STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002463	A. BUILDING: _____ B. WING _____	C 12/27/2024

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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S 000	Initial Comments Complaint Investigation 24710427/IL183060	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify a resident's skin breakdown.
As a result of this failure, R7 developed a Stage 3 pressure ulcer.

This applies to 1 of 1 resident (R7) reviewed for pressure ulcers in a sample of 10.

The findings include:

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The EMR (Electronic Medical Record) shows R7 was admitted to the facility on September 11, 2024, with diagnoses of hemiplegia and hemiparesis, bacteremia, dependence on respiratory status, hypertension, gastrostomy status, and tracheostomy status.

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].

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.

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.

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.

On December 24, 2024 at 10:50 AM, V22 (Wound Care Coordinator) said R7 did not have

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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.

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.

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.

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.

R7's progress note, written by V22, dated

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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."

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.

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.

On December 26, 2024 at 2:40 PM, V4 (Nurse Consultant) said the wound doctor would be seeing R7 tomorrow and might debride it.

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S9999	Continued From page 5 R7's Assessments were reviewed, and no assessments were completed for impaired or open skin since admission. 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). (B)	S9999		