

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 04/17/2025
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330</p> <p>Based on observation, interview, and record review, the facility failed to complete a wound or skin event in risk management when a skin abnormality was found on a resident, failed to seek medical attention for a resident who developed rash-like skin redness, failed to monitor the skin rash/redness for improvement or worsening, failed to implement wound nurse practitioner's recommendations to keep the area clean and dry, and failed to implement wound nurse practitioner's recommendations for treatment of the rash.</p> <p>These failures resulted in R1 developing a rash/reddened area under her breasts that went without assessment or treatment, experiencing a rash/redness on her groin and buttocks that did not improve, and R1 expressing she experienced extreme pain and discomfort for many months due to the rash/redness.</p> <p>This applies to 1 of 3 residents (R1) reviewed for skin rashes in the sample of 3.</p> <p>The findings include:</p> <p>On April 16, 2025 at 9:18 AM, R1 was lying in bed. R1 had a tracheostomy in place and was unable to speak out loud, but was able to mouth intelligible words and make hand gestures. R1 said she was experiencing pain, and pointed to her perineal area and buttocks when asked where her pain was located. R1 was wearing an incontinence brief. The brief was closed at each side of R1's hip with the adhesive closures from the incontinence brief. R1 had an indwelling urinary catheter in place draining cloudy, yellow urine.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On April 16, 2025 at 10:38 AM, R1 continued to be lying in bed. V10 (Mother of R1) was sitting at R1's bedside. V4 (CNA-Certified Nursing Assistant) and V5 (CNA) came to R1's room to provide incontinence care. V5 said she arrived at the facility at 6:00 AM and was assigned to care for R1. V5 continued to say she had not had time to check R1's incontinence brief or provide incontinence care since she started her shift over four hours earlier. V5 said R1 was wearing the incontinence brief from a previous shift. V4 and V5 unfastened R1's incontinence brief. V4 and V5 said they had not been instructed to leave R1's incontinence brief open. As V5 pulled back R1's incontinence brief, the brief had a strong odor and appeared wet, despite R1 having an indwelling urinary catheter. V5 said the catheter must have leaked. R1's front perineal area had a rash over R1's entire pubic area, along both groin areas, and extending to her inner left and right thigh, approximately six inches in diameter. The rash appeared as solid, bright red areas. As R1 was turned to her right side, R1's buttocks were exposed. The red rash encompassed R1's entire buttocks, approximately 12 inches in diameter and extended up her back, approximately six inches, on R1's right side. The rash on R1's buttocks was bright red and appeared as one solid red area. As the rash extended up R1's back, the rash appeared to be a spottier, red pattern. R1 flinched when V5 tried to use a disposable wipe to clean R1's buttocks. V4 and V5 said they did not have barrier cream to apply to R1's buttocks or groin area because they were not allowed to keep the cream in the resident's rooms, and they would have to ask V7 (LPN-Licensed Practical Nurse) to obtain the cream. V4 and V5 applied a clean incontinence brief to R1 and did not apply barrier cream and prepared to leave the room. V5 (CNA) said she has been assigned to care for R1 many times, and the rash on R1's perineal area and buttocks had been present since at least February 2025. V4 and V5 lifted R1's gown. R1 was not wearing a bra. V5 lifted R1's right and left breast. R1's skin appeared bright red under R1's right and left breasts, approximately one to two inches wide, and approximately 4 inches long. A white, pilled substance was under each breast and V5 speculated it was old powder. V5 used a disposable wipe to clean the white substance from under R1's breasts, and R1 flinched when V5 cleaned the area and indicated the area was painful by mouthing the words that hurts. As V4 and V5 were ready to leave R1's room, V7 (LPN) entered the room with a small medication cup filled with a white cream and a wood tongue depressor. V7 said the white cream was zinc oxide. V4 and V5 opened R1's incontinence brief and again turned her to her right side. V7 (LPN) used her gloved hand to smear the zinc oxide on R1's buttocks. V7 did not cover the rash on R1's upper back with the zinc oxide. R1 was turned to her back by V4 and V5. With approximately one teaspoon of zinc oxide left in the medicine cup, V7 (LPN) used the wood tongue depressor to smear the remaining zinc oxide to R1's front perineal area in a swiping motion. The remaining zinc oxide ointment did not cover all red areas of R1's front perineal area, or R1's inner thighs. V7 (LPN) said she would have to return with more zinc oxide ointment to cover the reddened areas.</p> <p>On April 16, 2025 at 11:11 AM, V10 (Mother of R1) remained at R1's bedside, and said V7 (LPN) had not returned to R1's room to apply zinc oxide ointment to R1's front perineal area. V7 also said no other facility staff had come to the room to apply the ointment.</p> <p>On April 16, 2025 at 11:45 AM, V10 (Mother of R1) remained at R1's bedside, and said V7 (LPN) had not returned to R1's room to apply zinc oxide ointment to R1's front perineal area. V7 also said no other facility staff had come to the room to apply the ointment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On April 16, 2025 at 11:50 AM, V7 (LPN) came to R1's room and applied zinc oxide ointment to R1's front perineal area, and said she was unable to do it sooner due to caring for other residents. V7 did not assess the skin under R1's breasts or apply the zinc oxide ointment. As V7 was ready to leave R1's room, V7 was asked what the treatment would be for R1's skin redness under her bilateral breasts, and V7 turned around and applied the remaining zinc oxide ointment to the area under R1's bilateral breasts.</p> <p>The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy, pneumonia, UTI (Urinary Tract Infection), acute and chronic respiratory failure, COPD (Chronic Obstructive Pulmonary Disease), acute pulmonary edema, myotonic muscular dystrophy, ascites, dependence on ventilator, gastrostomy tube, tracheostomy, and intestinal obstruction.</p> <p>R1's MDS (Minimum Data Set), dated February 6, 2025, shows R1 is cognitively intact, requires partial/moderate assistance with oral hygiene, substantial/maximal assistance with bed mobility, and dependent on facility staff for all other ADLs (Activities of Daily Living). R1 has an indwelling urinary catheter and is always incontinent of stool. The MDS continues to show R1 receives 51 percent or more of her total calories from tube feeding. R1 had no unhealed pressure ulcers, rashes or MASD (Moisture-Associated Skin Damage) at the time of this MDS assessment.</p> <p>R1's care plan for potential/actual impairment to skin integrity, created on January 31, 2025, shows multiple interventions initiated on January 31, 2025 including, keep skin clean and dry. Identify/document potential causative factors and eliminate/resolve where possible.</p> <p>On January 31, 2025 at 6:46 AM, V6 (LPN) documented, [R1] buttock dry, redness, and flaky to touch</p> <p>V6's (LPN) Admission/Readmission Evaluation, dated January 31, 2025, shows R1 was readmitted to the facility with groin redness, redness on her inner thighs, and perineal area. The evaluation also shows R1 was high risk for skin breakdown.</p> <p>The EMR shows the following order, dated January 31, 2025: Zinc oxide external ointment 20 percent to groin, peri, and buttock topically every 12 hours for redness.</p> <p>The facility's Skin Monitoring/CNA Shower and Grooming sheets show the following for R1:</p> <p>January 21, 2025: Redness on R1's bilateral groin areas and redness on R1's buttocks.</p> <p>March 18, 2025: Redness under R1's right breast, and redness in R1's perineal area.</p> <p>April 1, 2025: Redness under R1's right and left breasts, and redness in R1's perineal area.</p> <p>The facility does not have documentation to show R1's physician was notified about the redness/rash on R1's skin, or that the redness/rash was assessed by nursing staff between January 31, 2025 and April 9, 2025. The facility does not have documentation to show the nurse assessed the reddened areas or completed a wound or skin event within risk management. The facility does not have documentation to show the wound care nurse checked risk management and proceeded with an assessment or investigation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On April 17, 2025 at 2:55 PM, V11 (Physician) said, Based on (V9's, Wound Care NP) documentation dated April 9, 2025, there has been an acute change in (R1's) skin since last week, possibly caused by the antibiotic medication (R1) was taking. V11 said it would be his expectation that facility staff follow provider recommendations for wound care, and they should follow the facility's policy for nursing assessment of abnormal skin conditions and completing wound or skin events in risk management.</p> <p>The facility's policy entitled Wound Prevention Program, dated March 2025, shows, Purpose: The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as non-pressure related wounds. Process: 1. Upon admission and in conjunction with the Resident Assessment Instrument, and when a significant change in the resident status occurs, the resident's skin will be evaluated head-to-toe by licensed nurse. 2. Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's EMR. 3. Daily, during routine care, the CNA will observe the resident's skin. When abnormalities are noted, this will be communicated to the licensed nurse and the licensed nurse will proceed as mentioned in step 2 and complete a wound or skin event within risk management. The wound care nurse will check risk management daily for any new wound/skin event and proceed with an assessment/investigation.</p> <p>The facility's policy entitled Wound Prevention and Healing, reviewed 06/01/2024, shows, Policy Statement: To provide wound care treatments/services using a multidisciplinary approach based on evidence-based standards of care under the direction of a physician. 1. Risk Assessment and Prevention: a. Braden Scale will be completed upon admission, readmission, quarterly, and when there is a change in condition by a licensed or registered professional nurse.c. Skin will be inspected during showers, following orders for daily and/or weekly skin checks as scheduled, and PRN (as needed).</p>		