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	04/30/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident who was admitted with an unstageable pressure ulcer was seen by a wound care physician or nurse practitioner in a timely manner and failed to follow recommended wound treatment. This failure resulted in a resident (R1) to develop an infection in the wound and require surgical debridement.This applies to 1 of 3 residents (R1) reviewed for wound care in the sample of 3.The findings include:R1's electronic medical record (EMR) showed R1 was admitted to the facility on [DATE]. R1 was 75 years-old, who had multiple medical diagnoses including type 2 diabetes mellitus, pressure ulcer in the sacral region, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, necrotizing fasciitis, deep vein thrombosis, and hypothyroidism. On September 30, 2025, V3 (Wound Care Nurse) assessed R1 and noted R1 had an unstageable pressure ulcer to the sacral-coccyx area which measured as 1.5-centimeter (cm/centimeters) x 1.5 cm x 0 cm. (Length x Width x Depth). The wound surface was covered with slough and there was a moderate amount of serosanguinous exudate (drainage). This wound already existed prior to R1's admission to the facility. V3 noted the wound was clean, there was no odor, and no sign of infection. R1's Physician Order Summary (POS), dated September 29, 2025, shows R1 may be seen by a wound care physician.On September 30, 2025, the wound care treatment order showed: clean coccyx area, paint with skin prep, apply Medi honey, and fluff gauze, and cover with dry dressing three times a week and as needed. On November 19, 2025, the POS showed the wound treatment as : apply Dakin's (1/4 strength) External Solution to sacral wound topically one time a day from Monday through Friday for 14 days. On November 24, 2025, the POS showed the wound treatment as: apply Santyl External Ointment to sacral wound topically as needed. V3 continued to monitor and assess R1's wound and documented in the weekly wound assessment report. Assessments showed R1's wound remained unstageable; however, the wound size became bigger with each assessment. By November 1, 2025, the wound was measured as 4.3 cm x 3.80 cm. The wound was also noted with slight excoriation to surrounding wound bed which was fully covered with slough. The treatment administration record (TAR) for the month of November 2025, showed R1 continued to receive the same treatment of Medi honey three times a week. On November 5, 2025, V4's (Wound Specialist Nurse Practitioner/NP) documented R1 had an unstageable/unclassified pressure ulcer and has received a status of Not Healed. Upon initial wound encounter the wound measurements were 5.0 cm x 6.0 cm x 0.2 cm, with area of 30 square cm (cm2) and volume of 6 cubic cm (cm3). There was no tunneling, no sinus tract, and no undermining noted. There was a moderate amount of serosanguinous drainage, which has no odor. R1 reported wound pain of 0/10. The wound margin was attached to wound base. Wound bed has no granulation, it has 100% slough, no eschar and no epithelialization noted. The peri-wound color was normal. The temperature of the skin was within normal limits. The peri-wound did not exhibit signs and symptoms of infection. V4's recommended treatment was to clean the wound, apply Medi honey, calcium alginate, and cover with foam dry dressing three times a week and as needed. On November 8, 2025, V3's (Wound Care Nurse) documentation showed R1 was seen by V4 (Wound NP). Debridement procedure was discussed with V8 (R1's POA/Power of Attorney) and consent was obtained. Debridement was done to remove the (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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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	be seen by a wound care physician. However, R1 was seen by a wound care specialist (V4) five weeks after she was admitted , after R1's wound continued to deteriorate. R1 received debridement procedure on November 12, and November 19, 2025. V4 gave an order to cleanse wound with Dakin's solution daily and as needed after the first debridement on November 5, and an order of Dakin's solution and Silvadene ointment daily and as needed after the second debridement was performed on November 19, 2025. However, R1's TAR showed that R1 continued to receive Medi honey treatment three times a week. Dakin's solution was applied to wound only on November 20, 21, and 24. There was no Silvadene treatment provided to R1. On November 19, V4 noted the foul odor from R1's wound, she ordered a wound culture, the result showed R1 was positive for MRSA. R1 was sent to the hospital after V8's (R1's POA) insistence where R1 was admitted for an infected stage 4 pressure ulcer with osteomyelitis and where she underwent surgical debridement. The Facility's Policy and Procedure for Wound Prevention and Healing with revision date of April 2026 shows:Intent: To provide wound care treatment/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician.Procedure:Goal will focus on the clinical status of the wound, guide the appropriate intervention for the wound, indicate that, if there is no change in wound status within a pre-determined timeframe, re-assess and alter the plan, monitor and evaluate overall client outcomes (progression or regression), and determine the effectiveness of treatment. Continued/Ongoing Treatmenta. Nurse will provide wound care per physician orders and continue to implement and evaluate the plan of care based on the effectiveness of treatment. The nurse will notify the physician for any change in the patient's condition or lack of progress. d. If the patient is not responding to established treatment regimen, the Wound MD/NP shall evaluate the need for treatment change. Wound Care and Treatment:a. Wound care treatments are provided within an individualized plan of care under the direction of the physician.