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 _____	11/22/2013

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 159 SS=E	Annual Licensure and Certification Survey 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		

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 _____	11/22/2013

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 159	Continued From page 1	F 159		

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to obtain written authorization from residents for management of personal funds and failed to utilize accepted book keeping practices to account for those funds for 2 of 2 residents (R6, R10) reviewed for accounting of personal funds in the sample of 15 and 7 residents (R27, R35, R46, R54 and R57, R61 and R62) reviewed in the supplemental sample.

The findings include:

1. On 11/19/2013 at 2:00 PM, E1- Administrator indicated that the facility did not manage personal funds for residents. Upon further discussion, E1 stated that he did have some monies that were kept in individual envelopes for residents. An observation was made, while in E1's office on 11/20/2013 at 3:30 PM, of several white envelopes which contained varying amounts of paper currency, coins and receipts. The outside of each envelope was labeled with a resident name and notations of dates and amounts taken or added to the envelope were written on the envelope. E1 stated that a written quarterly

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 _____	11/22/2013

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 159	Continued From page 2 accounting is not provided to the resident or the Power of Attorney. E1 provided a list of residents for whom he had an envelope for as follows: R6, R10, R27, R35, R46, R54 and R57, R61 and R62. R10 and R 61 were present during the group interview on 11/20/2013 at 10:00 AM and both stated that they have monies kept in the office for their personal use but do not receive a written quarterly statement.	F 159		
F 164 SS=C	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164		

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 _____	11/22/2013

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 164	Continued From page 3	F 164		

release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, the facility failed to ensure that all resident information, including care issues and care needs, are kept confidential. This has the potential to affect all 67 residents living in the facility.

The findings include:

1. During the initial tour of the facility on 11-19-13 at 9:30 am, the main entrance area by the administrators office was observed to have a tall cabinet with glass doors. In the area behind the glass doors, there are 11 three ring binders that contain resident Minimum Data Set information and Resident Assessments for all residents in the facility. These binders are accessible to anyone who opens the glass doors.

E1, Administrator, on 11-20-13 at 10:00 am, stated that the Minimum Data Set information and the Resident Assessments for all residents have been kept there for a long time. E1 also stated that he never realized that outside people might look at the information.

The facility's Resident Census and Conditions of Residents form dated 11-20-13 documented the facility had a census of 67 residents.

2. R 61 was present during the group interview

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 _____	11/22/2013

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 164	Continued From page 4 on 11/20/2013 at 10:00 am and stated that he had a concern with "books that have residents medical information in them" being left out on the dining room tables during the night shift, where anyone could look at them.	F 164		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an adequate Care Plan for 4 of 15 residents (R1, R6, R7, and R9) reviewed for Care Plans in the sample of fifteen.	F 280		

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 _____	11/22/2013

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 280	Continued From page 5	F 280		

The findings include:

1. According to Nurses Notes dated 6/19/13, 9/6/13, 9/19/13, 9/24/13, and 9/27/13, R6 sustained falls on those dates. When asked for incident reports corresponding to each of these incidents, on 11/19/13 at 3:15 p.m., E2, Director of Nurses, retrieved reports for all but the 9/6/13 incident. When questioned regarding the 9/6/13 incident, on 11/19/13 at 3:15 p.m., E2 stated that the facility had no report for an incident on that date. Surveyor reviewed the pertinent Nurses Note with E2. The note states, "Res (Resident) in room. Laundry staff called for help. Found res in w/c (wheelchair) but had slid down to where buttocks were almost touching floor. Res holding self in w/c with left arm." E2 stated that the facility did not consider that an incident, because R6 had not actually touched the floor. According to the Care Plan, updated 9/27/13, no new intervention to prevent falls from the w/c was planned following this incident.

According to a Nurses Note dated 6/29/13 at 10:00 a.m., R6 was found on the floor in R6's room. The note states that R6 was attempting to transfer self from w/c to bed, and that R6 was placed in bed and a personal body alarm (PBA) was applied, and that R6 was instructed to wait for assist with transfers. A follow-up Nurses Note,dated 6/9/13 at 12:30 p.m., states "No injury noted. Res does not ask for assist with transfers. Staff responds to PBA." During the subsequent falls on 9/6/13, 9/19/13, 9/24/13, and 9/27/13, according to corresponding Nurse's Notes and Fall Details Reports, no alarm was in place at the time of any of these falls. The Care Plan was updated following the last fall on 9/27/13 to include the use of an alarm. Only one other

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 _____	11/22/2013

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 280	Continued From page 6	F 280		

intervention, to change R6's wheelchair for a different one, was added to R6's Care Plan between 8/21/13 and 9/27/13.

2. According to a Nutritional Progress Note dated 2/20/13, R6 was readmitted to the facility from the hospital with a diagnosis of Aspiration Pneumonia. On 11/21/13 at 2:00 p.m. Z1, R6's family member, stated that R6 had been sent to the hospital with Aspiration Pneumonia 3 more times during the summer of 2013.

According to a Speech Language Pathology note dated 7/23/13, Speech Language Pathology recommended a slow rate of eating with small bites of mechanically altered foods due to a high choking risk, and also recommended that staff monitor R6 for pocketing of food.

On 11/19/13, 11/20/13, and 11/21/13, during the noon meal from 12:30 p.m. until 1:15 p.m., R6 was in the hallway of the facility eating her meal independently at an overbed table.

R6's Care Plan, with a target date of 10/19/13, fails to outline how staff will monitor R6 for safely eating while eating alone in hallway.

Surveyor: Lapington, Karen
3. R7's Physician's Order Sheet dated November, 2013 documents that R7 has physician's orders for Norco 7.5 milligram (mg)/325 milligram (mg), take one tablet by mouth every 4-6-hours as needed and Ativan 0.5 mg, take one tablet by mouth twice a day as needed and may have up to 3 doses of Ativan in 24 hours.

R7's Care Plan dated 10-23-13 does not include

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 _____	11/22/2013

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 280	Continued From page 7 parameters for the use of the Norco and the Ativan. E2, Director of Nurses, stated on 11-21-13 at 11 am that R7 does use the Norco and the Ativan at times. Surveyor: Foster, Robin 4. R9 has a diagnoses that includes Mood Disorder and Depression as noted on the November 2013 Physician Order Sheet (POS). An order for Ativan 0.5 mg twice daily as needed was noted on the current November 2013 POS. The plan of care does not address parameters for the use of this "as needed" medication. 5. On 11/21/13 at 11:45 AM, R1 was observed being transferred to the toilet with one staff person assisting her. The Fall Details Report showed that R1 fell on 9/25/13 when a staff member transferred her to the toilet, and on 10/31/13 and 11/16/13 when she attempted to transfer to the toilet unassisted. R1's Care Plan showed no modifications to the Care Plan Fall Interventions after the occurrences. On 11/21/13 at 1:30 PM, R2, Director of Nurses, confirmed that the Care Plan had not been modified in an attempt to prevent future falls.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	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 _____	11/22/2013

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 8	F 323		

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to investigate a fall incident and failed to plan and/or implement strategies to prevent subsequent falls for 3 of 5 (R1, R5 and R6) residents reviewed for falls in the sample of 15.

Findings include:

1. According to Nurses Notes dated 6/19/13, 9/6/13, 9/19/13/ 9/24/13, and 9/27/13, R6 sustained falls on those dates. When asked for incident reports corresponding to each of these incidents, on 11/19/13 at 3:15 p.m., E2, Director of Nurses, retrieved reports for all but the 9/6/13 incident. When questioned regarding the 9/6/13 incident, on 11/19/13 at 3:15 p.m., E2 stated that the facility had no report for an incident on that date. Surveyor reviewed the pertinent Nurses Note with E2. The note states, "Res in room. Laundry staff called for help. Found res in w/c (wheelchair) but had slid down to where buttocks were almost touching floor. Res holding self in w/c with left arm." E2 stated that the facility did not consider that an incident, because R6 had not actually touched the floor. According to the Care Plan, updated 9/27/13, no new intervention to prevent falls from the w/c was planned following

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 _____	11/22/2013

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 9	F 323		

this incident.

According to a Nurses Note dated 6/29/13, at 10:00 a.m. R6 was found on the floor in R6's room. The note states that R6 was attempting to transfer self from w/c to bed, and that R6 was placed in bed and a personal body alarm (pba) was applied, and that R6 was instructed to wait for assist with transfers. A follow-up Nurses Note dated 6/9/13 at 12:30 p.m. states, "No injury noted. Res does not ask for assist with transfers. Staff responds to PBA."

According to a Fall Details Report dated 9/19/13 at 3:35 p.m., R6 was found on the floor of the bathroom. The report indicates that no alarm was in use. The report notes that the action taken to prevent further incidents was, "(R6) redirected not to transfer self use call light or ask staff help get to toilet."

According to an Occurrence Report dated 9/24/13 at 10:25 a.m. R6 was found lying on the floor in R6's room. The report states that one of the contributing factors to the fall was, "R6 attempted to transfer independently." The report also notes that damage was noted to R6's w/c, and it was subsequently replaced. The report indicates that an alarm was not in use.

According to a Fall Details Report dated 9/27/13 at 1:00 p.m., R6 was found on the floor in the B hall bathroom. The report indicates that no alarm was in use. The report states that contributing factors to the fall included "transferring self independently," and that the action taken by the facility was "chair alarm applied in w/c."

According to the current quarterly Minimum Data

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 _____	11/22/2013

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 10	F 323		

Set, dated September 16, 2013, R6 requires extensive assist of one for transfers. According to the Care Plan with a target date of 12/19/13, staff are to "remind (R6) to ask for assist when transferring at all times."

During a family interview on 11/21/13 at 2:00 p.m., Z1 (family member) stated that while visiting R6 on 11/8/13 at 12:05 p.m., Z1 asked a Certified Nurse Aid (CNA)(did not remember which one) to assist R6 to the toilet, and was told that R6 was able to transfer self to the toilet independently.

At 12:45 p.m. on 11/22/13, R6 was in R6's room, in the wheelchair, going into the bathroom. E8, Licensed Practical Nurse entered the room, and when asked, stated that R6 had a string alarm but not a pad alarm in R6's chair, and pointed to the string attached to R6's chair.

2. On 11/21/13 at 11:45 a.m., R1 was observed being transferred to the toilet with one staff person assisting her.

Fall Details Reports showed that R1 fell on 09/25/13 when a staff member transferred her to the toilet, and on 10/31/13 and 11/16/13 when she attempted to transfer to the toilet unassisted. R1's Care Plan showed no modifications to the Care Plan Fall Interventions after these occurrences.

On 11/21/13 at 1:30 p.m. R2, Director of Nurses,confirmed that the Care Plan had not been modified in an attempt to prevent future falls.

3. R5's Care Plan initiated 2/01/12 and updated

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 _____	11/22/2013

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 11	F 323		

10/11/2013 identifies the Problem of : High risk for falls due to poor balance, flexed forward posture, leaning to left. Intervention # 10 for this problem is to use a soft lap cushion device which attaches to wheel chair when up in wheelchair for safety and positioning due to frequent falls. R5's initial Physical Restraint Assessment was completed by nursing staff on 11/9/12 . This assessment was repeated on 7/8/13. Benefits of this device on this assessment include: Prevents injury to self, Maintain correct positioning, Prevent falling. The comments include: Soft lap device to assist to keep resident from leaning forward due to poor trunk control at times. A note was entered on this assessment on 10-5-13 stating "Information current." A Physical Therapist's evaluation was not found in R5's Medical Record.

On 11/20/13 at 11:30 a.m., R5 was observed leaning forward in wheelchair. The lap device was in place and attached to the arms of the wheelchair. The lap device rested approximately 8 inches from R5's trunk.

Entries in R5's Nurses Notes include the following: 1.) 7/5/13 1:00 pm .Poor posture in wheelchair leaning forward. Personal body alarm and lap device on. 2.) 7/8/13 Poor Posture. Leans forward in wheelchair. 3.) 81/13 11:00 am Resident up in wheelchair. Continues with very poor posture. Lap device on.

The following falls by R5 were described on Falls Detail Reports: 1.) 6/24/13 at 10:30 a.m. Resident observed leaning forward in her wheelchair pushing furniture around. Staff then heard personal body alarm sound and found resident on floor in another residents room lying on her left side. No injuries noted. The Care Plan

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 _____	11/22/2013

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 12	F 323		

was updated on 6/25/13 with the following intervention: Give verbal cues and assist resident to sit up when leaning forward. Assist to lay down as tolerated. 2.) 8/7/13 at 8:15 a.m. Staff was pushing resident down hallway and resident put her foot down on floor causing her to fall forward out of wheelchair resulting in 3 centimeter (cm) laceration to her left eyebrow. The resident was sent to the emergency room and received 14 sutures and sent back to facility that same morning. The Nurses's Notes describing this incident indicate that lap device was on. The Care Plan was updated on 8/8/2013 with the intervention of : May apply foot pedals when staff or family transporting in wheelchair. 3.) 9/3/13 at 16:30 pm the resident was bending down over the lap device then the lap device was removed by the resident and fell to left side on floor. An update to R5's Care Plan was not noted for this incident. 4.) 9/16/13 at 11 a.m. Heard resident yell out. Resident in central dining room. Saw resident lean forward. Entire wheelchair fell forward with resident still in it. Personal body alarm still on. Lap device still on.
Noted lump on forehead. An update to R5's Care Plan was not noted for this incident.

On 11/22/13 at 8:50 a.m., E7 (Certified Nurse Assistant) stated that she thinks the lap device does help keep R5 from bending too far forward, "but obviously does not keep her from tipping over in the wheelchair."

On 11/22/13 at 10:00 a.m. E2 (Director of Nurses) stated that she thinks the lap device keeps R5 from rolling out of the wheelchair. When asked if the incident of R5 tipping over in wheelchair could have been caused by R5 being too far forward in the wheelchair, stated

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 _____	11/22/2013

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 13 "Probably." On 11/22/13 at 12:15 p.m., E6 (Care Plan Coordinator) stated that a Physical Therapy evaluation for R5 for use of lap device and positioning had not been done, but would be completed today.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		

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 _____	11/22/2013

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 329	Continued From page 14	F 329		

Based on record review and interview, the facility failed to conduct specific behavior tracking for Psychoactive medications and/or did not conduct dose reductions for 2 of 6 residents (R7,R9) reviewed for psychoactive medications in the sample of 15.

The findings include:

1. R7's Physician's Order Sheet dated November, 2013 documents that R7 has physician's orders for Ativan 0.5 milligram (mg) every day at bedtime since 10-23-12 and Zoloft 25 mg daily since 10-23-12. This Physician's Order Sheet also documents that R7 has a diagnoses of Anxiety and Depression.

R7's behavior tracking for August, 2013 through November, 2013 indicates there are no specific behaviors being tracked.

E2, Director of Nurses, stated on 11-21-13 at 11 am that R7 is not being tracked for Anxiety and/or Depression. E2 also stated that the facility pharmacist did not recommend a dose reduction until the October, 2013 pharmacy visit (a year after the medications were started) and the physician has not answered back on this recommendation.

The facility Psychoactive Drug Monthly Flow Record verified that Anxiety and Depression are not being monitored for R7.

2. R9 has a diagnoses that include Mood Disorder and Depression as noted on the November 2013 Physician Order Sheet (POS).

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 _____	11/22/2013

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 329	Continued From page 15 An order for Ativan 0.5 milligram (mg) twice daily as needed was noted on the current November 2013 POS. The plan of care does not address parameters for the use of this medication. Review of the October 2013 Medication Administration Record (MAR) indicated that Ativan 0.5 mg was given to R9 on 10/1/2013 at 8 pm. There is no documentation found in the record as to why the Ativan was given. Behavior tracking sheets for October 2013 were reviewed and no behaviors were documented on 10/1/2013.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		

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 _____	11/22/2013

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 356	Continued From page 16	F 356		

standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to post the required staffing data and failed to ensure the posting was retained for 18 months. This has the potential to affect all 67 residents and visitors.

The findings include:

The facility's Resident and Census and Conditions of Residents form, dated 11/20/13, documents that the facility had a census of 67 residents.

On 11/19/13 at 11:00 AM and on 11/20/13 at 1:00 PM a dry erase board was observed hanging on the wall behind the A and B Hall nurses station. The current date along with the total Registered Nurse (RN) hours, the total Licensed Practical Nurse (LPN) hours, and the total Certified Nurse Aide (CNA) hours for a 24 hour period were written on the dry erase board.

On 11/21/13 at 1:00 PM, E2 stated that the breakdown of the number of RN's, LPN's, and CNA's working per shift, the breakdown of the actual hours worked per shift and the census are not written on the dry erase board. E2 went on to say that each morning the facility's staffing data is written on the dry erase board and the previous days staffing data is erased. E2 said that the

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 _____	11/22/2013

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 356	Continued From page 17 facility does not keep any posted daily nurse staffing data and did not know that they should keep this information.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's pharmacist failed to evaluate whether a resident's psychoactive medication has indications for use and the required gradual dose reductions for 1 of 6 residents (R7) reviewed for psychoactive medications in the sample of 15. The findings include: 1. R7's Physician's Order Sheet dated November, 2013 documents that R7 has physician's orders for Ativan 0.5 milligram (mg) every day at bedtime since 10-23-12 and Zoloft 25 mg daily since 10-23-12. R7's behavior tracking for August, 2013 through November, 2013 indicates there are no specific	F 428		

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 _____	11/22/2013

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 428	Continued From page 18 behaviors being tracked. E2, Director of Nurses, stated on 11-21-13 at 11 am that R7 is not being tracked for Anxiety and/or Depression. E2 also stated that the facility pharmacist did not recommend a dose reduction until October, 2013 pharmacy visit (a year after the medications were started) and the physician has not answered back on this recommendation. The facility Psychoactive Drug Monthly Flow Record verified that Anxiety and Depression are not being monitored for R7.	F 428		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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 _____	11/22/2013

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 431	Continued From page 19	F 431		

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to dispose of six outdated stock medications. This has the potential to affect all 67 residents living in the facility.

Findings include:

On 11/21/13 at 2:45 p.m. the medication room on C/D hall had the following outdated stock bottles of medication: B Complex expired 8/13.

On 11/21/13 at 3:00 p.m. the medication room/nurses office on D hall had the following outdated stock bottles of medications: Senna Plus expired 9/13, and Bisacodyl expired 2/13.

On 11/21/13 at 3:15 p.m. the medication room on A/B Hall had the following outdated stock bottles of medications: Aspirin 325 mg expired 3/13, Equate Fiber Therapy expired 7/13, and Docusate Sodium Liquid expired 9/13.

On 11/21/13 at 3:30 p.m. E5, the Assistant Director of Nurses, stated that stock medications

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 _____	11/22/2013

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 431	Continued From page 20 are checked monthly by nursing staff and confirmed that the above medications should have been discarded. According to the Resident Census and and Conditions of Residents report dated 11/20/13, the facility had 67 residents.	F 431		
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, record review, and measurements, the facility failed to provide 80 square feet of floor space per resident for 10 of 10 residents (R1 - R 6 & R9 - R 12) reviewed for undersized rooms in the sample of 15 and 44 residents (R16 - R27, R29 - R60) in the supplemental sample. The findings include: 1. Resident rooms A 1 through A 12 have 2 beds each and only provide 75 square feet of floor space per resident bed instead of the required 80 square feet. These rooms were observed during the environmental tour of the facility on 11-21-13 at 12:30 pm. Resident rooms B1 through B1 through B6, and B8 have 2 beds each and only provide 75 square feet of floor space per resident bed instead of the required 80 square feet. These rooms were	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 _____	11/22/2013

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 21	F 458		

observed during the environmental tour of the facility on 11-21-13 at 12:50 pm.

Resident rooms C1 through C8, C10, and C12 have 2 beds each and only provide 75 square feet of floor space per resident bed instead of the required 80 square feet. These rooms were observed during the environmental tour of the facility on 11-22-13 at 1:15 pm.

Resident rooms D1 and D4 are undersized certified rooms and at the time of this survey were set up and used with 2 residents in each room. These rooms are licensed for 4 residents according to E1, Administration during an interview on 11-22-13 at 9:15 am. These rooms were observed during the environmental tour of the facility on 11-20-13 at 1:30 pm.

2. Residents who reside in these rooms are R1-R6, R9-R12, R16-R27, and R29 - R60 according to the facility Resident List by hall and room given to the surveyors on 11-19-13 at 9:15 am during the entrance interview.

3. The undersized rooms on A hall, C hall, and D hall are all Medicaid certified. The undersized rooms on B hall are Medicaid and Medicare certified according to E1, Administrator on 11-22-13 at 9:15 am.

4. At the time of the survey, the residents who reside in these rooms are happy with their rooms. There is adequate space for medical equipment, assistive devices, and personal items observed during the environmental tour of the facility on 11-21-13 at 12:30 pm to 1:30 pm and on 11-22-13 at 9:15 am.