

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/16/2025
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 66 residents residing in the facility. Findings Include: The facility schedule dated August 11, 2025 through September 11, 2025 was reviewed and on 8/9/25, 8/27/25, 8/29/25, 9/1/25, 9/3/25, 9/6/25, 9/7/25 and 9/8/25 the facility did not have an Registered Nurse providing resident care for 8 Consecutive hours. On 9/12/25 at 9:00 AM V3 (Infection Preventionist) stated she completed the working schedules for the facility, and she scheduled what staff was available. At the time the facility only had 1 Registered Nurse. On 9/12/25 at 9:15 AM V2 (Director of Nursing) stated she was new to the facility and understands that the facility has been unable to provide Registered nurse coverage in the past. However, she has been providing coverage on her off days when the facility has not been able to find Registered Nurse coverage. On 9/12/2025 at 10:00 AM V1 (Administrator) stated the facility has been unable to find Registered Nurses willing to travel to the area. The facility is doing the best that it can. Resident care has not suffered. The facility policy on Staffing undated documents RN coverage will be provided 8 hours per day, 7 days per week.		

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the Facility failed to store foods in a manner that prevents foodborne illness. This has the potential to affect all 66 residents living in the Facility. Findings include: On 9/9/25 at 11:30 AM, in the standing refrigerator in the main kitchen, there was a container labeled tartar sauce with the date 8/29. There was a container labeled banana pudding and a pitcher labeled CB (cranberry) juice that were both labeled 9/2. There were two containers, each with 28 individual cups of various colored liquids that were not labeled or dated. V12 (Dietary Aid) stated leftover food items should be thrown out after three days. On 9/12/25 at 2:30 PM, V1 (Administrator) stated she expects staff to follow dietary policies regarding labeling, dating and discarding items after 7 days. The Facility's Food Storage (Dry, Refrigerated, and Frozen) Policy dated 2016 documents, Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. Leftover contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and/or freezers. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 9/9/25 documents there are 66 residents living in the Facility.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the Facility failed to ensure adequate food was prepared for 5 of 5 residents (R10, R24, R51, R57, R63) reviewed for food and nutrition services in the sample of 60. Findings include: On 9/9/25 at 12:40 PM, V11 (Cook) was scraping the bottom of the pan of chili on the steam table. She asked, Do we think (R57) is going to eat this? V3 (Infection Preventionist/IP), stated, We will see when we take it down there to her (in her room). V11 continued to scrape the pan and was able to fill the bowl about half full. V3 stated, She wanted a grilled cheese yesterday, so maybe give her that and a little bit of chili. V11 stated sometimes we do run out of food and have to offer them something else. On 9/9/25 at 12:45 PM, meal service was complete. There was not enough remaining chili or peas to obtain temperatures. On 9/9/25 at 12:50 PM, V12 (Dietary Aid) stated sometimes the kitchen runs out of food because of the budget. The Facility is always removing items from our food order after we place it. On 9/11/2025 at 11:00 AM, during the Resident Council Group Meeting: R10 stated there is not enough food because the Facility company is not giving the kitchen enough money for their food budget. She stated her sister has to bring in snacks, so the Facility has something to give out during Bingo, and none of the residents here are getting enough calories each day. R10's Minimum Data Set (MDS) dated [DATE] documented R10 was cognitively intact. R24 stated the Facility does not provide enough food, and they are always out of sugar and pink sugar. R24's MDS dated [DATE] documented R24 was cognitively intact. R63 stated they ran out of chili last night, and she did not get any. The kitchen said they would put a tray back for her, but they did not do it. She got two pieces of ham instead and was mad about it. R63's MDS dated [DATE] documented R63 was cognitively intact. R51 stated he asks for more food at meals but does not get it. R51's MDS dated [DATE] documented R51 was cognitively intact. On 9/12/25 at 11:45 AM, V1 (Administrator) stated if there is ever a concern of not having enough food, dietary staff should go to the local store and buy it. She stated the Facility does not have a policy specific to dietary adequacy.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, observation and record review the facility failed to ensure that Fentanyl patches were removed from 1 of 3 residents (R75) from a sample of 25 as ordered by the physician. Findings include: R75's Face sheet undated documents an admittance date of 9/8/25 with pertinent medical diagnoses of Unspecified Acquired Deformity of Right Lower Leg and Unspecified Osteoarthritis, unspecified site. R75's Physician Order Summary dated September 2025 documents pain medications as Fentanyl Transdermal Patch 72 hour 37.5 Micrograms/hour (Fentanyl), Celebrex Oral Capsule 200 Milligram Daily, Voltaren External Gel 1 % every 8 hours, as needed, Tramadol 50 Milligram every 6 hours and Tylenol oral tablet 325 Milligram x's 2 three times day. On 9/11/25 at 10:11 AM V13 (Granddaughter of R75) stated while her grandmother was in physical therapy, she discovered that her grandmother had three (3) Fentanyl patches on her back. Two (2) were on the right shoulder and the third patch was on her left shoulder. The Director of Nursing did remove two (2) patches from R75's left shoulder. On 9/11/25 at 11:30 AM V2 (Director of Nursing) stated she did remove 2 patches from R75's shoulder which should have been removed before the third patch was applied. V2 director of Nursing stated a Medication Error report is being compiled. On 9/11/25 at 3:02 PM V15 (Primary Medical Physician) stated he had been notified by the facility of the three (3) Fentanyl patches being on R75. V15 stated the hospital placed two (2) patches (a 25 Microgram and 12 Microgram) because they did not have the prescribed dosage of 37.5 Microgram. Since the two (2) patches had been applied more than 72 hours ago it was doubtful that it contained any medication that would harm R75. The facility had been encouraged to monitor R75 for any sedation, falls or drowsiness. V15 stated he did not view the additional patch as significant especially since R75 did not experience any negative outcomes. The facility staff have been ordered to continue to monitor resident for any side effects. R75's Electronic Medication Administration Record (eMAR) dated September 2025 documents the 8:00 PM scheduled Fentanyl Patch was placed on R75's shoulder at 9/11/25 at 00:38 AM. The facility policy Administering Topical Medications revised October 2010 documents remove old patch.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide 80 square feet of floor space per resident bed for 53 out of 53 residents (R1, R2, R3, R4, R5, R7, R8, R10, R11, R12, R14, R17, R18, R19, R20, R21, R23, R24, R25, R27, R28, R29, R30, R31, R32, R33, R34, R37, R38, R40, R41, R42, R43, R47, R48, R49, R50, R51, R52, R53, R54, R55, R56, R57, R59, R61, R62, R63, R64, R66, R67, R72, and R75) reviewed for room size in the sample of 61. Findings include: A Hall Rooms 1 - 12 are all Medicaid certified and provide 75 square feet per bed. B Hall Rooms 1 - 6 and 8 are all Medicaid certified and provide 75 square feet per bed. C Hall Rooms 1 - 8, 10 and 12 are all Medicaid certified and provide 75 square feet per bed. D Hall rooms [ROOM NUMBERS] are Medicaid certified and provide 77 square feet per bed. On 09/16/25 at 9:36 AM, V18 (Housekeeper) measured the rooms and verified that R1, R2, R3, R4, R5, R8, R10, R11, R12, R14, R17, R18, R19, R20, R21, R23, R24, R25, R27, R28, R29, R30, R31, R32, R33, R34, R37, R38, R40, R41, R42, R43, R47, R48, R49, R50, R51, R52, R53, R54, R55, R56, R57, R59, R61, R62, R63, R64, R66, R67, R72, and R75 all reside in rooms that are waived. Interviews were conducted throughout the survey from 09/09/25 through 09/12/25 demonstrate no concerns or complaints vocalized by residents in relation to the room size. On 09/11/2025 at 12:10 PM, V1 (Administrator) stated that there have been no changes to the room sizes.		