STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016786	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK	777 DRAPER AVENUE JOLIET, IL 60432

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S 000	Initial Comments Complaint Survey: 2477006/IL177507	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements wereNOT MET as evidenced by: Based on interview and record review, the facility	S9999		

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failed to provide supervision to a cognitively impaired resident, while outdoors, to prevent prolonged sun exposure that resulted in burns to the skin.

This applies to 1 of 3 (R1) residents reviewed for improper nursing care.

This failure resulted in R1 obtaining full thickness burns to the upper back and posterior neck due to prolonged sun exposure.

The findings include:

R1 was identified by the facility with a skin condition incident report dated July 28, 2024, and identified on the facility wound report as a resident with full thickness skin injury.

R1's "New Skin Condition" report, dated July 28, 2024, written by V9 (RN) showed R1 was noted with blisters left shoulder to mid back. The report also showed R1 required a cream be applied to R1's face and arms. On September 9, 2024, at 2:43 PM, V9 stated that she recalls R1's face and arms were also discolored and required treatment and stated the skin injuries were determined to be caused by sunburn.

R1's "Initial Wound Evaluation and Management Summary" dated July 29, 2024, documented by V3 (Wound Physician) identified a "burn wound to the left upper back full thickness" that measured 5.3 x 14.3 x 0.1 cm (centimeters) that required debridement and identified a second wound "burn wound to the posterior neck full thickness" that measured 2.1 x 1.5 x 0.1 cm.

On September 9, 2024, at 3:05 PM, V3 stated the cause of R1's wounds were from sunburn due to

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prolonged sun exposure. V3 identified R1 as having dementia and stated to prevent sunburn, facility staff should know how long R1 was exposed to the sun especially since R1 was cognitively impaired. V3 stated R1's dementia had also resulted in delayed wound healing due to R1's behavior of removing the wound dressing and not eating resulting in weight loss.

R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on January 18, 2024, with multiple diagnoses including chronic obstructive pulmonary disease, Alzheimer's disease unspecified, fibromyalgia, basal cell carcinoma of the skin overlapping sites, chronic pain syndrome, and adjustment disorder with mixed anxiety and depressed mood.

R1's MDS (Minimum Data Set) dated June 25, 2024, showed R1 was severely cognitively impaired, and required assistance with ADL's including dependent on staff assistance for bathing, required substantial staff assistance with dressing, toileting and personal hygiene, supervision with bed mobility, transfer and walking 150 feet and set up assistance with eating.

On September 9, 2024, at 3:54 PM, V13 (LPN) stated she worked on July 28, 2024, during the day shift on R1's unit. V13 stated the door to the patio was left unlocked so independent residents and staff were able to exit at any time. V13 stated R1 was able to ambulate independently and liked to go outside a lot. V13 stated it was possible for R1 to go outside and staff may or may not have known when R1 did go out.

On September 9, 2024, at 11:50 AM, R1 was seated in a reclining padded wheelchair, in the

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dining room and being fed an ice slushy drink by V6 (CNA) with V7 (CNA) in attendance. V6 stated R1's condition is declining, R1 is not eating, and she is walking less and R1 use to independently walk around the unit and liked to go outside on the patio. V7 stated R1 was able to ambulate independently and like to go outside at the time R1 was found with the sunburn.

R1's progress note dated September 6, 2024, at 1:54 PM, written by V5 (LPN) showed R1 was noted to be walking down the hallway when staff noted a skin tear to R1's left forearm, with an unknown etiology.

On September 9, 2024, at 4:10 PM, V14 (Activity Assistant) stated on July 28, 2024, she worked from 8:30 AM until 4:45 PM and supervised the patio during the smoking breaks, as she does as part of her daily work assignment. V14 stated the patio doors are kept unlocked however V14 takes smoking group outside for 15-20 minutes at a time during the smoking times of 9:30 AM, 11:30 AM, 2:00 PM, and 4:30 PM. V14 stated when the smoking group is over V14 returns to do her activity groups inside the building. V14 stated other than the assigned smoking breaks staff are not assigned to supervise outside. V14 stated she has worked in the facility for 5 months and is unsure who R1 is.

R1's care plan with date initiated of January 29, 2024, problem statement showed R1 was known to have a movement behavior which may be interpreted as wandering, pacing, or roaming and had problems understanding the immediate environment. R1's care plan had an intervention added to the care plan on June 25, 2024, that showed " If the resident leaves the building, goes in a peer's room, or becomes aggressive, redirect

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by: Walk in the same direction as the resident. Do not initially try to "force" the person to change direction. Chat with the resident about his/her "theme." Eventually, use a strategy such as therapeutic fib to bring the person to the area where you would like him or her to be".

On September 9, 2024, at 4:03 PM, V2 (DON, Director of Nursing) stated there is no investigation regarding how long R1 was outside in the sun, and when and how long the sun exposure occurred prior to the sunburn and remains unknown. V2 did state the patio door was unlocked and remains unlocked during daytime hours. V2 stated the redness to R1's upper back and neck was first reported during the evening shift (3PM-11PM) on July 27, 2024, the redness then developed into blisters on July 28, 2024. V2 stated there is not a log of when people go outside the patio door to determine how long someone such as R1 was subjected to sun exposure, even during the weather change to hot, sunny weather. V2 stated that R1's caregivers were unable to identify the amount of time or when R1 was on the patio exposed to the sun that resulted in the sunburn. V2 stated there is no facility policy regarding Supervision of Residents while outdoors on the patio.

(A)