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	03/09/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the standard of practice and physician orders for the care of urinary catheters. This applies to 2 of 3 residents (R2 and R4) reviewed for catheter care in a sample of 6.The findings include:1.R2 is an [AGE] year-old female admitted on [DATE], having severe cognitive impairment as per the Minimum Data Set (MDS) dated [DATE].On 3/7/26 at 10:05 AM, R2 was observed on her bed with her spouse (V10) at bedside. V10 stated, My wife was sent to the local hospital due to a severe infection. They are not changing gloves between care, which is causing infection.On 3/7/26 at 10:40 AM, observed V12 (Certified Nursing Assistant / CNA) providing urinary catheter care for R2 with stool on catheter. V12 provided urinary catheter care by wiping the catheter toward the urethra and then away from it.On 3/7/26 at 2:10 PM, V2 (Director of Nursing / DON) stated, As per standard of practice, the catheter itself should be wiped from the insertion site outward to prevent infection. I will conduct an in-service to educate staff on providing catheter care.A review of the health status note dated 12/1/25 documented that R1 was admitted to the local hospital for urinary tract infection (UTI) and sepsis. A further review of the health status note dated 2/12/26 and 1/7/26 documented that R2 was admitted to the local hospital on 2/12/26 and 1/7/26 due to sepsis.2.R4 is a [AGE] year-old male with intact cognition per the Minimum Data Set (MDS) dated [DATE].On 3/7/26 at 11:25 AM, R4 was observed in his bed with his suprapubic catheter site dirty and dry blood almost four inches around the insertion site.A review of R4's physician order sheet (POS) document: Cleanse suprapubic catheter insertion site daily and as needed (PRN). Use soap and water, as needed, unless otherwise ordered.On 3/7/26 at 2:10 PM, V2 added that the suprapubic catheter should have been kept clean to prevent potential infection.

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	03/09/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to follow its appointments and transportation policy by not arranging transportation for outside appointments. This applies to 1 of 3 residents (R1) reviewed for appointments and transportation in a sample of 6.The findings include:R1 is a [AGE] year-old male with mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. A review of the MDS also documented that R1 was admitted with an admitting diagnosis including malignant neoplasm of the mouth.On 3/7/26 at 9:15 AM, R1 was observed in his bed with swollen lips and was unable to communicate effectively.On 3/6/26 at 2:15 PM, V8 (Oncology Clinic Nurse Practitioner) stated, I am R1's oncology clinic nurse practitioner. R1 missed so many appointments, I would say around five appointments, between other care providers and us. R1 said he missed his appointments due to a lack of transportation, communication, and not writing it down in the records for staff to follow up after setting transportation. R1 is at high risk for relapse if he misses his oncology appointments.A review of the clinical physician orders documented that R1 was scheduled for a cardiology appointment on 2/4/26 at 9:05 AM, an oncology appointment at 12:00 PM, and an infusion appointment at 2:00 PM.A review of the transportation schedule for 02/2025 and nursing progress notes from 2/1/26 through 2/6/26 documented that R1 was sent only for cardiology appointments, not for oncology or infusion appointments.A further review of the January transportation schedule and nursing progress note from 1/25/26 through 1/30/26 documented that R1 was not sent for the oncology appointments on 1/27/26 at 11:40 AM.On 3/7/25 at 2:10 PM, V2 (Director of Nursing / DON) stated, I can't remember exactly why he missed appointments. The resident has the right to go for an appointment, and we are supposed to set it up.A review of the facility's appointments and transportation policy, reviewed on 4/16/2025, documented that when a resident has an appointment outside the facility, staff will make the transportation arrangements unless the responsible party chooses to make them themselves.