

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  10/25/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31327</p> <p>Based on observation, interview, and record review, the facility failed to obtain physician orders for medications brought from home and to be placed at the bedside. The facility also failed to complete self-administration of medication assessments for residents. This applies to 6 of 6 residents (R14, R32, R53, R70, R91, R103) reviewed for medications in a sample of 26.</p> <p>The findings include:</p> <p>On 10/22/24 the following observations were made during initial tour:</p> <p>1. On 10/22/24 at 10:35 AM, R70 was lying in bed. On his bedside table, there was a Lidocaine pain relief roll on, a container of smooth antacid tablets, and two Bactine Max Pain Relieving Cleansing sprays. R70 stated that he brought these from home and it's always kept in his room. R70 stated no one assessed him if he could take the medications.</p> <p>Review of R70's POS shows that he has no orders for these medications and no order for them at the bedside.</p> <p>Review of R70's electronic medical record shows there was no self-administration of medication assessment done.</p> <p>R70's MDS (Minimum Data Set) dated 10/17/24 shows a BIMS (Brief Interview for Mental Status) score of 15 which means he is cognitively intact.</p> <p>2. On 10/22/24 at 11:00 AM, on R14's bedside table, there was a Deep Sea saline nasal moisturizing spray. R14 stated it's always kept in her room and she administers it by herself.</p> <p>Review of R14's POS shows she has an order for the nasal spray, but there is no order for it to be at the bedside.</p> <p>Review of R14's electronic medical record shows there was no self-administration of medication assessment done.</p> <p>R14's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 10/22/24 at 11:05 AM, on R53's bedside table there a sodium chloride nasal spray, artificial tears eye drops and gental tears eye drops. R53 stated she brought them from home. She stated she administers it by herself.</p> <p>Review of R53's POS shows she has no orders for the medications and no orders for them to be at the bedside.</p> <p>Review of R53's electronic medical record shows there was no self-administration of medication assessment done.</p> <p>R53's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact.</p> <p>4. On 10/22/24 at 11:25 AM, on R91's shelf, there was a Nystatin topical powder. R91 stated, It's always kept here.</p> <p>Review of R91's POS shows she has an order for the medication, but no order for it to be at the bedside.</p> <p>Review of R91's electronic medical record shows there was no self-administration of medication assessment done.</p> <p>R91's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact.</p> <p>5. On 10/22/24 at 11:55 AM, on R103's bedside table there was a Deep Sea nasal spray. R103 stated that it's always kept in her room and she administers it by herself.</p> <p>Review of R103's POS shows there is order for the nasal spray and no order for it to be at the bedside.</p> <p>Review of R103's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact.</p> <p>Review of 103's electronic medical record shows there was no self-administration of medication assessment done.</p> <p>R14, R53,70, R91, and R103 did not have any care plans discussing self-administration of medications.</p> <p>On 10/22/24 at 12:30 PM, V2 (DON-Director of Nursing) stated, Meds brought from home should have orders for them. Any medication that is left in the resident's room should have orders for it to be at the bedside. The resident has to be assessed if he or she can safely administer the medications. I'm the one who does it, not the nurses on the floor. The assessments are in the electronic medical record. I don't have any residents that currently self administers medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility's policy titled Self-Administration of Medications Procedure (9/2020) documents the following: 1. Residents who request to self-administer drugs will be assessed at the time of admission or thereafter, to determine if the practice is safe. This will include documentation when medications are used. 2. The assessment results will be discussed with the attending physician and an order obtained to self administer, if appropriate. 8. Drugs in the room should be written on the medication record as may keep at bedside and the expiration date. 11. Drug storage is the responsibility of the nursing staff, even when the resident self administers. 12. A care plan indicates the resident's self administering of medications.</p> <p>45906</p> <p>6. On 10/22/24 at 11:08 AM, a bottle of bisacodyl 5 mg (milligram) stimulant laxative was seen on the bedside table of R32. On 10/24/24 at 9:40 AM, R32 said she takes the bisacodyl when she is constipated. R32 said she last took the bisacodyl about a week prior and did not tell her nurse that she took it. R32 said her nurse will also give her a stool softener when she asks for it.</p> <p>On 10/24/24 at 1:53 PM, V8 (LPN/Licensed Practical Nurse) said all of her residents (including R32) get their medications from her, there are no residents that can keep their medications at the bedside. V8 said the risk with residents keeping medications at the bedside include: over-medicating, drug interactions, and another resident wandering into the room and taking the medication. On 10/24/24 at 2:28 PM, V2 (DON/Director of Nursing) said there are currently no residents in the building that are able to keep oral medications at the bedside to self-medicate. V2 said the harm in residents self-medicating includes drug interactions with their other prescribed medications and other residents coming into the resident's room and taking the medications left sitting out.</p> <p>R32's Face Sheet shows a diagnosis of constipation. R32's POS (Physician Order Sheet) does not show a current order for bisacodyl stimulant laxative. R32's POS shows an order dated 5/20/24 for Sennosides-Docusate Sodium tablet 8.6-50 mg (milligrams) 1 tablet by mouth every 12 hours as needed for constipation and an additional order dated 5/21/24 for Sennosides-Docusate Sodium tablet 8.6-50 MG 1 tablet by mouth one time a day for constipation scheduled.</p> <p>The facility's policy titled, Storage of Medications effective 10/25/14 states, Policy: Medications and biologicals are stored safely, securely, and properly .The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46409</p> <p>Based on observation, interview, and record review, the facility failed to apply splints and braces to residents who required them.</p> <p>This applies to 2 of 2 residents (R11, R15) reviewed for splints and braces in a sample of 26.</p> <p>The findings include:</p> <p>1. On October 22, 2024 at 1:12 PM, R11 was sitting in bed and the fingers on her right hand were curled inwards and she was unable to open them without assistance. R11 did not have a splint or brace applied. On October 23, 2024 at 9:56 AM, R11 did not have a splint or brace on. On October 24, 2024 at 12:44 PM, R11 did not have a splint on the right hand.</p> <p>R11's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic pain, cerebral infarction, nontraumatic intracerebral hemorrhage, and altered mental status. R11's POS (Physician Order Sheet) dated April 18, 2024 showed an order for [patient] to wear right resting hand splint during the day as tolerated. R11's Restorative assessment dated [DATE] showed R11 had Range of Motion impairment in the right upper and lower extremity and was recommended a splint/brace by the restorative nurse. R11's care plan dated April 19, 2024 showed Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and would benefit from wearing right resting hand splint during the day as tolerated to prevent further contracture of the right wrist/hand.</p> <p>On October 24, 2024 at 1:53 PM, V12 (Restorative Nurse) said R11 was supposed to wear the splint during the day as tolerated, and the splint should be on. V12 said if the splint was not applied, it could increase the contraction.</p> <p>2. On October 23, 2024 at 11:57 AM, R15 was lying in bed and there was no palm protector on the left hand. At 2:54 PM, R15 had the palm protector on the left hand but not on the right hand. On October 24, 2024 at 9:47 AM, R15 was in the dining room in her high back wheelchair, and neither hand had the palm protectors on them.</p> <p>R15's face sheet showed R15 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of muscle, multiple sites, right hand and left hand, and need for assistance with personal care. R15's POS dated October 10, 2024 showed to Apply palm protector to bilateral hands. Check skin for redness, irritation, or skin breakdown. As tolerated. The POS also showed an order dated August 15, 2024 showing to Apply palm protector to left hand. Check skin for redness, irritation, or skin breakdown. As tolerated every day shift related to contracture, left hand. R15's care plan dated August 13, 2024 showed R15 would benefit from participation in the splint/brace program. [R15] to wear bilateral palm protectors [due to] muscle stiffness manifested by [diagnosis] of CVA (Cardiovascular Accident) with hemiplegia and hemiparesis. R15's Restorative assessment dated [DATE] showed R15 was recommended to continue splint/brace usage.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 24, 2024 at 1:53, V12 said she had not had a chance to put R15's splints on that day and when she had gone to her room, R15 was already in the dining room. V12 said R15 wore palm protectors, and it was not supposed to be off. V12 said the night CNAs (Certified Nurse Assistant) took them off to give her hands a chance to breathe, but the orders did not say to remove them. V12 said if the palm protectors were not on, it could cause her hands to contract. V12 said she would expect the nighttime staff to keep it on unless they were doing hygiene. V12 said she would expect them to put them back on after the hygiene was completed.</p> <p>On October 24, 2024 at 12:56 PM, V16 (LPN/Licensed Practical Nurse) said if there were orders for splints, they should be on the residents. V16 said if the residents were refusing to wear their splints, the staff should be documenting refusals.</p> <p>On October 24, 2024 at 1:20 PM, V17 (CNA) said the restorative staff were the ones who knew who had the splints and would put them on the residents.</p> <p>On October 24, 2024 at 2:19 PM, V2 (DON/Director of Nursing) said the residents should have splints and palm protectors on. V2 said if the residents refuse to wear them, they should document refusal and the resident should be care planned for refusing to wear the splints or palm protectors.</p> <p>The facility's Activities of Daily Living (ADLS) policy dated September 2020 showed to Use orthotic device as ordered and Apply splint safely and with correct position.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46003</p> <p>Based on observation, interview and record review the facility failed to implement interventions that would prevent fall injuries and cigarette smoking hazards this applies to 6 of 11 (R15, R32, R46, R47, R73 and R93) residents reviewed for accidents in a sample of 26.</p> <p>Findings include:</p> <p>1.</p> <p>R46 admitted to the facility with diagnoses that includes cellulitis of the right lower limb, muscle wasting, protein calorie malnutrition, hemiplegia/ hemiparesis, type 2 diabetes, anxiety, glaucoma, hypertension and legal blindness. R46's MDS (Minimum Data Set) dated 9/25/24 indicates he cognitively intact and uses a manual wheelchair for mobility. Per the MDS R46 has impairment to on side of his upper extremities and require partial staff assistance with mobility.</p> <p>On 10/24/24 at 09:36AM, (R46) was being pushed by activity staff onto the smoking patio. R46's wheelchair did not have footrests attached to his chair. R46 was attempting to hold his feet off the ground as he was being pushed. While being pushed by staff R46's feet hit a raised section of the concrete. R46 yelled out watch my feet.</p> <p>2.</p> <p>R73 admitted to the facility with diagnoses that includes vascular dementia with agitation, peripheral vascular disease, Alzheimer's disease, localized swelling mass and lump to bilateral lower limbs. R73's MDS (Minimum Data Set) dated 9/12/24 indicates he has severe cognitive impairment and does not use any assistive devices for mobility. R73's current care plan states he demonstrates movement behavior that maybe interpreted at pacing or roaming related to the diagnosis of dementia and problems understanding the immediate environment. R73 demonstrates cognitive impairment related to dementia. Symptoms are manifested by poor insight, reasoning, and impulse control. R73's fall assessment dated [DATE] shows he takes 1-2 medications that may impact his fall risk, has poor vision without glasses, is ambulatory, incontinent, disoriented x 3 (person, place and time) at all times, exhibits loss of balance while standing, balance problems while walking, changes gait when walking through doorways and has decreased muscle coordination.</p> <p>On 10/22/24 at 11:27 AM, the room occupied by R73 had two beds. The unoccupied bed 2 being stored did not have a mattress and the metal bed frame was exposed.</p> <p>3.</p> <p>R93 admitted to the facility with diagnoses that includes dementia, anxiety, hypertension, muscle weakness, restlessness and agitation. R93's MDS (Minimum Data Set) dated 9/8/24 indicates she has severe cognitive impairment and does not use a mobility device. R93's fall risk assessment dated [DATE] shows she takes 1-2 medications that may impact her fall risk, ambulatory, incontinent, has a decrease in muscle coordination and has 1-2 predisposing conditions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/22/24 at 11:18 AM, R93 was walking the third-floor hallways without shoes and wearing regular socks without skid protection.</p> <p>On 10/24/24 at 01:59 PM, V2 DON (Director of Nursing) stated R73 is ambulatory and does not have a roommate. Maintenance is responsible for making sure bedframes have a mattress in place. A metal bed frame without a mattress is not safe. Someone may attempt to sit on the frame and could potentially be injured.</p> <p>Ambulatory resident should have nonskid socks or well-fitting shoes to prevent fall injuries.</p> <p>V2 DON stated R46 is blind and can self-transfer short distances, but he does not generally walk. R46 would not be walking from his room to the patio to smoke. He normally has footrests on his wheelchair and should have them in place if he is being pushed by staff in his wheelchair.</p> <p>On 10/24/24 at 02:54 PM, V10 Activity Aide stated R46 placed himself in his wheelchair. V10 stated she rolled him out to the patio to smoke. V10 stated she didn't know if he had footrests for his wheelchair. R46 feet were dragging and caught on the cement, but the issue was R46's not hers. V10 stated she may have overlooked the bump in the cement. V10 stated she did not know if having footrests would have made a difference to keep his feet up. V10 stated she is not a CNA (Certified Nursing Assistant) and not responsible to put footrests on the wheelchair. V10 stated she was not trained in wheelchair safety as she works in the activities department.</p> <p>The facility policy Safety and Supervision of Residents dated 9/2022 states the facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision and assistance to prevent accidents are facility wide priorities. Employees shall be trained and in-serviced on potential accident hazards ad how to identify and report accident hazards and try to prevent avoidable accidents.</p> <p>46409</p> <p>4. On October 22, 2024 at 10:32 AM, R15's was lying in a low air loss mattress and was angled in the reverse Trendelenburg position and the bed was not in a low position. V15 (RN/Registered Nurse) was disconnecting R15's G-tube (Gastrostomy) tube feeding and then left the room with R15's bed high. On October 23, 2024 at 9:45 AM, R15's bed was about three feet high, which was not in the lowest position. R15 did not have fall mats and her call light was behind the resident, out of reach to the resident. At 11:01 AM, V3 (ADON/Assistant Director of Nursing) came to R15's room to provide repositioning for R15 and did not lower the height of the bed, which was about four feet high off the ground. At 11:24 AM, V8 (LPN/Licensed Practical Nurse) started R15's feed and left her bed about four feet off the ground.</p> <p>R15 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of muscle, multiple sites, and a history of falling. R15's care plan dated August 13, 2024 showed [R15] is at risk for falls [related to] other injury of unspecified kidney disease; depressive episode; pressure ulcer of sacral regional stage 3; [Chronic Obstructive Pulmonary Disease; diabetes mellitus with neuropathy; aphasia following cerebral infarction; contracture of [right] shoulder, left elbow, bilateral hip, knee, and ankle; retention of urine, history of falling [As Evidenced By] inability to use call light or request staff assistance. R15's Fall Risk Review dated September 2, 2024 showed R15 was a moderate fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 24, 2024 at 1:53 PM, V12 (Restorative Nurse) said R15's bed should be in the low position and should not be elevated if no one is in the room.</p> <p>5. On October 22, 2024 at 10:52 AM, R47 was lying in bed which was about four feet off the ground. R47 had one fall mat folded up and behind the head of the bed, against the wall. On October 23, 2024 at 10:05 AM, R47's bed was at the same height, and no fall mats were in place or found in the room. On October 24, 2024 at 9:49 AM, R47's bed was around three feet off the ground and there were no fall mats in place.</p> <p>R47 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, dysphagia, and dysarthria. R47's MDS (Minimum Data Set) dated August 1, 2024 showed R47 had moderate cognitive impairment. R47's care plan dated January 26, 2024 showed [R47] is at risk for falls [related to Cardiovascular Accident] with hemiplegia. [R47] prefers to keep bed in high position .with interventions including Floor mats on both sides of the bed. R47's Fall Risk Review dated August 1, 2024 showed R47 was a moderate fall risk.</p> <p>On October 24, 2024 at 1:53 PM, V12 said R47 liked his bed high, and they have spoken to him about the height of the bed. V12 said they were supposed to put floor mats on both sides of R47's bed when he was in bed, and she was not aware they were not in place.</p> <p>On October 24, 2024 at 12:47 PM, V11 (LPN) said the height of the bed should be in the lowest position for residents on fall precautions as it was a shorter distance if the resident did fall and could cause less injury. V11 said if the resident was care planned for fall mats, they should be in place.</p> <p>On October 24, 2024 at 12:56 PM, V16 (LPN) said the height of the bed should be at the lowest position and this would prevent them from falling from higher heights and if the resident's fall prevention interventions include fall mats, the fall mats should be in place. V16 said the fall mats were to soften the fall.</p> <p>On October 24, 2024 at 1:20 PM, V17 (CNA/Certified Nurse Assistant) said the resident's bed should not be in a high position. V17 said if a resident was a fall risk, the bed should be low, the rails should be up, and the fall mats should be in place. V17 said the fall mats help the resident not hit their head on the floor. V17 said R47 liked his bed high up but said he does have fall mats. At 1:24 PM, V17 looked at R47's bed and said she did not pay attention to see if he had his fall mats in place.</p> <p>On October 24, 2024 at 1:32 PM, V3 (ADON/Assistant Director of Nursing) said there should be fall mats in place if there was a care plan for fall mats to be in place.</p> <p>On October 24, 2024 at 2:19 PM, V2 (DON) said the bed should be in the lowest position if residents were at risk for falling. V2 said R47 would manipulate his own bed height and preferred to be up high. V2 said fall mats should be in place if it was in his care plan as an intervention, as the fall mat was used to try to reduce the risk for injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility was unable to provide a Fall Prevention policy. The facility provided a Safety and Supervision of Residents policy dated September 2022 which showed, Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. assigning responsibility for carrying out interventions; d. ensuring that interventions are implemented . Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently.</p> <p>45906</p> <p>6. On 10/22/24 at 11:08 AM, a lighter that said keep your spirit high was found on the bedside table of R32 next to an aerosol spray can of body spray.</p> <p>On 10/24/24 at 9:40 AM, R32 said she does not smoke cigarettes, she only smokes weed. R32 said she had never been assessed for safe smoking. R32's MDS (Minimum Data Set) dated 10/1/24 shows her cognition is intact.</p> <p>R32's Care Plan initiated on 5/9/24 states the resident will be monitored to fully assess compliance and ability to smoke independently. R32's most current Smoking Risk Review assessment dated [DATE] was completed by V5 (SSD/Social Services Director), which shows R32 may not be capable of handling/carrying any smoking materials and requires supervision when smoking.</p> <p>On 10/23/24, during the survey, V5 (SSD) revised R32's Care Plan, after being made aware of R32 having a lighter in her possession. V5 revised R32's Care Plan on 10/23/24 to say that R32 demonstrated compliance with safe smoking. V5 updated R32's Care Plan without completing a new Smoking Risk Review Assessment.</p> <p>On 10/24/24 at 12:23 PM, V5 (Social Services Director) said he was unsure if R32 smoked or not, as he did not always go outside with the smoking residents.</p> <p>On 10/24/24 at 1:53 PM, V8 (LPN/Licensed Practical Nurse) said R32 requires supervision with smoking and her last smoking assessment on 10/1/24 said R32 may not be capable of carrying smoking materials.</p> <p>On 10/24/24 at 2:28 PM, V2 (DON/Director of Nursing) said if a resident is not safe to smoke independently, their smoking materials should be kept with the staff, so they do not attempt to smoke without supervision, risking their safety.</p> <p>The facility's undated policy titled, Facility Smoking Safety Policy states, Policy Objective: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member, and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. Guidelines: 1 .The facility has the right to enforce a policy prohibiting residents from keeping any smoking materials in his/her possession for health, safety, and security reasons .3. Smokers will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials. Residents requiring supervision shall receive this monitoring consistent with their assessment and plan of care .</p>		

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NAME OF PROVIDER OR SUPPLIER  Spring Creek		STREET ADDRESS, CITY, STATE, ZIP CODE  777 Draper Avenue Joliet, IL 60432	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>46409</p> <p>Based on observation, interview, and record review, the facility failed to check R15's G-tube (Gastrostomy) placement prior to administration of G-tube feeding and administer the feeding at the ordered rate.</p> <p>This applies to 1 of 1 resident (R15) reviewed for G-tube feeding administration in a sample of 26.</p> <p>The findings include:</p> <p>R15 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, dysphagia, and gastrostomy. R15's POS (Physician Order Sheet) dated August 9, 2024 showed R15 was NPO (Nothing By Mouth). R15's POS also showed R15 had an Enteral Feed Order every shift Vital 1.5 [at] 75 ml/hr [times] 20 hours (or until total volume of 1500 cc in 24 hours) via G-tube. Stop at 6 am. Start at 10 AM. Hold if residual [greater] 100. Enteral Feed Order every shift check tube placement and function [every] shift. Check residual before administering feeding; hold if residual [greater] 100 ml.</p> <p>On October 22, 2024 at 10:43 AM, R15's G-tube was started and was running at a rate of 70 ml/hr (Milliliters per Hour). At 11:06 AM, V3 (ADON/Assistant Director of Nursing) came to R15's room, turned off her G-tube feeding, and transferred R15 to her high back wheelchair. R15 was taken from her room to the dining room without the G-tube feeding. At 12 PM, R15 was observed in the dining room without the G-tube feeding connected.</p> <p>On October 23, 2024 at 11:01 AM, R15 did not have the G-tube feeding connected or started. At 11:14 AM, V8 (LPN/Licensed Practical Nurse) came to R15's room to start the G-tube feeding. V8 put her stethoscope on and pushed air into the G-tube with the piston syringe to check for placement. V8 did not check the residual by aspirating the stomach contents prior to starting R15's G-tube feeding. V8 then restarted the feeding pump, which was already set to the rate of 70 ml/hr and started the feeding. At 3:33 PM, R15's G-tube feeding was still running at 70 ml/hr. The surveyor checked the label of the bottle, and V8 had written the rate of 75 ml/hr on the sticker.</p> <p>On October 24, 2024 at 10:12 AM, V11 (LPN) started to set the G-tube feed up for R15. V11 began to flush 300 ml of water into the G-tube. V11 did not check placement by checking for residual prior to flushing the G-tube with water. V11 attached the tubing to R15's G-tube port, said R15's rate was 70 ml/hr, turned the pump on, which was programmed to 70 ml/hr, and started the feeding at a rate of 70 ml/hr.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 24, 2024 at 12:47 PM, V11 (LPN) said she should have checked the placement by either auscultating or by withdrawing the contents. V11 said she should have checked the placement prior to starting the feeding. V11 also said R15's formula feed rate was 75 ml/hr, which was what was written on the MAR (Medication Administration Record). V11 said she just turned the machine on and should have checked the machine prior to leaving the room. V11 checked R15's POS, and said the other G-tube resident received 70 ml/hr. V11 said R15 was supposed to be weighed depending on the doctor's orders, and V11 was a weekly weight on Tuesdays. V11 said the last weight documented was 177.8 pounds on October 3, 2024. At 1 PM, V11 went to R15's room and looked at R15's pump and said she normally had it at 75 ml/hr and the rate must have been what was on previously. V11 said she would correct the rate and should have checked placement by checking the residual. At 1 PM, V11 said the nurse was responsible to make sure the CNAs were getting the weights.</p> <p>On October 24, 2024 at 12:56 PM, V16 (LPN) said prior to starting a G-tube feeding, she would assess the bowel sounds and check for placement by pushing 10 cc [milliliters] of air through the syringe. V16 said she also checked by pulling back to check for residual. V16 said if there was more than 100 ml, she would hold the feeding and call the doctor. V16 said she would check the POS to know which rate the resident was supposed to get.</p> <p>On October 24, 2024 at 1:32 PM, V3 (ADON/Assistant Director of Nursing) said to check for placement, the nurse should pull back to check for residual volume to be less than 60 ml. V3 said for R15, the nurse would hold the feeding and notify the physician if the residual volume was more than 100 ml. V3 said if the nurse did not check for residual prior to starting a feeding, the resident could experience emesis, and the G-tube could have shifted and popped out. V3 said the facility staff should not push air to check for placement.</p> <p>On October 24, 2024 at 2:19 PM, V2 (DON/Director of Nursing) said it was her expectation that the nurses aspirate and then return the feeding to check the residual prior to starting a G-tube feeding. V2 said pushing air in and auscultating was an old practice. V2 said pushing air and not checking for residual was not how to check for placement. V2 said the staff should check for placement to make sure the feed was going to the right place. V2 said the resident could have an adverse effect if the feed goes somewhere it was not supposed to go. V2 also said the staff should check the doctor's orders to confirm the rate the resident was supposed to be on. V2 said the staff should be programming the pump themselves, not just restarting the feed. V2 said the risk was it could result in the resident not getting enough nutrition they were needing.</p> <p>The facility's Gastrostomy or Jejunostomy Feedings policy dated September 2020 showed to Refer to MAR for orders for feeding amount frequency and water flushes before beginning .Do not give feeding if resident indicates any distress or retention. Residual or retention can lead to regurgitation or aspiration .Insert barrel of syringe into tube. Aspirate tube to check for placement and for excess residual. Because amount of residual may affect volume of formula to be given, consult with physician regarding orders for specific resident.</p> <p>The facility's Weight Assessment and Interventions policy revised January 2024 showed Ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>46409</p> <p>Based on interview and record review, the facility failed to staff Registered Nurses (RNs) 8 consecutive hours, 7 days a week.</p> <p>This has the potential to affect all the residents in the facility.</p> <p>The findings include:</p> <p>The facility's 671 (Long Term Care Application for Medicare and Medicaid) dated October 22, 2024 documents a total of 107 residents in the facility.</p> <p>On October 23, 2024 at 3:11 PM, the surveyor and V18 (Scheduler/CNA/Certified Nurse Assistant) went over the schedule from September 28, 2024 through October 23, 2024. V18 said there were managers on call every weekend, which included V2 (DON/Director of Nursing), V3 (RN), V19 (Wound Care Nurse/RN), V7 (Infection Preventionist/LPN), V18 (Scheduler/CNA) and V12 (Restorative Nurse/LPN).</p> <p>-On Sunday, September 29, 2024, the schedule showed there was no RN in the facility for 24 hours. The on-call manager schedule showed V18 was on call the weekend of September 29, 2024.</p> <p>-On Sunday, October 13, 2024, the schedule showed there was no RN in the facility for 24 hours. The on-call manager schedule showed V2 (DON) was on call the weekend of October 13, 2024.</p> <p>-On Saturday, October 19, 2024, the schedule showed there was no RN in the facility from 12 AM until 11 PM. At 11 PM, an RN came to the facility, but did not meet the standard requirement of RNs on site for 8 hours consecutively. The on-call manager schedule showed V19 was on call the weekend of October 19, 2024.</p> <p>On October 24, 2024 at 1:47 PM, V3 (ADON) said she worked Monday through Friday and did not work on the weekends unless something was happening at the facility. V3 said she did not work September 29, 2024, October 13, 2024, or October 19, 2024.</p> <p>On October 24, 2024 at 1:48 PM, V19 (RN) said she worked Monday through Friday and did not work on the weekends unless necessary. V19 said V3 and V19 had not had to come to the facility in September or October 2024 when they were on call.</p> <p>On October 24, 2024 at 3:08 PM, V2 (DON) said she did not have documentation to show she was in the facility on September 29, 2024, October 13, 2024, or October 19, 2024. V2 said it was a goal to have an RN in the facility for 8 hours a day, but for weekends, she would need to check and get back to the surveyor on the answer.</p> <p>On October 24, 2024 at 3:20 PM, V1 (Administrator) said he was aware the facility needed to have RNs in the building minimally 8 hours a day. V1 said he was not aware there were days there were no RNs in the building.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Registered Nurse Staffing policy dated January 2024 showed The facility shall ensure that a Registered Nurse is available for supervision in the facility .The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, except when waived.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48526</p> <p>Based on observation, interview, and record review the facility failed to administer medications as ordered.</p> <p>There were 30 opportunities with 3 errors resulting in a 10% error rate.</p> <p>This applies to 1 of 4 residents (R82) observed in the medication pass.</p> <p>The findings include:</p> <p>On 10/23/24 at 8:05 AM V15 (Registered Nurse) administered one tablet of Folic Acid 1000 mcg, one tablet of Torsemide 20 mg, one tablet of Soanz (Torsemide) 60 mg to R82. V15 did not administer Ezetimibe 10 mg to R82 as ordered.</p> <p>On 10/23/24 at 12:15 PM V15 stated Torsemide and Soanz are the same thing. V15 stated she administered Torsemide 20 mg and Torsemide 60 mg to R82. V15 stated she did not administer Ezetimibe 10 mg to R82 due to the resident not having any, but she signed it as given in the MAR (MAR/Medication Administration Record).</p> <p>R82's Order Summary Report for October 2024 showed R82 was prescribed Ezetimibe 10 mg one tablet by mouth in the morning, Folic Acid 400 mcg one tablet by mouth in the morning, and Torsemide 60 mg one tablet by mouth in the morning. R82's Order Summary Report for September 2024 showed Torsemide 20 mg was discontinued on 09/28/2024. R82 did not have active orders for Torsemide 20 mg. R82's MAR did not show Torsemide 20 mg.</p> <p>On 10/24/24 at 2:11 PM V2 (Director of Nursing) residents should not receive another dosage of medication other than what is prescribed. It is not following the doctor's orders. Medications that have been discontinued should not be in the med cart. Adverse reactions could happen, depending on the medications. If medications are not available, the nurse should obtain the medication from the Nexus machine. If the medication is not in the Nexus machine, we would call the pharmacy to obtain the medication. The nurse should not sign out a medication stating it was administered if it was not given.</p> <p>R82 was admitted to the facility on [DATE] with multiple diagnoses which included hypertension, hyperlipidemia, lymphedema, and atrial fibrillation. R82's MDS (MDS/Minimum Data Set) dated 09/04/24 showed R82 was cognitively intact.</p> <p>The Facility's Policy for Administering Medications issue date 1/1/2020 showed Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure: 3. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that particular drug and document a rationale.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31327</p> <p>Based on observation, interview, and record review, the facility failed to remove expired food items, clean the refrigerator, complete temperature logs, and have a thermometer in residents' personal refrigerators in their room. This applies to 3 of 3 residents (R14, R56, R95) in a sample of 26 reviewed for refrigerators.</p> <p>The findings include:</p> <p>1. On [DATE] at 10:51 AM, R95 was in her room. Inside, she had a small refrigerator with some bottles of soda. There was no thermometer inside. R95 did not have a log sheet as well. R95 stated her refrigerator was new and she had never seen staff check her refrigerator.</p> <p>R95's MDS (Minimum Data Set) dated [DATE] shows a BIMS (Brief Interview for Mental Status) score of 14, which means she is cognitively intact.</p> <p>2. On [DATE] at 11:00 AM, R14 stated the staff don't check her refrigerator or remove expired items. R14 told surveyor she didn't know that she had a lot of expired food in her fridge. She had surveyor throw them out in her garbage can. Inside her refrigerator, the following items were found: Two (,d+[DATE] pint) cartons of vitamin D whole milk with a best by date of [DATE], 2 French vanilla cartons of yogurt that expired on [DATE], 1 vanilla [NAME] drink that expired on [DATE], 2 cartons of yogurt that expired on [DATE], 1 carton of key lime pie flavored yogurt that expired on [DATE] and 1 low sugar tropical fruit drink that expired on [DATE]. R14 did not have thermometer in the fridge. On [DATE], V1 (Administrator) submitted copies of temperature log sheets for resident refrigerators from housekeeping. There was no log sheet for R14.</p> <p>R14's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact.</p> <p>On [DATE] at 9:34 AM, V1 (Administrator) stated, Housekeeping is responsible for checking the residents' refrigerators. There should be a thermometer in each fridge. They should be doing the log sheets. They should also remove any expired items.</p> <p>Facility's policy titled Policy &amp; Procedure-Food Brought into the Facility by Friends/Family/Others (Outside Sources) for Residents (,d+[DATE]) documents the following: Procedure: 1. Any food or beverage brought into the facility by friends/family/others for resident consumption will be encouraged to be checked by a nursing staff member. Any suspicious or obviously contaminated items (due to appearance/odor or expiration date that has passed-if the food is packaged by the manufacturer) will be discarded immediately. An explanation will be provided to the party who brought it in. 3. Facility staff will monitor resident rooms and resident personal refrigerators for safety needs. 5. All refrigerators in use in the facility have an internal thermometer to monitor temperature. All refrigerators have their internal temps recorded daily.</p> <p>48526</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. On [DATE] at 10:25 AM R56's personal refrigerator in her room contained six oranges that were old, soft, brown, with mold on them. One 16-ounce container of half and half with an expiration date of [DATE]. One half pint of two percent milk with an expiration date [DATE]. One cup of vanilla pudding with an expiration date [DATE]. The refrigerator was cluttered and sticky. The freezer was filled with ice and contained six pot pies, and two frozen pizzas. R56 stated she eats the food in the refrigerator and freezer. R56 stated housekeeping cleans her refrigerator. R56 stated she did not know the last time they cleaned it. R56 stated she is unable to clean it on her own.</p> <p>On [DATE] at 10:41 AM The refrigerator continued to contain six oranges that were old, soft, brown, and mold on them. One 16-ounce container of half and half with an expiration date of [DATE]. One half pint of two percent milk with an expiration date of [DATE]. One cup of vanilla pudding with an expiration date [DATE]. The refrigerator remained cluttered and sticky. The freezer continued to be filled with ice and the six pot pies, and two frozen pizzas.</p> <p>On [DATE] at 10:42 AM V9 (Housekeeper) stated she is the housekeeper for R56's room. V9 stated she is supposed to clean the residents refrigerator out. V9 stated she does not know why R56's refrigerator was not cleaned out.</p> <p>On [DATE] at 10:49 AM V3 (Assistant Director of Nursing) stated R56 should not have old or expired food in her refrigerator. V3 stated R56 could get sick, food poisoning, or diarrhea. V3 stated the fruit in R56's refrigerator is not edible and the milk and is not drinkable. V3 stated the housekeeping department is responsible for cleaning the refrigerators. The refrigerators should be checked weekly and cleaned as needed.</p> <p>R56 was admitted to the facility on [DATE] with multiple diagnoses which included cerebral infarction, hemiplegia and hemiparesis, peripheral vascular disease, major depressive disorder, anxiety, and chronic pain syndrome per the face sheet. R56 MDS dated [DATE] showed R56 was cognitively intact. The same MDS showed R56 had an impairment on one side of her upper and lower extremity.</p>		