STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. Building B. Wing	01/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Hillside,the	4600 North Frontage Road 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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure a thorough and credible investigation was conducted for 1 of 3 residents (R1) reviewed for abuse. Specifically, the facility's investigative process failed to: 1) Reconcile conflicting evidence between a staff member's motive and the resident's initial allegation of being 'hit'; 2) Include critical witness testimony from the first clinician on the scene (V4 Agency RN) in reports provided to law enforcement; 3) Conduct a clinical review to assess the feasibility of a catastrophic orbital globe rupture and depressed fracture being caused by a minor 'accidental' strike; and 4) Factor the resident's Mild Alzheimer's and high-risk use of Eliquis into the evaluation of the incident and subsequent 'recantation.' As a result of this incomplete investigative process, the facility provided a medically implausible and incomplete narrative to law enforcement, which contributed to the premature closure of an abuse investigation into a life-altering injury. Review of the facility's undated policy titled Abuse Prevention Training Program, stated in part but not limited to: Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, physical abuse, and mental abuse . Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. The policy further states that Abuse is most likely to happen in situations that result in frustration, annoyance, and anger, and directs staff to manage these situations with self-control and to remove themselves from the situation when in doubt. Review of the facility's final investigative file regarding the incident on 11/08/25 revealed that the facility neglected to document or include critical testimony and clinical evidence: During an interview on 01/16/26 at 11:55 AM, V4 Agency RN stated he was the first clinician on the scene and documented R1's immediate allegation that the CNA hit me. V4 also observed the CNA's agitated state and perceived anger toward R1 over a broken necklace as a possible motive. V4 stated he reported these findings to the Administrator and management, yet the facility's formal report to Law Enforcement did not include these observations and the fact that a staff member had reported the incident as an assault via a 911 call. The facility concluded R1's injury was accidental, suggesting the resident's eye was struck by the resident himself and did not include the possibility that the necklace chain or pendent may have been the contributing blunt object. Review of the hospital discharge summary confirmed a depressed orbital floor fracture and left orbital globe rupture requiring emergent surgical intervention. There was no evidence the facility consulted a medical professional to determine if a swinging pendant or a self-inflicted blow from an elderly resident with Mild Alzheimer's could generate the force required to fracture the bony orbit. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. Building B. Wing	01/18/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence that R1's use of Eliquis (Apixaban) and the associated risk of hemorrhage were evaluated. Clinical literature indicates that geriatric patients on anticoagulant therapy are at an increased risk for sight-threatening retrobulbar hemorrhages following blunt trauma. Despite R1 requiring emergent surgery for severe hemorrhaging, the facility did not conduct a clinical review to reconcile how a minor accident could lead to such a catastrophic emergency. Review of Police Report #25-002908 indicated the Administrator (V1) provided a statement asserting the resident recanted the allegation. However, the facility's records do not indicate that R1's cognitive impairment (Mild Alzheimer's) or potential suggestibility following traumatic injury were considered when evaluating the validity of this recantation. Furthermore, the facility did not demonstrate that a neutral advocate or social worker was present during the interview where the recantation occurred. A review of the facility's internal abuse investigation procedures revealed that the facility lacked a thorough and complete investigative process as required by Federal regulations. Specifically, by omitting documented allegations of physical assault from the formal report and failing to clinically validate the feasibility of the injury, the facility lacked a thorough implementation of a system that ensures residents are protected. This facility's investigative process mischaracterized a major physical assault as an accident, resulting in profound clinical and legal consequences for R1. The resident sustained a permanent left orbital globe rupture and total loss of vision in the affected eye. Additionally, the apparent incomplete narrative provided to law enforcement resulted in the closure of the criminal investigation without charges, depriving a resident with Mild Alzheimer's of the legal recourse and protective oversight necessary following a life-altering injury.