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	10/04/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48944 Based on observation, interview, and record review, the facility failed to assess and obtain treatment orders for a resident (R2) with known skin tears. This applies to 1 of 4 residents (R2) reviewed for quality of care. The findings include: R2's Care Plan, dated 10/02/2024, said R2 was at risk for potential impairment of the skin integrity related to fragile skin and a history of skin tears. R2's care plan showed multiple interventions including, If skin tear occurs, treat per facility protocol and notify MD . Monitor/document location, size, and treatment of skin tear . On 10/02/2024 at 11:24 AM, R2 was observed with a dressing on her right lower leg. R2 was confused and not interviewable. At 12:20 PM, V3 (Wound Care Nurse/WCN) and V4 (Wound Care Aide) were asked to assess R2's right lower leg dressing. V3 said she was not aware of R2 having active wounds. V3 said R2 had frail skin and was prone to skin tears. V3 removed R2's right lower leg dressing, and R2 had two dry scabs to her mid-shin and lower lateral areas. Then V3 noticed R2 had other dressings on her left lower leg and bilateral upper arms. V3 removed R2's dressings to assess her extremities, R2 had old, opened skin tears to her left mid-shin and right elbow, and then had another skin tear to her left upper arm which was actively bleeding. V3 said she was unaware of R2's opened skin tears, and R2 did not have treatment orders in her EMR (Electronic Medical Record). Then V3 said she asked V15 (Registered Nurse/RN) about R2's skin tears, and V15 said they were last changed by V16 (Hospice RN) on 9/30/2024. V3 said she would return to assess R2's wounds and notify the physician to obtain treatment orders. V3 said all wounds need to be reported to the wound care and be assessed and documented weekly. On 10/02/2024 at 1:30 PM, V15 (RN) said on 9/30/2024, she asked V16 (Hospice RN) to change R2's soiled dressings on her lower legs and right elbow. V15 said she was unaware of R2's left upper arm skin tear. V15 said R2 did not have skin tear treatment orders, and was unsure where V16 documented R2's weekly hospice visit. (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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(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	On 10/03/2024 at 12:05 PM, V16 (Hospice RN) said she visited R2 weekly for hospice services. V16 said she was asked by V15 to change R2's dressings on 9/30/2024. V16 said she did not have access to R2's facility EMR to check her treatment orders. V16 said she applied the same type of dressings she removed from R2's extremities. V16 said she changed R2's right elbow and left upper arm dressings. V16 said she also applied protective dressings to R2's lower legs. V16 said the facility nursing staff should be monitoring hospice residents' wounds and treating them per their protocol. V16 said hospice nursing staff does assist the facility staff with providing routine care, including wound care, during scheduled weekly visits. V16 said she was not aware of how R2 sustained her skin tears, but knew R2 was prone to skin tears. V16 said she made a notation of R2's wounds and treatments she observed in R2's weekly hospice documentation. On 10/02/2024 at 4:05 PM, V2 (Director of Nursing/DON) said she expects staff to be assessing residents' skin and reporting any abnormalities including skin tears. V2 said she also expected nurses to obtain wound care orders and enter them in the residents' EMRs and notifiy V3 (WCN). V2 said she was unsure when R2's skin tears were identified because R2's EMR did not have active wound care orders for her current skin tears. R1's Order Summary Report reviewed on 10/02/2024 did not show treatment orders for R2's right elbow, left lower leg, and left arm wounds prior to 10/02/2024. The facility does not have documentation to show R2's right elbow, left lower leg, and left arm wounds were assessed by the facility prior to 10/03/2024. R2's Wound Assessment Details Report, dated 10/03/2024, documented R2's left arm skin tear wound was assessed on 10/03/2024. The report said R2's wound measured 2.8 cm in length x 2.6 cm in width x 0.1 in depth. The report said R2's wound was partially-thickness with a light amount of serosanguineous drainage. R2's Wound Assessment Details Report, dated 10/03/2024, documented R2's left lower leg front skin tear wound was assessed on 10/03/2024. The report said R2's wound measured 3 cm in length x 2.5 cm in width x 0.1 in depth. The report said R2's wound was partial-thickness with a light amount of serous drainage. R2's Wound Assessment Details Report, dated 10/03/2024, documented R2's right elbow skin tear wound was assessed on 10/03/2024. The report said R2's wound measured 1.2 cm (centimeters) in length x 0.4 cm in width x 0.1 in depth. The report said R2's wound was partial-thickness with a scant amount of serous drainage. The facility's policy titled Wound Prevention and Healing, dated 6/01/2024, showed, Policy Statement: To provide wound care treatment/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician. 1. Risk Assessment and Prevention c. Skin will be inspected during showers, following orders for daily or weekly skin checks as scheduled, and PRN. 2. Wound Assessment and Documentation Tool a. Complete the Wound Assessment Record when a wound is identified, weekly and or as needed. The facility's policy titled Hospice Program dated 6/05/2024 showed, 8. Facility will be responsible to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48944 Based on observation, interview, and record review, the facility failed to report a new skin alteration for a resident (R3) with a known history of a right hip pressure injury. This failure resulted in R3's right distal hip stage 3, and right proximal hip stage 2, new facility-acquired pressure injuries not being assessed and treated once identified. This applies to 1 of 3 residents (R3) reviewed for pressure wounds. The findings include: R3's EMR (Electronic Medical Record) showed R3 had multiple diagnoses including a history of pressure injuries, sequelae of cerebral infarction, traumatic subarachnoid hemorrhage, peripheral vascular disease, major depressive disorder, anxiety, dementia, neuropathy, cervical disc degeneration, hypertension, dysphagia, right eye blindness, and malnutrition. R3's MDS (Minimum Data Set), dated 7/04/2024, showed R3 was dependent on staff assistance for personal hygiene and required substantial to maximal two-staff assistance with bed mobility. R3's EMR showed R3 was at risk for developing pressure injuries because R3 had a history of a facility-acquired stage 3 pressure injury to her right hip. On 10/02/2024 at 10:10 AM, R3 was in bed on her right side. At 10:47 AM, R3 was still in the same position. Surveyor asked V5 (Certified Nurse Assistant/CNA) to do a skin check on R3. V5 initially said R3 had no wounds. Then V5 turned R3 on her left side, and R3 had uncovered open areas on her right hip. Then V5 said she had observed those new open areas on R3's hip earlier in the shift during care. V5 said her shift started at 6 AM. V5 continued to say she would now go notify V8 (Licensed Practical Nurse/LPN). At 11:07 AM, V8 (LPN) said she was not aware of R3 having wounds, and was just now notified by V5. V8 proceeded to assess R3's right hip wounds and said they were pressure injuries. V8 cleaned the wounds and covered them. V8 said V3 (Wound Care Nurse/WCN) was just now notified and would be coming to assess R3's wounds. R3 appeared uncomfortable and said her side was hurting. At 11:53 AM, V3 (WCN) and V4 (Wound Care Aide/WCA) assessed R3's right hip wounds. V3 said R3 had two newly acquired pressure wounds to her right hip, a stage 2 and stage 3 cluster. V3 said R3's skin had to be monitored because she had a history of a right hip pressure wound, and because she favored positioning on her right side. On 10/02/2024 at 4 PM, V3 (WCN) said she expects nursing staff to report any skin alterations immediately to the nurses on duty and complete the facility's skin reporting referral slip. V3 said, additionally, the nurses on duty were also responsible for contacting the physician and initiating wound care immediately. V3 said she had just educated the nursing staff on reporting newly identified skin alterations. On 10/03/2024 at 12:30 PM, V18 (Nurse Practitioner/NP) said she oversees R3's medical care. V18 said she expected facility staff to monitor residents' skin and report any skin alteration when identified to initiate treatment right away and monitor the wound's progress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/02/2024 at 4:05 PM, V2 (Director of Nursing/DON) said she expects nursing staff to follow the facility's skin prevention process of assessing residents' skin and reporting any abnormalities immediately. R3's Wound Assessment Details Report, dated 10/02/2024, showed R3 had a Braden Score of 12 (High Risk) for pressure injuries completed on 8/15/2024. R3's Care Plan reviewed on 10/02/2024 showed R3 was at risk for developing pressure injuries to her right hip with a revised date of 3/18/2024. The care plan showed multiple interventions including, Follow facility policies/protocols for the prevention/treatment of skin breakdown initiated on 8/31/2022. R3's Order Summary Report, dated 10/02/2024, showed an order dated 11/23/2022 to, Assess skin for impairment daily. Notify wound care for any issues observed. The report also showed orders initiated on 10/02/2024 to, Clean Right trochanter distal wounds, paint with skin prep. Apply medi-honey fiber sheet. Cover with adhesive foam three times weekly and PRN and Clean Right (Trochantar) proximal wound, Paint with skin prep. Cover with adhesive foam three times weekly and PRN. R3's Wound Assessment Details Report, dated 10/02/2024, showed R3 acquired a stage 3 pressure injury to her right distal trochantar (hip). The report showed R3's wounds were clustered together and measured 1.6 cm (centimeter) in length x 0.7 cm in width x 0.1 cm in depth. The report showed R3's wounds had 50% slough (necrotic non-viable tissue), 10% pale pink non-granulating, and 20% epithelial tissues and had light serous drainage. R3's Wound Assessment Details Report, dated 10/02/2024, showed R3 acquired a stage 2 pressure injury to her right proximal trochantar (hip). The report showed R3's wound measured 0.4 cm in length x 0.4 cm in width x 0.1 cm in depth. The report showed R3's wound had 90% pale pink non-granulating and 10% epithelial tissues with light serous drainage. The facility's policy titled Treatment/Services to Prevent/Heal Pressure Ulcers, dated 6/16/2024, showed, 1. The facility will ensure that based on the comprehensive Assessment of a resident: a. A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers . The facility's policy titled Wound Prevention and Healing dated 6/01/2024 showed, Policy Statement: To provide wound care treatments/services (using a multidisciplinary approach) .1. Risk Assessment and Prevention .b. Braden scale will be completed to determine the patient's level of risk and implement interventions to prevent development of pressure ulcers. c. Skin will be inspected during showers, following orders for daily and or weekly skin checks as scheduled, and PRN .12. Staff Education and Competency Testing .2. All nursing staff will complete competency assessments for basic wound care and prevention including other wound related topics that would be beneficial to patient care .