| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145946 | A. Building<br>B. Wing | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl of Hillside,the | 4600 North Frontage Road<br>Hillside, IL 60162 |

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) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview and record review, the facility failed to check and provide incontinence care at least every two hours for one resident who was identified as dependent on staff for toileting. This affected one of three residents (R3) reviewed for incontinence care. This failure resulted in R3 being saturated with a urine filled adult brief for over four hours. Findings Include:R3 was diagnosed with Hemiplegia and Hemiparesis following other Nontraumatic Intracranial Hemorrhage affecting left dominant side. R3's care plan dated 3/28/24 documents: provide incontinence care after each incontinent episode. Section C (cognitive patterns) dated 6/20/25 documents a score of twelve which indicated moderate cognitive impairment. Section GG (functional abilities) documents dependent with toileting hygiene. Section H (bladder and bowel) documents: urinary continence always incontinent.On 9/23/25 at 12:53pm, R3 said, he needed changed. V3 (unit supervisor), checked R3's adult brief. R3's entire brief was saturated with urine. V3 asked, R3 when was he changed last. R3 replied at 7:30am or 8:00am. V3 said, residents should be provided incontinence care every two hours and as needed. V5 (certified nursing assistant/cna) said, she was R3's assigned cna. V5 said, she last provided care for R3 at 9:00am. R3 was observed with a brief full of yellow urine, with a large yellow irregular ring on his bed pad and a smaller irregular shaped ring on his fitted sheet. V5 said, R3's bed pad is wet with urine. R3's sheet has a dried urine stain. V5 said, residents should be changed every two hours. V5 said, R3 is a heavy wetter.Urinary Continence and Incontinence-Assessment and Management dated 2/13/25 documents: Staff will ensure that incontinence care needs are met. |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a plan of care with increased monitoring /supervision for a resident identified to have safety awareness of urinating in a trash can, resident had a history of falls and unsteady gait. This affected one of three residents (R1) reviewed for falls, supervision and safety awareness. This failure resulted in slipping his own urine falling to the floor sustaining a bump to the head and change in consciousness.Findings Include: R1 was admitted on [DATE] with the diagnosis of abnormal gait and mobility, lack of coordination, dizziness and giddiness, hypotension, cerebral infraction due to embolism of left middle cerebral artery and aphasia following a cerebral infraction. Care plan initiated: 09/03/2025 documents: Resident (R1) has potential for falls secondary to functional deficits, fluctuating blood sugars, cognitive deficits. Care plan initiated 9/04/2025 documents: resident has an ADL self-care performance deficit related to right side weakness, hypotension. Unwitnessed fall report dated 9/5/25 documents: R1 urinated on the floor, he also was laying on the floor on his back, a bump was noted on the back of his head. R1 complained while touching that area. Unable to give any statement resident does not speak English. Predisposing environment factors: wet floor. Other information: R1 urinated on the floor then he fell. Fall event dated 9/5/25 documents: Mental status: Lethargic/drowsy- does not perceive the environment fully, responds to stimuli appropriately slowly and with a delay. Was there a deviation from usual mental status? Yes, drowsier. Left/right upper and lower extremities: weak. Nursing note dated 9/5/25 documents: This AM (morning) I/(V8) Nurse, was getting a nurse's report, The activity aide (V14) came to us to let us know that the resident was walking in the room, we went into the room, we noticed that the resident urinated on the floor, he was laying on the floor on his back, able to move all four extremities, a bump was noted on the back of his head, resident complained of pain while touching that area, resident was assisted back to his bed, MD aware with an order to send the resident to the ER via 911. admitted to hospital with the diagnosis of intracranial bleeding.On 9/24/25 at 10:46am, V2 (Director of Nursing/DON) said, R1was a new admit. V14 walked past R1's room and saw R1 standing at the doorway. V8 and V14 returned to R1's room. R1 was laying in the floor. R1 urinated on the floor, sipped in the urine and fell backwards. R1 had a bump on the back of his head and started blinking. On 9/24/25 at 11:15pm, V8 (nurse) said, R1 was on the respiratory unit. V8 said, R1 should have been on the transitional care unit. V8 said, he was getting report from the nurse when V14 (activity aide) reported that R1 walking in his room and trying to urinate in the red isolation container/trash can. V8 said, R1 urinated on the floor and slipped in his urine. R1 only spoke mandarin. V8 said, R1 sustained a lump on the back of his head. V8 said, R1 had decreased motor functioning and had increased confusion after the fall. R1 was discharged to the hospital via 911. On 9/24/25 at 11:25, R1 was interview via V7 (translator). R1 was unable to answer the orientation questions. V7 said, R1 could only answer simple things. V7 said, R1 reported he just fell down. V7 said, R1 reported he fell down before he arrived at the facility. V7 said, R1 was unable to recall the details if his fall at the facility. R1's witness statement dated 9/5/25 documents: R1 was standing at the door of room, lost balance and fell backwards. Why do you believe the event occurred: blood pressure dropped. On 9/24/25 at 11:41am, V2 (DON) said, R1 had a fall in the community. R1 was found down. V2 said, she is not sure where R1 was found. On 9/25/25 at 10:22am, V14 (activity aide) said, V14 said, she was walking, reporting to work with her bags on her shoulders and she walked past R1's room. V14 said, R1 was urinating in the trash can. V14 said, she walked to the nurse station to inform the nurse. V14 said, when she and the nurse returned to R1's room, R1 was on the floor. V14's witness statement dated 9/5/25 documents: time of event 7:30am. Type of event: fall. Walking down hall seen R1 up went to get the nurse. R1 was on the floor when nurse came back. Lying on his back. On 9/25/25 at 12:06pm, V2 said, the day shift CNA for R1's unit was in another resident's room. On 9/25/25 at 12:42pm, V2 said, R1's did not have a fall care plan implemented upon admission. V2 said, when a resident does not have a fall care plan staff follows the facilities fall focus system. Fall focus system no date documents: (6 pearls)- personal needs: staff will assess and anticipate resident's personal and activity for daily living (ADL) needs such as toileting, incontinent care during rounds. Staff will attend to needs as they are identified.Hospital paperwork dated documents: CT scan of the head showed multiple rounded areas of hemorrhage in left cerebral hemisphere representing intraparenchymal contusion with hemorrhagic conversion. It also shows extensive edema involving left parieto-occipital region and left temporal region with associated internal hemorrhage. MRI of the brain shows subacute infarct with |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Based on observation, interview and record review, the facility failed to implement an effective pest management program. This affected two of four (R5, R6) residents reviewed for pest. This has the potential to affect all 154-resident having their meals prepared in the kitchen. This failure resulted in gnats being observed in R5, and R5 rooms and observed in flying in the kitchen dish area.Findings Include:On 9.23.25 there were currently 154 residents residing in the facility that utilize the kitchen to have their meals prepared. On 9/23/25 at 12:15pm, R5's room was observed with two trash cans with lids near his entry way. Multiple gnats were observed flying around the two trash cans when surveyor entered R5's room. More than ten gnats were crawling on the outside of R5's white trash can. R5 was observed in bed asleep with a few gnats on his bed sheet resting above R5's head.On 9/23/25 at 12:18pm, R6 was observed resting in bed. R6 was assessed to be alert and orient to person place and time. Three gnats were observed flying around R6's bed and bedside table. R6 said, she has been having a problem with gnats. R6 said, it's nasty to have gnats flying around.On 9/23/25 at 12:19pm, V4 (maintenance director) said, there are gnat in R5's entry way surrounding the trash cans and in R5's trash can. R5's white trash can was observed full with trash. V4 said, the gnats are in the trash due to the certified nursing assistance (CNA) not emptying R5's trash. On 9/23/25 at 12:48pm, R5 was observed awoke in bed and eating lunch. R5 said, he has had a problem with gnats. On 9/23/25 at 12:51pm, V3 (unit manager) said, she saw one gnat around R5's bed. V3 said, R5 cannot swat the gnats away. On 9/23/25 at 1:06pm, during the tour of the kitchen, three to four gnats and one large mosquito were observed flying in the corner near the handwashing sink. V6 (dietary manager) identified the insect flying around as gnats and a mosquito. V6 said, this is the dish washing area. V6 said, she has not seen any gnats prior to today.Service Inspection Report dated 9/24/25 documents: Main Kitchen Area: Comments: Fruit flies were present during the time of service. Kitchen floor needs to be regrouped to prevent fruit flies from breeding.On 9/23/25 at 3:43pm, R5 was observed with a partially open bag of restaurant food on his bedside table with seven or more gnats crawling around top, inside and on the outside of his food bag. Three gnats were resting on R5's wall near his bedside table. V4 said, there are gnats in and around R5's food bag. V4 said, there are gnats on the wall. Pest control Policy dated 3/22/21 documents: Provide a healthy environment for residents. Mosquitoes-they not only bite patient and cause allergic reaction at times but also carry disease like [NAME] Nile virus. Often, elderly patient is more susceptible to this infection when compared to younger population and have more difficulty recovering. Keep trach cans lined and empty them regularly. |