STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146172	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, and record review, the facility failed to ensure a timely ambulance transfer for a resident experiencing respiratory distress. This applies to 1 resident (R1) reviewed for change in condition in a sample of 4. The findings include: On 6/26/25 at 11:47 AM, V6 (LPN/Licensed Practical Nurse) said on 6/22/25, R1 requested to go the emergency room multiple times because she was short of breath and didn't feel well. V6 said she called for a routine ambulance for R1, but the ambulance dispatcher told her to call 911 due to R1's abnormal vital signs. Nursing Progress Note dated 6/22/25 at 20:30 documents R1's vitals were as follows: Blood pressure 79/49, heart rate 103, respiratory rate 18, and oxygen saturation 79% on 4 liters per nasal cannula. V6 said that when she increased R1's oxygen, R1 did not say she felt better and R1 told her to call 911. On 6/27/25 at 2:25 PM, V12 ADON (Assistant Director of Nursing) said for a change condition related to respiratory distress, nursing staff should not wait and should call 911 without delay. On 6/27/2025 at 11:10 AM, V8 (LPN) stated R1 is alert an oriented and has a lot of respiratory issues with her quadriplegia diagnosis and she has a hard time coughing. V8 stated if vital signs change all at once, she would call 911. On 6/27/2025 at 1:30 PM, V9 (LPN) stated if a resident has a decrease in blood pressure with increased heart rate and is complaining of difficulty breathing, that warrants a 911 call. V9 stated R1 is a full code and she would not hesitate to call 911. On 6/26/25 at 12:28 PM, V4 (EMT/Emergency Medical Technician) said V20 (Ambulance Dispatcher) advised V6 (LPN) to call 911 due to the time it would take for ambulance to arrive, but V6 said she was going to try other ambulance companies instead. V4 said V6 called V20 back 20 minutes later requesting their service again. V4 said when she arrived at the facility on 6/22/25, there was no nurse present at R1's bedside and R1 was observed gasping for air. V4 said at 9:15 PM upon her arrival to facility, R1's vital signs were as follows; heart rate 108 bpm (beats per minute); respirations 28 bpm (breaths per minute); blood pressure was critically low at 66/46 mmHg (millimeters of mercury), and oxygen saturation was 91% on 5 liters of oxygen via nasal cannula. V4 said R1 told her that she was not usually on oxygen. Upon assessment, V4 noted R1 with diminished breath sounds in all fields. V4 said she was concerned R1's lungs sounded junky (congested). V4 said V6 did not mention why she didn't call 911. V4 said she started a breathing treatment right away and R1 was transferred to the hospital. Per V4, she was concerned because R1 is paraplegic and is unable call 911 herself. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/2025 at 2:45 PM, V2 DON (Director of Nursing) stated if an ambulance dispatcher said to call 911 instead of waiting for routine ambulance transport due to a resident's condition and vital signs, staff need to call 911. V2 said if something is off with a resident and it looks like it could be an emergency and the resident is requesting 911, the nurse should just call 911. On 06/29/25 at 2:39 PM, V19 (NP/Nurse Practitioner) said that on 6/22/25, she was notified about R1 after she was transferred to the emergency room. V19 said that if a resident's vital signs show a drop in blood pressure, a rise in heard rate, a drop in oxygen saturation (to the 70s), and an increased need for oxygen, her expectation would be for the nurse to send the resident out via 911. Per V19, the risk involved in waiting for routine ambulance transportation instead of calling 911 is that the resident could deteriorate and may even code (go into cardiac or respiratory arrest). R1's POS (Physician Order Sheet) shows an advanced directive order for Full Code. R1's Face Sheet shows medical history of acute respiratory failure with hypoxia, sepsis, shortness of breath, and quadriplegia. R1's Care Plan dated 6/06/25 shows R1 is at risk for respiratory complications due to history of pneumonia, centrilobular emphysema, and repeated hospitalizations related to shortness of breath. Care Plan interventions include staff responding promptly to all requests for assistance and anticipating R1's individual needs, monitoring for signs and symptoms of infection, and notifying R1's physician for any significant changes with the goal to improve respiratory status and be free from respiratory distress. The facility's policy titled; Emergency Care last reviewed January 2025 lists Acute Respiratory Distress as an example of residents' urgent and critical care needs. The facility's policy states the protocol for managing residents with Acute Respiratory Distress includes assessing the airway, repositioning in high fowler's position, giving respiratory treatment as ordered, and calling 911.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and maintenance of a tunneled PICC (Peripherally Inserted Central Catheter). This applies to 1 resident (R1) reviewed for central intravenous catheter line care in a sample of 1. The findings include: On 6/26/25 at 9:57 AM, V3 (Hospital RN/Registered Nurse) said when R1 was admitted to the hospital on [DATE], R1's PICC line dressing was dated 5/28/25 (22 days earlier). V3 said PICC line dressings are supposed to be changed every 7 days. R1's POS (Physician Order Sheet) shows she has a right upper chest dual lumen tunneled PICC with order for weekly site care, cap change, and dressing change. R1's MAR (Medication Administration Record) for the month of June shows documentation V8 (LPN/Licensed Practical Nurse) changed R1's dressing on 6/10/25 and 6/17/25. Both R1's TAR (Treatment Administration Record) and MAR for the month of June do not show any documentation of PICC line cap changes. On 6/27/25 at 11:11 AM, V8 (LPN) said central line dressings are changed when the resident is admitted , and then every 7 days after that, but V8 does not provide central line care including dressing or cap changes because an RN (Registered Nurse) has to do it, not an LPN. V8 said she has never received any training in the facility on changing central line dressings. V8 said she does not know how often PICC line caps need to be changed because the RNs take care of it. V8 said alcohol caps for central lines are hard to come by, but when they have some available, they use them. On 6/27/25 at 1:03 PM, V8 said if she documented something on the MAR or TAR it means she did it. V8 then stated she did document in R1's MAR that she changed her PICC line dressing on 6/10/25 and 6/17/25, but she did not change the PICC lines dressing on those dates. V8 said she would have asked an RN to change R1's PICC line dressing, but she doesn't remember who she asked. V8 said she might have forgotten to double check if R1's PICC dressing was changed. On 6/27/25 at 2:42 PM, V2 DON (Director of Nursing) said central line dressings are to be changed upon admission and every 7 days thereafter. V2 said if a nurse signs off a task was done on the MAR or TAR, it means that nurse completed the task. V2 said an LPN cannot change a central line dressing, it needs to be an RN. V2 said the she herself and another RN provide annual education on central line care to nurses, but she is not sure how often PICC line caps need to be changed or if alcohol caps are used on central lines. V2 said they do not have residents that have central lines often and it has been brought to their attention that nurses need to be reeducated on central line care. On 6/27/25 at 2:39 PM, V19 (NP/Nurse Practitioner) said she is providing care for R1 and she expects the facility staff to follow their policy regarding central line care, dressing changes, and cap changes. V19 said if central line dressings and/or caps are not changed as ordered, there is a risk of central line infection for the resident. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Guidelines for Preventing Intravenous Catheter-Related Infections last revised 9/1/2016 states, Policy: The purpose of this procedure is to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters .Catheter Site Dressing Regimens: 1. Change initial dressing after catheter placement within 24 hours .4. Change . dressings . every 5-7 days or PRN if damp, loosened, or visibly soiled. This does not require a physician's order .Replacement of Administration Sets, Needleless System Equipment: .2. Replacement of the Needleless System Equipment .b. Change needleless connections devices if there is blood or debris in the connector, before obtaining blood samples for culture, after blood draws, upon contamination, and in accordance with manufacturer recommendations . Documentation: The following information should be recorded in the resident's medical record: .2. Any interventions that were done (dressing change, cultures, etc.) .