

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Spring Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 777 Draper Avenue Joliet, IL 60432	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, and record review, the facility failed to provide one resident (R1) access to their funds as per their request.</p> <p>Finding include:</p> <p>R1 is a [AGE] year old male admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including infection and inflammatory reaction due to internal left knee prosthesis, hypertension, hypoglycemia, hepatitis C, and aftercare following joint replacement surgery.</p> <p>On 5/29/24 at 11:38am, V1 (Administrator) said that he spoke with R1 about a month after he was discharged and R1 said that he was looking for his Trust Fund money. V1 said he had told R1 that if he confirmed that the money was due to him, the facility would send him a refund check in the mail. V1 verified that R1's Trust Fund account showed that 60 dollars remained in the account.</p> <p>On 5/29/24 at 1:02pm V4 (Director of Accounts Receivable) verified that R1 had the funds in his account and the facility should have sent R1 the money.</p> <p>R1's Resident statement 11/03/23 - 5/1/24 showed an ending balance on 5/1/24 in the amount of \$60.04.</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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