flow Sheet, dated 08/05/15, states that neurological checks were initiated at 12:00 PM on 08/05/15. E2, (Director of Nurses), stated on 10/21/15 at 2:00PM that E3 should have notified the physician of R11's fall after the incident, and neurological checks should have been initiated at the time of the fall.	F 157		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 2 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: Based on observation, record review and interview the facility failed to operationalize their Abuse Policy and timely report an allegation of abuse to the Administrator and failed to ensure that Abuse Policies and Procedures are updated to include Addendum Section 1150B of the Social Security Act for Abuse Prevention. This has the potential to affect all 59 residents in the facility. Findings include: The Resident Census and Conditions of Residents dated 10/19/15 states there are 59 residents in the facility. 1. The Facility's Resident Abuse Prevention Program policy dated 01/13 failed to include the section for Reporting Reasonable Suspicion of a Crime in Long Term Care Facilities. (Section 1150B of the Social Security Act.) Observations in the facility at 1:00PM on 10/19/15 indicated that there was no posting of the Employees' Rights to Report Reasonable Suspicion of a Crime in Long Term Care Facilities. (A requirement of the Act.) E1 (Administrator) stated at 4:10PM on 10/20/15 that he was unaware of the Addendum Section 1150B, or the need to post an Employees' Rights Notice. 2. The Abuse Allegation form, dated 5/7/2015 at	F 226		

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F 226	Continued From page 3 8:40AM, documents that R51 requested to speak with E16 (Assistant Director of Nurses - no longer employed at the facility) regarding E8 (Certified Nurse Aide - CNA), as being rough with R6 on the evening of 05/06/15. At that time, E16 reported the allegation to E2 (Director of Nurses - DON) and an investigation was started. A typed report dated 05/08/15 and signed by E2 details the incident. The report states that on the evening shift of 05/06/15, R51 confronted E8 complaining that she was rough with R6 during resident care. The report states that E8 went to E17 (Licensed Practical Nurse) and informed him of the accusation. The report states that E17 directed E8 to trade halls with another CNA, allowing her to complete her shift. E2 stated, on 10/20/15 at 11:00AM, that E17 should not have allowed E8 to continue working in the facility, and should have reported the incident immediately to E1. The Facility's 1/13 Abuse Investigation Procedure Policy states, "It is the policy of this facility that reports of abuse be promptly and thoroughly investigated. 1. When the incident or alleged abuse is suspected, it will be reported to the Administrator."	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.	F 241		

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to promptly respond to call lights to provide needed assistance for 1 of 13 residents, (R7), reviewed for call light response in the sample of 15, and 5 residents, (R39, R44, R51, R52, R53), in the supplemental sample. The findings include: 1. The facility Resident Council reports from January 2015 to present were reviewed on 10/20/15, and the issue of untimely call light response was noted as a concern in January, July, August and October. 2. Residents were questioned on 10/21/15 at 10:00am, during the Quality of Life Assessment Group Interview, regarding call light response. The 6 residents (R7, R39, R44, R51, R52, R53) in attendance all agreed that the response time from staff varies, but at times is too long. 3. The residents (who wish to remain anonymous) expressed the following comments: *A resident stated that it has taken staff over an hour to respond to a call light. The resident indicated that they kept track of the length of time with a clock. *Four residents stated they have heard staff talking and laughing at the nurses station while their call light was activated. *A resident stated they have gone to the door and yelled out in the hall for help.	F 241		

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F 241	Continued From page 5 *A resident stated that at times, the staff all gather in one resident's room, and the others must wait. * Two residents stated that, at times, they have called the facility with their cell phones to get assistance. They both indicated that their call lights had been on for an extended period of time before calling. *A resident stated they have observed nurses and Certified Nurse Aides, (CNAs), texting on their cell phones while call lights were activated. *All of the residents agreed that staff will answer the call light, state that they are going to be "right back," and fail to return. *A resident stated they have activated the call light when finished with a bedpan and have waited so long that their bottom hurt. They further indicated they have waited long enough to fall asleep while on the bedpan. *When asked, one resident stated that they have waited too long for assistance and have soiled themselves. *Two residents stated that it often takes a very long time to have a urinal emptied. 4. Included in the Resident Council concerns is a written statement from December 2014, which was reviewed. The undated statement was prepared by R53 to relate an incident from the evening of 12/24/14. R53 wrote that R55 had fallen at approximately 6:10pm. The statement says that R53 activated the call light and began using a cell phone to call the facility to get assistance. R53 further wrote that he yelled and	F 241		

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F 241	Continued From page 6 continued to call the facility, (line busy), until 6:50pm when the staff responded to assist R55 on the floor. Review of the related incident report from 12/24/14 for R55 stated that the time of the incident was 6:50pm. 5. E2, (Director of Nurses), stated on 10/21/15 at 2:30pm that an observation call light response survey has been started. Review of the undated form found only 7 entries from January 2015, 1 entry from February 2015 and 3 from October of 2015.	F 241		
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	F 322		

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F 322	Continued From page 7	F 322		

by:
Based on observation, record review and interview the facility failed to document accurate intake and output measurements for one of one resident (R2) receiving gastrostomy feedings in the sample of fifteen.

Findings include:

1. According to the Physician's Order Sheet, (POS), dated 10/01/15, R2 has the following diagnoses: History of Cerebrovascular Accident, Parkinson's Disease, Dysphagia, and History of Dehydration.

According to R2's Care Plan dated 10/02/15, R2 has been receiving nothing by mouth, (NPO), since 7/31/14.

R2's POS has orders dated 10/05/15 for Jevity 1.5 at 70 cubic centimeters (cc) per hour via pump x 22 hours and 600 cc flushes every shift. The pump is off from 9:00 AM - 11:00 AM daily. According to E15 (Registered Dietician) on 10/21/15 at 1:20 PM, R2 needs to receive 2,864 cc free fluids daily via the gastrostomy tube.

R2's Care Plan dated 10/02/15 documents under Interventions to: Monitor Intake and Output.

On 10/21/15 at 1:20 PM, when E4 (Licensed Practical Nurse) was asked how R2's daily Intake and Output (I & O) was monitored, E4 stated, "We write it down in a book. We have an I & O Book." Review of R2's Intake and Output - PO (By Mouth) And TF (Tube Feeding) sheet from the I & O Book fails to document how many cc's of fluid R2 received. It documents R2 received his tube feeding without actual numbers being

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F 322	Continued From page 8 documented. E4 stated on 10/21/15 at 1:20 PM, that staff should not record the fluid intake by documenting TF rather than the actual volume. E4 stated, "They shouldn't record his I & O that way."	F 322		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide liquids in a form to meet the resident's needs for 1 of 1 resident (R11) reviewed for thickened liquids in the sample of 15 and 1 resident (R25) in the supplemental sample. Finding include: 1. A Nurse's Note, dated 10/02/15, states that R11 had a Modified Barium Swallow procedure and a referral was made to the Speech Therapy Department for a liquid consistency change. A Physician's Order dated 10/05/15 stated that R11 is to be changed from nectar thickened liquids to honey consistency liquids. On 10/21/15 at 12:05 PM, E3 (Licensed Practical Nurse) administered oral medications to R11 with a glass of water. This surveyor asked E3 if the the water was thickened. E3 took the glass of water away from R11 and went to the Medication Room and added Thickener to the water. E3	F 365		

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F 365	Continued From page 9 stated that R11 is to be on honey thickened liquids and R11's water was not thickened. 2. On 10/20/15, at 1:15 PM, near the end of the noon meal, R11's thickened fluids, (water, a red fluid, and a brown fluid), were very thick and congealed. R11 took a drink of the fluid and the liquid did not flow freely, appearing lumpy. The 10/5/15 Physician's Order for R11's liquids state that R11 is to receive honey thickened liquids. 3. On 10/20/15, at 1:18 PM, in the small dining room, R25 was eating and drinking. The fluids included with R25's meal were stirred, and a thicker layer of fluid with thickener was found at the bottom of each glass. When stirred and tested the fluid was quite thin and ran freely from the spoon. R25's Physicians Order from 6/26/15 states that R25 is to have honey thickened fluids. 4. E18 (Dietary Manager) stated at 3:00pm on 10/20/15 that the staff assisting the residents are to thicken the resident's fluids with thickener as instructed on the back of the resident's tray card. E18 stated that the kitchen provides the thickener and the measuring device. E18 further stated that in the past, approximately 2 years ago, the Speech Therapist had done training for the staff.	F 365		
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.	F 458		

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F 458	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide 80 square feet of floor space per resident bed for 10 of 15 residents, (R1, R2, R5, R6, R7, R9, R10, R11, R12 and R13), in the sample of 15 and 35 residents (R17 through R51) in the supplemental sample. Findings include: 1. E1 (Administrator) stated on 10/21/15 at 12:50 pm that there have been no changes to the waivered resident room numbers, certifications and that the historical measurements are accurate. 2. Twenty nine, two bed resident rooms provide only 75 square feet per bed: A hall rooms 1 - 12 all Medicaid certified, B hall rooms 1 - 6 and 8 all Medicare certified, C hall rooms 1 - 8, 10 and 12 all Medicaid certified. Two - four bed resident rooms provide only 77 square feet per bed: D1 and D4, Medicaid certified. 3. Observation of these rooms throughout the survey from 10/19/15 to 10/22/15 found no issues related to room size. Observation of the rooms found there was adequate space to meet the medical and personal needs of the residents living in the waivered rooms.	F 458		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.	F 466		

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F 466	Continued From page 11	F 466		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to store drinking water to ensure availability in case of loss of normal water supply. This has the potential to affect all 59 residents in the facility.

Findings include:

1. On 10/20/15 at 4:10 PM, E1 (Administrator) said the facility does not store water on site for residents to drink in case of loss of water. During intermittent observations between 10/19/15 and 10/21/15, no drinking water was available in storage to be used in case of loss of normal water supply.

An Emergency Menu dated Spring Summer 2015, Procedure 1 notes: a minimum three-day water supply will be available. The undated Emergency Water Supply policy, 5) notes the back-up water supply will be rotated to insure it does not go beyond the use date on the bottle. The last paragraph notes the facility will maintain an emergency water supply in the facility.

The Resident Census and Condition of Residents dated 10/19/15 notes the facility census is 59 residents.