STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145372	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Joliet, The	306 North Larkin Avenue Joliet, IL 60435

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to monitor and check glucose blood sugar levels for a resident with a known history of Diabetic Ketoacidosis and elevated blood sugars. This failure resulted in R1 needing hospitalization for Diabetic Ketoacidosis (grossly elevated blood sugars). This applies to 1 of 3 residents (R1) review for Diabetes and blood glucose monitoring in the sample of 4. The findings include: Face sheet shows R1 is [AGE] years-old who has multiple diagnoses which include acute embolism and thrombosis of deep veins of upper extremity, bilateral, type 2 diabetes mellitus with ketoacidosis without coma, cardiac arrest due to other underlying condition, cardiac arrest, cause unspecified, diabetes mellitus due to underlying condition with ketoacidosis without coma, elevated white blood cell count, unspecified, schizoaffective disorder, bipolar type, acute kidney failure, unspecified, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, acute respiratory failure with hypoxia, unspecified protein-calorie malnutrition, anemia in other chronic diseases classified elsewhere, hyperkalemia, pneumonia due to streptococcus, group b, pneumonia due to klebsiella pneumoniae, sepsis, unspecified organism, acute diastolic (congestive) heart failure, metabolic encephalopathy, hypoxic ischemic encephalopathy, unspecified, acute metabolic acidosis, type 2 diabetes mellitus with hyperglycemia, essential (primary) hypertension, other hypotension, other symptoms and signs involving cognitive functions and awareness, relevant medical history is: CHF diabetes chronic renal failure/ESRD. Nurse Practitioner Notes, dated May 17, 2024, shows R1 is a [AGE] year-old male who was admitted to the facility on [DATE], after suffering a cardiac arrest and was resuscitated in the emergency room . R1 was also diagnosed with DKA (Diabetic Ketoacidosis), AKI (Acute Kidney Injury), EKG showed right bundle branch block, septal infarct, MI (Myocardial Infarction). In the ER, R1 became bradycardic and went into cardiac arrest. His blood sugar was 1229 mg/dL (milligram per deciliter). Medication Administration Record (MAR) showed R1's blood sugar level is to be monitored every 7:30 AM, 12:00 PM, and 4:30 PM. The same MAR shows Insulin Aspart 35 units was given twice a day (9 AM and 5 PM) and 15 units every 12 PM. Humalog Insulin sliding scale was also prescribed according to the blood sugar result every 7:30 AM, 12 PM, and 4:30 PM. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145372	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Joliet, The	306 North Larkin Avenue Joliet, IL 60435

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(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 - Actual harm Residents Affected - Few	R1's blood glucose monitoring log shows the following readings: 5/21/2024, at 1:14 PM- 400.0 mg/dL, 5/21/2024 at 5:04 PM- 345.0 mg/dL, 5/22/2024 at 9:20 AM- 400.0 mg/dL, 5/22/2024 at 4:33 PM- 350.0 mg/dL, 5/22/2024 at 4:34 PM- 399.0 mg/dL, 5/23/2024 at 6:15 AM- 600.0 mg/dL. R1's blood glucose monitoring from May 21 at 1:14 PM through May 22, 2024, at 4:34 PM showed his blood sugar level was consistently elevated, ranging from 345 mg/dL to 400 mg/dL, despite routine Insulin dose plus sliding scale order. The progress notes of the same dates lacked documentation the staff rechecked R1's sugar after dinner and at bedtime, or monitored R1 for change in condition. There was no documentation of notifying V4 (R1's Physician) of R1's consistent elevation of sugar level despite the insulin doses. On May 23 at 6:15 AM, R1's blood sugar level was 600 mg/dL. R1 displayed lethargy and slurred speech, resulting to being sent and admitted to the hospital with diagnosis of diabetic ketoacidosis (DKA). R1's health status notes, dated May 23, 2024 at 9:15 AM, shows R1was found on floor the floor lying on his back. R1 was lethargic with slurred speech. R1's blood sugar level reads high. R1 was given insulin coverage per V4's order. R1's glucose level was rechecked, results showed HI (High). R1 was sent the hospital emergency department via 911. Hospital Physician Endocrinology Report, dated May 24, 2024, shows R1 was seen in consultation for management of type 2 diabetes with hyperglycemia. R1 was brought into the hospital from the nursing home facility after an unwitnessed fall and altered mental status. Upon admission, R1's sugar was quite elevated, and he was acidotic. The same hospital record shows on May 23, 2024, at 9:47 AM, R1's blood glucose level was 810 mg/dL, his Ketones result showed 5.7 mmol/L, which was also very high. On May 28, 2024, at 4:00 PM, R1 was observed in the hospital. He was resting on his bed awake but confused. R1 was only oriented to himself and to his family. R1 was on 2-point soft restraint to his upper extremities only. V12 (Hospital Nurse) stated when R1 first got admitted to the hospital, his blood sugar was very high; he had DKA. R1 was initially placed in ICU (Intensive Care Unit) and was later transferred to the medical floor. On May 29, 2024, at 8:55 AM, V6 (Nurse) stated R1 got up from bed without calling for help and fell . V6 assessed R1 and checked his vital signs, including his blood sugar level. R1's sugar registered HI (High). When he fell , he did not sustain injury, he just said he was getting up. He was sent to the hospital because he had slurred speech. When V6 rechecked R1's sugar, it remained high despite being given Insulin (Humalog) 10 units. On May 29, 2024, at 1:55 PM, V4 (R1's Physician) stated, For brittle diabetics, the standard glucose monitoring is 3-4 times a day, and as needed. When R1's glucose level was consistently elevated despite administration of prescribed insulin, the staff should have rechecked the sugar 2 hours after dinner and rechecked it again at bedtime. If there was no order, the staff should have called me. V4 stated the staff should have reported R1's condition to him and he could have given new orders for care and review the medications and see if it needed adjustment. V4 added when the blood sugar is consistently elevated, the staff should follow up with the physician, and closely monitor resident's condition and sugar level.