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	02/18/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect and prevent one (R1) of three residents from injury of unknown origin. This failure resulted in R1 sustaining multiple fractures, left subdural hematoma, right parietal subarachnoid hemorrhage, anterior wall bruising, and left shoulder bruising. This failure affected R1 and has the potential to affect all 163 residents residing at the facility. Findings include:R1's admission Record documents initial admission as 2/28/25 and latest admission as 7/05/25.R1's electronic medical record admission Record documents diagnose that includes but not limited to Unstable burst fracture of T11-T12 vertebra subsequent encounter for fracture with routine healing, altered mental status unspecified, unspecified fall subsequent encounter, unspecified cirrhosis of liver, hepatic encephalopathy, other pancytopenia, major depressive disorder, single episode moderate and alcohol dependence uncomplicated.R1's primary language is SpanishFacility Reported Incident dated 1/27/2026 at 3:50pm final report documents in part: Incident Date 1/27/2026 Time 3pm, R1 alert and oriented times 3 with a BIMS of 15 with no diagnosis of dementia or cognitive impairment. On 1/27/26 resident complained of left shoulder pain, receive pain medication that was not effective nurse placed a call to DR. New order to send patient to ER for evaluation. When asked if someone hurt him, R1 responded that no one hurt him. When asked if he felt safe at the facility, R1 responded yes I feel safe here. Hospital informed facility of multiple fractures with some being acute and chronic, intraabdominal hemorrhage, intracranial hemorrhage. Brusing noted to anterior chest wall and left shoulder. V25, Facility Liaison, interviewed R1 at hospital on 1/28/2026. V25 stated she was there to interview him to see if he remembers anything from the day that he was sent out. R1 stated that he was doing exercises in bed, and he felt stronger than normal. He wanted to walk, and he attempted to get out of bed. When he attempted, he fell to the side that was close to the window. R1 stated that a staff member assisted him back to bed and at that time R1 did not have pain. R1 stated that he doesn't want anyone to get in trouble, and he felt he could walk but he knows he can't now. R1 was asked why he didn't share this information with the hospital or the police, and he stated that he did not feel comfortable because they kept coming in and out and he didn't know them. Resident interview was not witnessed.R1's Emergency Medical Run sheet dated 1/27/2026 at 8:26.54 documents in part, Patient Evaluated, and care provided. Primary Symptom: Pain Narrative: 49yo male (R1) with numbness and pain to his left shoulder. Upon arrival crew found the pt laying semi-Fowlers in bed, aox4, in no distress, holding his left wrist. Pt informed crew that his left shoulder and left hip hurt. Pain began last night and has not gone away. Pain starts at shoulder down to elbow and from his feet up to his knee. Pt. Denies falls/trauma.R1's medical record showed that R1 was sent to the local hospital ER (Emergency Room) on 01/27/2026 for complaint of pain in his left arm. R1's hospital record 1/27/2026 showed that R1 had Multiple fractures that include Acute comminuted and displaced Left humeral head fracture and displaced left humeral head fracture, bilateral sub capital (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	8:00am and when she walked into his room to check on him, he (R1) was showing sign of pain groaning, and I could tell from his face expression that he was in pain. V17 further stated, I (V17) asked him if he was in pain and he said yes using head gestures to point to his left arm which was kind of swollen. V17 said as she was about to leave the room she saw V18 and V19 come into the room, as they walked into R1's room V18 translated what R1 was saying to V19. R1 said he did not know what happened, he said he had been laying on the left side on his arm for a long time. V19 then called the physician, and he was sent out because I did not see him for the rest of the day.On 01/29/2026 at 2:59pm, V19 Registered Nurse (RN) stated, she was the nurse that sent R1 out to the ER (Emergency room) and she worked from 7am to 3pm on 1/27/29 and she was familiar with R1. V19 stated, R1's call light was going off and V18 came out of R1's room telling me (V19) that R1 was complaining of pain. V19 stated, I went to assess him and V18 helped in translating. R1 complained of pain to left arm and left leg with limited mobility. R1 could not move. I (V19) called V34, Nurse Practitioner (NP) and V34 ordered to send R1 to the hospital to rule out stroke. V19 stated, the night nurse did not report any incidents with R1 and did not report that R1 fell and R1 did not say he fell.During the same interview V19 stated that I have worked with R1 before (01/27/2026). Normally he is in bed and will not go to the dining room to eat. He does not get up in wheelchair. I have never seen him out of bed. V19 stated, she has never seen him get out of bed by himself. V19 stated that (R1) needs staff to assist him using a transfer device if he needs to get up in a wheelchair or for any transfer. V19 stated that R1 needs two people's assistance for transfer.On 02/03/2026 at 11:17am, R1 was observed in bed. During interview with R1 with V3, Assistant Director of Nurses (ADON) present and on-line video Spanish interpreter, V23 (interpreter). R1 stated to interpreter, in part that he did not know what happened to him. He woke up and was in pain and was being sent to the hospital. R1 was asked if he fell. R1 stated, he did not remember falling and he did not remember telling anyone that he fell. R1 stated that he told them he was in pain.On 02/03/2026 at 11:36am, V22, Therapy Director stated in part that R1 was not currently getting PT/OT (Physical Therapy/ Occupational Therapy). V22 checked the computer and stated in part that R1 had PT from 07/10/25 to 07/23/25 and OT from 07/11/2025 to 7/23/2025. V22 stated, R1 is now in facility restorative program. V22 further stated R1 cannot transfer from bed to chair or vice versa independently. PT discharge instructions for R1 with supervision/touch assistance, a staff must be with resident because it documented maximum assistance that means staff helping with transfer 75% and R1 helping at 25%. OT with personal hygiene documented that R1 upper body with set up only and with lower body maximum assistance, staff must assist.R1's PT (Physical Therapy) discharge summary presented with dates of service from 7/10/2025 to 7/23/2025 documented under Functional Skills Assessment that bed mobility roll left and right =setup or clean-up assistance, sit to lying=supervision or touching assistance, lying to sitting on side of bed = supervision or touching assistance, Transfer sit to stand=substantial/maximal assistance. Mobility score Mobility function score (ranges from 0-12; 12 being the highest function) = 0, Mobility Performance raw score = 1. On 02/03/2026 at 2:15pm, V20, Physician stated, that R1 is one of my patients he came to us (facility) from the hospital after a fall. R1 has alcoholic history, fracture of the spine. He was seen by neurosurgeons and was sent to the facility for rehab (rehabilitation) since I met him, he has not been able to walk any more. He has no place to go. He has memory change; he cannot recall things, repeats himself. He (R1) had therapy for about a year with no change. When I talk to nursing (staff), they say he does not get out of bed and is not able to walk. That became his (R1)'s new baseline. V20 stated that he last saw R1 in December 2025, and V34 I saw him on 23rd of January 2026. V20 stated that R1 cannot walk independently. He cannot and has never tried to walk before as far as I know. (continued on next page)

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