

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Pearl of Joliet, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409</p> <p>Based on observation, interview, and record review, the facility failed to provide information to install cameras in a resident's room.</p> <p>This applies to 1 of 1 resident (R2) reviewed for resident rights in a sample of 10.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) shows R2 was admitted to the facility with diagnoses including hemiplegia and hemiparesis of the left non-dominant side, type 2 diabetes mellitus, delusional disorders, bipolar disorders, dementia, epilepsy, low back pain, and gastroesophageal reflux disease.</p> <p>R2's MDS (Minimum Data Set), dated October 18, 2024, showed she was moderately impaired. R2 required moderate assistance with eating, oral hygiene, substantial assistance for upper body dressing, and personal hygiene, and was dependent on staff for shower/bathing, toileting hygiene, lower body dressing, putting on/taking off footwear.</p> <p>R2's progress notes, dated December 13, 2024 at 1:27 PM, showed the following, Care conference was held for (R2) on the 5th of December with family, and IDT (Interdisciplinary Team), in attendance, which included Social services, Activities, Dietary, Nurse practitioner and Ombudsmen. Residents medical progress and goals were discussed. Resident is long term care and a full code. Family would like for her to receive 1:1 activities in her room and pertaining to dietary with no added salt, nutrition shakes and fresh fruit request. Family would like Nursing to get her up more, and possibly have a camera installed in her room. Staff will follow up w/request and grievance policy was discussed. Social Services remain available and will continue to monitor progress of residents care and family request.</p> <p>On December 19, 2024 at 8:09 AM, V31 (Family Member) said two weeks earlier, the facility was supposed to give V31 information about installing a camera in R2's room. V31 said she contacted V6 (Director of Social Services) on December 11, 2024, and emailed V6 to request to receive the information to install the camera. At 1 PM, R2's room did not have a camera installed and there were no signs posted about her having a camera in the room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On December 19, 2024 at 3:29 PM, V5 (Social Services) said there were no residents in the facility who had cameras in their rooms. V5 said R2's family had mentioned wanting a camera during the care conference. V5 said she was not at the meeting, but wrote the note. V5 said she was not sure what happened with the request, so was not sure if it was a yes or no.</p> <p>On December 19, 2024 at 3:41 PM, V6 (Director of Social Services) said V31 asked about getting the grievance and camera policies. V6 said she asked V31 for her email, and V31 asked for V6's email instead. V6 said V31 did not email her and V6 did not follow up about sending the information. V6 said she did not put a note about having a follow up conversation, but she had last spoken to V31 on December 11, 2024, on the phone.</p> <p>On December 19, 2024 at 4 PM, V1 (Administrator) said no one had mentioned about R2 needing a camera in the room. V1 said if a family wanted a camera in the room, she would need to bring it up to corporate. V1 said the facility allowed cameras, but did not install them. V1 said it was her expectation when concerns or requests came up during care plan meetings, it should be addressed within 72 hours.</p> <p>On December 20, 2024 at 9:55 AM, V31 said from what the Ombudsman told her, it was understood R2 was allowed to have a camera. V31 said the Ombudsman told her the only caveat was if R2 had roommates and they did not agree to having the camera, they were not allowed to have the camera placed. V31 said they had not even gotten to that point as two weeks earlier, when they had all met for a care plan meeting, V31 had asked for the camera and V6 immediately said no, and then said, Well it would have to be drilled in. V31 said, The Ombudsman asked how long that would take and what the policy said, and (V6) indicated they would get (V31) the policies by December 6, 2024, which did not happen.</p> <p>On December 20, 2024 at 10:10 AM, V31 (Family Member) provided an email communication between V31 and V6, which showed on December 12, 2024 at 10:18 AM, V6 said, Per your request, here is the email you requested during the call on December 11, 2024.</p> <p>The facility's Video Surveillance/Electronic Monitoring policy, dated April 6, 2024, showed, In order to meet the requirement of the Electronic Monitoring Act of Illinois (public act [PHONE NUMBER]), a resident or specific agents of the resident may place electronic monitoring equipment in the nursing facility room after the following criteria have been met.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409</p> <p>Based on observation, interview, and record review, the facility failed to identify a resident's skin breakdown.</p> <p>As a result of this failure, R7 developed a Stage 3 pressure ulcer.</p> <p>This applies to 1 of 1 resident (R7) reviewed for pressure ulcers in a sample of 10.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) shows R7 was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis, bacteremia, dependence on respiratory status, hypertension, gastrostomy status, and tracheostomy status.</p> <p>R7's POS (Physician Order Sheet), dated December 24, 2024, showed an order for Daily skin check if moderate risk to high risk based on Braden scale- perform daily skin check if any skin issues are identified please complete the skin assessment form, every night shift for prevention, which was ordered on October 24, 2024. The POS also showed orders dated November 1, 2024 for Weekly skin check, complete weekly skin check in assessment one time a day every [Thursday] assessment and Weekly skin check, complete weekly skin check in assessment one time a day every [Tuesday].</p> <p>R7's care plan, dated September 13, 2024, showed R7 has potential for impairment to skin integrity (related to) immobility and (respiratory) failure/hypoxia with a goal to maintain clean and intact skin by the review date.</p> <p>R7's Admission Assessment, dated September 11, 2024, showed R7 was at moderate risk for skin breakdown. R7 had no skin breakdown on his coccyx or buttocks upon admission.</p> <p>R7's Readmission Assessment, dated October 24, 2024, showed R7 was at a very high risk for skin breakdown. R7's assessment did not show any skin breakdown on his coccyx or buttocks.</p> <p>On December 24, 2024 at 10:50 AM, V22 (Wound Care Coordinator) said R7 did not have any skin concerns the wound team was seeing him for. At 11:47 AM, V22 did a skin observation. R7's incontinence brief was removed, and R7's skin on his buttocks had several areas of open, broken, and bloody skin. V22 said R7 did not have any skin issues before. V22 said the area needed to be treated, as it was a Stage 3 pressure ulcer and was draining a moderate amount of serosanguineous drainage. R7's buttocks did not have any dressings in place.</p> <p>On December 24, 2024 at 11:55 AM, V21 (CNA/Certified Nurse Assistant) said she had provided incontinence care for him earlier that morning, and she had not noticed anything when she was changing him, but was changing him very quickly. V21 said R7 did not have a dressing on the buttocks when she had previously cleaned him up. V21 said she should have told the nurse so they could put a dressing or apply a cream. V21 said the previous shifts had not reported any concerns about R7's skin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On December 24, 2024 at 12:23 PM, V25 (CNA) said she helped V21 provide incontinence care for R7 and had not noticed any issues with his skin. V25 said she was not the one wiping his perianal area. V25 said she had worked with R7 in the past week and had not seen any broken skin.</p> <p>On December 24, 2024 at 12:07 PM, V12 (LPN/Licensed Practical Nurse) said she had never seen him before and was not treating him for any skin concerns. At 12:13 PM, V12 measured the area of broken skin, which was nine by nine centimeters. V12 said there appeared to be seven areas with broken skin.</p> <p>R7's progress note, written by V22, dated December 24, 2024 at 1:18 PM, showed, Body assessment completed, multiple open areas noted, scattered to buttocks and coccyx area. Wound noted with dusky discoloration, granulation, epithelial and slough noted to wound bed. Wound clustered and measured as one. Resident noted alert and oriented +0 and [diagnosis] with [respiratory] failure with ventilation dependence, hemiplegia following [Cerebrovascular Accident], obesity, [Hypertension] and history of wounds. Alternating air mattress noted in place. [Power of Attorney] [name] called and wound to buttocks/coccyx communicated with intervention and treatment plan. No concerns voiced at this time. [Medical Doctor] called for orders, no answer at this time. [Nurse Practitioner] notified and orders received to clean wound and apply medihoney fiber sheets three times weekly and cover with adhesive foam. Will continue to monitor.</p> <p>On December 24, 2024 at 1:54 PM, V27 (NP/Nurse Practitioner) said she was made aware of the skin issues for R7 on December 24, 2024. When showed the wounds, V27 said R7's wounds would be something she would defer to the wound doctor. V27 said it was her expectation any increasing redness should be notified to the nurse or the wound care team.</p> <p>On December 26, 2024 at 1:40 PM, V2 (DON/Director of Nursing) said she would have expected the CNAs to notify the nurses and the wound care nurses. V2 said when the CNAs saw the skin breakdown, she would have expected the CNA to notify the nurse.</p> <p>On December 26, 2024 at 2:40 PM, V4 (Nurse Consultant) said the wound doctor would be seeing R7 tomorrow and might debride it.</p> <p>R7's Assessments were reviewed, and no assessments were completed for impaired or open skin since admission.</p> <p>The facility's Wound Prevention and Healing policy reviewed on June 1, 2024 showed Skin will be inspected during showers, following orders for daily and or weekly skin checks as scheduled, and PRN (As Needed).</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46409</p> <p>Based on interview and record review, the facility failed to provide a resident with his scheduled anxiety medications, as ordered.</p> <p>This applies to 1 of 1 resident (R9) reviewed for pharmacy services in a sample of 10.</p> <p>The findings include:</p> <p>The EMR shows diagnoses including alcohol dependence, insomnia, chronic obstructive pulmonary disease, anxiety disorder, major depressive disorder, gastroesophageal reflux disease, hypertension.</p> <p>R9's MDS (Minimum Data Set), dated September 23, 2024, showed R9 was cognitively intact. R9 was independent with eating, oral hygiene, upper body dressing, and personal hygiene, required set up assistance for putting on/taking off footwear, and required supervision for lower body dressing, toileting hygiene, and shower/bathing.</p> <p>R9's care plan, dated July 11, 2024, showed R9 presents with signs and symptoms of anxiety that is manifested by restlessness, anxiousness, and having difficulty with sleep, thinking and concentration; related to psychiatric illness, anxiety disorder. Psychiatry will continue to evaluate and provide medication management .Administer my psycho-active medication as ordered. Record behaviors that [R9] display.</p> <p>R9's December 2024 MAR (Medication Administration Record) was reviewed and showed the following:</p> <p>Buspirone 15 MG (Milligrams) Give one tablet by mouth two times a day for anxiety and showed he did not receive both of the daily doses of the medications on December 21, 2024, December 22, 2024, December 23, 2024, and December 24, 2024.</p> <p>Clonazepam 0.5 MG Give 0.5 MG by mouth three times a day for anxiety related to anxiety disorder, which showed he did not receive the following doses: December 20, 2024 at 2 PM, December 21, 2024 at 9 AM, 2 PM, and 8 PM, December 22, 2024 at 9 AM, 2 PM, and 8 PM, December 23, 2024 at 9 AM, 2 PM, and 8 PM, and December 24, 2024 at 9 AM and 2 PM.</p> <p>Hydroxyzine HCl (HydroChloride) Give 50 MG by mouth three times a day for anxiety related to anxiety disorder, which showed he did not receive the following doses: December 21, 2024 at 9 AM and 2 PM, December 22, 2024 at 9 AM and 2 PM.</p> <p>On December 24, 2024 at 2:56 PM, R9 said he was out of three different medications. R9 said he spoke to the Nurse Practitioner 1.5 weeks ago, and was told it would be taken care of. R9 said he was missing three medications, which were all used for anxiety. R9 said without them, he had been really stressed out. R9 said when he spoke to the staff, they said they were looking into it, but he still had not gotten his medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On December 24, 2024 at 3 PM, V28 (LPN/Licensed Practical Nurse) said she was trying to get a hold of the Psych Nurse Practitioner because he was missing clonazepam. V28 said he was not missing any other medications. V28 said the overnight nurse did not tell her about R9 missing any medications. V28 said she typically reordered the medication when there were 10 pills left, and he should not have run out of the medication. V28 opened R9's medication drawer and controlled medication drawer, and he did not have any clonazepam or buspirone available in his drawer.</p> <p>On December 24, 2024 at 3:08 PM, V17 (LPN) said she would reorder the medication before it ran out. V17 said, If a resident does not get anxiety medication, it could cause them to have anxiety. Anti-anxiety and antidepressants should not be stopped abruptly.</p> <p>On December 24, 2024 at 3:12 PM, V16 (LPN) said she reordered medications seven to eight days before it ran out. V16 said there was a reorder option in the EMR (Electronic Medical Record). V16 said there were effects of a resident being abruptly stopped of anxiety or depression medications.</p> <p>On December 24, 2024 at 11:40 AM, V30 (Psychiatric Doctor) said the residents should not be missing the medications, and it was his expectation the staff gave the resident their ordered medications.</p> <p>On December 24, 2024 at 1:40 PM, V2 (DON/Director of Nursing) said the staff should not be running out of the medication because they have time to reorder the medication. V2 said the nurses started communicating with the pharmacy on December 22, 2024 and she spoke to the pharmacy on December 24, 2024, and the medications came the same day.</p> <p>The facility's Medication Ordering and Receiving from Pharmacy policy, reviewed November 2021, showed, Controlled substances are reordered when a five day supply remains to allow for transmittal of the required written prescription to the pharmacist.'</p>		