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	06/25/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to provide appropriate footwear as a fall prevention intervention for a cognitively impaired resident with a history of repeated falls. This failure affected one resident (R72), reviewed for fall prevention in a total sample of 68 residents.Findings include:R72's face sheet documents diagnoses which include but are not limited to Dementia, Repeated Falls, Osteoarthritis, and Adult Failure to Thrive.Fall assessment dated [DATE] showed that R39 is at risk for falls.BIMS (Basic Interview for Mental Status) did not have a score due to Severe Cognitive Impairment. Care plan dated 10/3/24 showed in part that R72 is at risk for falls due to impaired mobility, confusion, gait balance problems, incontinence, psychoactive drug use, unaware of safety needs and diagnosis of Dementia. Intervention states in part to follow facility fall protocol.MDS (Minimum Data Status) Section GG dated 3/27/26 showed that R72 requires assistance for functional abilities and R72 uses a wheelchair.On 6/22/26 at 10:45am, R72 was observed in the activity room sitting in the wheelchair at table with other residents during activities. R72 was wearing a pair of socks with blue and black color that was smooth on the bottom, not nonskid. Again, on 6/22/26 at 12:05pm, R72 was in the same position with the same pair of smooth bottom socks. At this time, V25(Activity staff) stated the name of the resident and checked the bottom of R72's socks and confirmed that the socks R72 was wearing had smooth bottom and were not non-skid. V25 and V6 (Activity Director) stated that they would inform the CNA (Certified Nurse Assistant) and Nurse to find nonskid socks for R72.On 6/23/26 at 11:20am, the surveyor asked V2(Director of Nursing) why a resident at risk for falls needed to wear nonskid socks or appropriate nonskid footwear. V2 stated nonskid socks are important to prevent falls and that she(V2) would remind staff to ensure that residents wear nonskid socks. V2 Added that she(V2) is relatively new at the facility, but she believes that nonskid socks are available in storage, and she would ensure that the socks are available in residents' rooms.Facility's policy titled Fall Prevention and Management with latest revision date 3/25/2026 states: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. #1d: High risk residents and patients for falls will receive individualized interventions as appropriate to risk factors.

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