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 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

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S 000	Initial Comments Complaint Investigation 2477949/IL178733	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	S9999		

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care needs of the resident.
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 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.

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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

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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.

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

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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,

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S9999	Continued From page 5 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 ..." (B)	S9999		