

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Three Springs Sr Living & Rhab		STREET ADDRESS, CITY, STATE, ZIP CODE 161 Three Springs Road Chester, IL 62233	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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.

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

TITLE

(X6) DATE

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who require assistance receive a shower or bath for 4 of 4 residents (R2, R8, R10, R11) reviewed for Activities of Daily Living assistance in the sample of 15. Findings Include: 1. R8's admission record, print date of 8/12/25, documented R8 has diagnoses including osteoarthritis, spinal stenosis, spondylosis of cervical region, depression, hypertension, bipolar disorder, schizophrenia, polyneuropathy, and intervertebral disc degeneration. R8's MDS (Minimum Data Set), dated 5/20/25, documented R8 is cognitively intact and requires partial to moderate assistance with bathing. R8's care plan, undated, documented R8 has an ADL (activities of daily living) self-care performance deficit impaired balance, requires assistance of 1 for transfers, and for bathing. On 8/11/25 at 9:40 AM R8 stated the facility does not have enough staff especially CNAs (Certified Nursing Assistants) and she has not been getting 2 showers a week because of it. R8 stated she had not received a shower for over a week until she finally got one yesterday. R8 stated her husband also resides at the facility and he has not been getting 2 showers a week. On 8/11/25 at 2:02 PM surveyor requested shower records for R2, R8, R10, and R11 for July and August of 2025. On 8/11/25 at 2:12 PM V1 (Administrator) stated R8 does not have any shower documentation for July. V1 provided R8's August shower records and they documented R8 only received 1 shower for the month of August on 8/10/25. 2. R2's admission record, print date of 8/7/25, documented R2 has diagnoses including heart failure, type 2 diabetes mellitus, atherosclerotic heart disease, hypothyroidism, bilateral primary osteoarthritis of knee, hyperlipidemia, orthostatic hypotension, hypertension, and gastro-esophageal reflux disease. R2's MDS, dated [DATE], documented R2 is cognitively intact and requires partial to moderate assistance with bathing and ADLS. On 8/11/25 at 11:17 AM R2 stated the facility is short staffed, it takes a long time to get her call light answered, and she has not had a shower for over a week. On 8/11/25 at 2:12 PM V1 (Administrator) stated she does not have any shower sheets for R2 for June nor July of this year. 3. R10's admission record, print date of 8/12/25, documented R10 has diagnoses including nontraumatic intracerebral hemorrhage, hemiplegia, cerebral infarction, muscle weakness, cognitive communication deficit, cerebral amyloid angiopathy, and a history of falls. R10's MDS, dated [DATE], documented R10 is moderately cognitively impaired and required substantial to maximal assistance with bathing. R10's care plan, undated, documented R10 has an ADL self-care performance deficit related to impaired balance due to stroke. This care plan documented R10 requires 2 staff with bathing/showering and toileting. On 8/11/25 at 8:32 AM as surveyor was entering the facility R10 stopped surveyor and stated, I still have not had a shower for over a week. Surveyor asked R10 how that makes her feel and R10 stated she feels dirty, and her hair feels greasy. R10 stated she used to get 2 showers a week but the last few months she has not been getting showers regularly because the facility does not have enough CNAs. On 8/11/25 at 12:10 PM R10 stated she has not had a shower for over a week. R10's hair appeared greasy. R10's shower records document R10 received showers on 7/4/25, 7/15/25, 7/18/25, 7/22/25, and 8/1/25. 4. R11's admission record, print date of 8/12/25, documented R11 was admitted to the facility on [DATE] and has diagnoses including cerebral infarction, intervertebral disc degeneration, sciatica, tremors, repeated falls, and retention of urine. R11's MDS, dated [DATE], documented R11 is moderately cognitively impaired and is dependent on staff for bathing. On 8/11/25 at 12:15 PM R11 stated to surveyor when do I get a shower? It's been a long time now. R11's hair appeared greasy and unkempt. On 8/11/25 at 2:12 PM V1 (Administrator) stated the facility does not have any documentation of R11 receiving a shower in July nor August. On 8/11/25 at 9:25 AM V11 (CNA) stated no administration staff help care for the residents when they are short staffed, and residents do not get showers on the days the facility does not have enough CNAs. On 8/11/25 at 9:48 AM V13 (CNA) stated the facility does not have enough CNAs, and showers don't get done like they are supposed to. On 8/11/25 at 2:02 PM surveyor requested shower records from V2 (Director of Nursing/DON). V2 stated she has no proof the showers were completed as there is missing documentation showing the showers were completed. V2 stated V1 started a QAPI (Quality Assurance Performance Improvement) on showers last week when she realized there was an issue. Surveyor asked V2 if the issue with showers not getting completed was due to lack of staff and V2 replied I don't know. On 8/11/25 at 2:12 PM V1 (Administrator) stated she started a QAPI on showers because last Friday one of the nurses called her and told her showers didn't get done. V1 stated she does not have any shower sheets for R2 nor R11 for June nor July. On 8/11/25 at 2:39 PM V2 (DON)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review the facility failed implement fall interventions as care planned for 1 of 3 residents (R5) reviewed for falls in the sample of 15. Findings Include:R5's admission record, print date of 8/7/25, documented R5 has diagnoses including metabolic encephalopathy, orthostatic hypotension, chronic atrial fibrillation, atherosclerotic heart disease, hypothyroidism, hyperlipidemia, major depressive disorder, cognitive communication deficit, hypertension, urine retention, and a history of falling. R5's MDS (Minimum Data Set), dated 7/25/25, documented R5 is moderately cognitively impaired and requires supervision or touching assistance with transfers. R5's progress note, dated 8/3/25 at 4:20 PM, documented resident got herself up (and was) unattended in the dining room, her alarm sounded, and she was on the floor, fall witnessed, and no head involvement. R5's progress note, dated 8/8/25 at 3:49 PM, documented staff call this LPN (Licensed Practical Nurse) to DR (dining room), upon entering DR resident was noted sitting on her buttocks in front of her w/c (wheelchair), no injury noted. ROM (range of motion) WNL (within normal limits) for this resident. R5's care plan, undated, documented R5 is at risk for falls. R5's care plan interventions include non-skid socks and non-skid mat below and on top of wheelchair pad. On 8/11/25 at 10:53 AM R5 was observed sitting in her wheelchair in the dining room. R5 was wearing black and white socks that did not have non-skid material on the sole of the sock. On 8/12/25 at 1:52 PM surveyor observed R5's wheelchair along with V1 (Administrator) to see if R5 had a non-skid mat below and on top of her wheelchair pad. V1 stood R5 up from her wheelchair and raised the wheelchair cushion. No non-skid mat was observed below nor on top of R5's wheelchair pad. V1 confirmed R5's fall intervention of a non-skid mat was not in place per R5's care plan. On 8/12/25 at 2:53 PM V1 (Administrator) stated she expects resident fall interventions to be in place per their care plans. The facility's Falls and Fall Risk Managing policy, dated 3/2018, documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. It continues, Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identified several possible interventions, the staff may choose to prioritize interventions. 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide enough nursing staff to adequately meet the needs for 4 of 4 (R2, R8, R10, and R11) residents reviewed for staffing in the sample of 15. These failures have the potential to affect all residents residing at the facility. Findings Include: 1. R8's admission record, print date of 8/12/25, documented R8 has diagnoses including osteoarthritis, spinal stenosis, spondylosis of cervical region, depression, hypertension, bipolar disorder, schizophrenia, polyneuropathy, and intervertebral disc degeneration. R8's MDS (Minimum Data Set), dated 5/20/25, documented R8 is cognitively intact and requires partial to moderate assistance with bathing. 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V11 stated no administration staff help care for the residents when they are short staffed, residents do not get showers on the days the facility does not have enough CNAs, and there are times she and the other CNAs must complete mechanical lift transfers with just 1 CNAs due to the lack of staff. On 8/11/25 at 9:32 AM V12 (CNA) stated the facility frequently does not have enough CNAs on the days shift, that there are days when they just have 3 CNAs to care for all the residents, and that the night shift is short staffed too. V12 stated the Administrator said it is not her problem if people call off, the nurses don't help when they are short staffed, and that the CNAs have to transfer residents with mechanical lifts by themselves all the time due to being short staffed. V12 stated there is supposed to be a nurse or CNA on call but they refuse to come in and work when they are short staffed. On 8/11/25 at 9:48 AM V13 (CNA)</p>		