

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                        | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         | S0000               |                                                                                                                          |  | 03/03/2026                                      |  |
|                                                              | Complaint Investigation: 2691165/2728192                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |                     |                                                                                                                          |  |                                                 |  |
| S9999                                                        | Final Observations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         | S9999               |                                                                                                                          |  | 03/03/2026                                      |  |
|                                                              | Statement of Licensure Violation:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.610a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.1210a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.1210b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | 300.1210d)6)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | Section 300.610 Resident Care Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall be<br>formulated by a Resident Care Policy Committee<br>consisting of at least the administrator, the advisory<br>physician or the medical advisory committee, and<br>representatives of nursing and other services in the<br>facility. The policies shall comply with the Act and<br>this Part. The written policies shall be followed in<br>operating the facility and shall be reviewed at least<br>annually by this committee, documented by written,<br>signed and dated minutes of the meeting.                                                                 |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | Section 300.1210 General Requirements for Nursing and<br>Personal Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                              | a) Comprehensive Resident Care Plan. A facility, with<br>the participation of the resident and the resident's<br>guardian or representative, as applicable, must develop<br>and implement a comprehensive care plan for each<br>resident that includes measurable objectives and<br>timetables to meet the resident's medical, nursing, and<br>mental and psychosocial needs that are identified in<br>the resident's comprehensive assessment, which allow<br>the resident to attain or maintain the highest<br>practicable level of independent functioning, and<br>provide for discharge planning to the least restrictive<br>setting based on the resident's care needs. The<br>assessment shall be developed with the active |                                                                         |                     |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

|                                                                       |       |           |
|-----------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|-----------------------------------------------------------------------|-------|-----------|

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 1<br/>participation of the resident and the resident's<br/>guardian or representative, as applicable. (Section<br/>3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and<br/>services to attain or maintain the highest practicable<br/>physical, mental, and psychological well-being of the<br/>resident, in accordance with each resident's<br/>comprehensive resident care plan. Adequate and properly<br/>supervised nursing care and personal care shall be<br/>provided to each resident to meet the total nursing and<br/>personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care<br/>shall include, at a minimum, the following and shall be<br/>practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure<br/>that the residents' environment remains as free of<br/>accident hazards as possible. All nursing personnel<br/>shall evaluate residents to see that each resident<br/>receives adequate supervision and assistance to prevent<br/>accidents.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to<br/>protect and prevent one (R1) of three residents from<br/>injury of unknown origin. This failure resulted in R1<br/>sustaining multiple fractures, left subdural hematoma,<br/>right parietal subarachnoid hemorrhage, anterior wall<br/>bruising, and left shoulder bruising. This failure<br/>affected R1 and has the potential to affect all 163 residents<br/>residing at the facility.</p> <p>Findings include:</p> <p>R1's Admission Record documents initial admission as<br/>2/28/25 and latest admission as 7/05/25.</p> <p>R1's electronic medical record Admission Record<br/>documents diagnose that includes but not limited to<br/>Unstable burst fracture of T11-T12 vertebra subsequent<br/>encounter for fracture with routine healing, altered<br/>mental status unspecified, unspecified fall subsequent<br/>encounter, unspecified cirrhosis of liver, hepatic<br/>encephalopathy, other pancytopenia, major depressive<br/>disorder, single episode moderate and alcohol<br/>dependence uncomplicated.</p> <p>R1's primary language is Spanish</p> <p>Facility Reported Incident dated 1/27/2026 at 3:50pm final<br/>report documents in part: Incident Date 1/27/2026 Time<br/>3pm, R1 alert and oriented times 3 with a BIMS of 15 with</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 2</p> <p>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. Bruising 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.</p> <p>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.</p> <p>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.</p> <p>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 femoral neck fractures, minimal displaced bilateral sacral body insufficiency type fracture at S2, minimal displaced right L4 transverse process fracture, small left subdural hematoma, right parietal subarachnoid hemorrhage, anterior chest wall bruising, left shoulder bruising, bruising is 3 to 4 days old.</p> <p>R1's hospital record 1/27/2026 documented in part that He (R1) at one point accepted that somebody hurt him, however (R1) is reluctant to give information about</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |  |                                                                                                      |                                                                                                                          |                                                 |                            |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                 |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                        | <p>Continued from page 3<br/>fear of police involvement or other social reasons.</p> <p>R1's MDS (Minimum Data Set) dated 12/05/2025 coded BIMS score as 15 indicating that R1 is cognitively intact. Section GG under GG0115 functional limitation documents under range of motion that R1 has no impairment. R1 uses wheelchair for ambulation, for transfer needs supervision or touching.</p> <p>R1's plan of care documents that R1 is unable to leave the facility independently on community pass. R1 cannot go out without an escort for appointments.</p> <p>R1's plan of care documented that R1 has self-care performance deficit and for transfer needs sit to stand transfer device ADLs (Activity of Daily Living).</p> <p>R1's fall assessment dated 9/5/25 R1 was categorized as a low risk for falls with a score of 11.0 and on 1/28/2026 a score of 10.0 indicating low risk for falls. V19, Registered Nurse (RN) documented that the patient (R1) complained of extreme pain and numbness in the left upper extremity. Limited mobility noted in the left arm and leg. Vitals are listed: B/P-120/ 54, pulse (Pulse) 60, O2% 95, RR (Respiration Rate) 15. AOX3. MD (Medical Director) paged. Orders received to send to ER (Emergency Room) to rule out stroke. Orders carried out. Patient (R1) sent to ER via 911.</p> <p>On 01/29/2026 at 9:12am, V1, Administrator stated, "I think this visit will be about (R1) because the hospital already told us they called it in to IDPH (Illinois Department of Public Health)". At 9:42am during conference meeting with V1 and V2, Director of Nursing (DON), both stated that R1 did not fall. V1 further stated, "I have interviewed the staff and they all said R1 did not fall".</p> <p>On 01/29/2026 at 10:00am, V1 stated, R1 is one of the residents that was admitted on a contract from a local hospital to be housed and care for because they have medical needs with their care.</p> <p>On 01/29/2026 at 10:04am, V3, Emergency Room Registered Nurse (RN) stated that she received R1 via ambulance from the facility with complaints of left shoulder pain and arm. V3 stated, R1's left shoulder was bruised and R1 could not lift his arms and there was visible bruising. R1's X-Ray showed both hips broken (fracture), Acute left shoulder fracture, C-T scan done and it showed that he had peritoneal hematoma, head and neck showed subdural bleeding on the left side. V3 stated that (R1) is alert, speaks Spanish and I am Spanish, so I was able to communicate in Spanish with</p> |                                                                         |  | S9999                                                                                                |                                                                                                                          |                                                 |                            |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 4</p> <p>R1. R1 said he did not remember what happened and that he had been living in the facility for eight to nine months. (R1) is bed bound, and he can only sit in bed when the head of the bed is raised.</p> <p>On 01/29/2026 at 2:31pm, V18, Certified Nurse's Aide (CNA) stated, she is familiar with R1, and she worked with R1 on 01/26/26 but was not his direct CNA for 01/27/26. V18 stated, she speaks Spanish so R1 likes to talk with her. V18 stated in part that on 1/26/26 there was no abnormal incident with R1. He was sitting in bed with his phone watching video on his phone. V18 explained that on 1/27/2026 R1 had his call light on so when I went into the room, he said he could not move and was in pain because he slept on his left side for a long time. R1 asked me to help him to turn on his back. I (V18) just helped by pulling his incontinent clothing pad under him to get him off his side. R1 kept complaining of pain to the left side holding his left arm saying it is painful. I let the nurse (V19) know, he said he could not move the left arm while complaining of pain. V18 stated in part that we (facility nursing staff) use a transferring Device to move R1 with 2 people's assistance. R1 is on fall risk, with his bed most of the time on low setting. V18 was asked if R1 fell on 1/27/2026. V18 stated, "Not that I know off".</p> <p>On 1/29/26 at 1:15pm, V17, Certified Nurse's Aide (CNA) stated that she was assigned to R1 on 1/27/26 morning shift. V17 stated she is familiar with (R1). V17 stated that on 1/27/26 she was late to work arriving at 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.</p> <p>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</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 5</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 6<br/>raw score = 1.</p> <p>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. R1 needs supervision in getting up with assistance from staff". V20 further stated in part, I looked at the hospital's report with the fractures, the injury was on the left side. It is very possible he fell, R1 is a high risk for falls. V20 stated that R1's injuries are consistent with falls. The surveyor asked if it is appropriate to rate R1 as a low risk for fall. V20 stated that R1 should never have been a low fall risk from admission. V20 stated in my professional opinion with transfer, I would recommend two people assist with device.</p> <p>On 2/11/2026 at 12:10pm V29, Certified Nurse's Aide (CNA) stated, R1 did not fall, and I did not pick up R1 off the floor. V29 further stated he will deny any accusation that he picked R1 off the floor. V29 worked 1/26/2026 into 1/27/2026.</p> <p>On 2/11/2026 at 12:38pm V1 (Administrator) stated, V29 has been suspended from the facility pending investigation after the facility was made aware of the allegation but was not reported to IDPH as fall with injury because V29 denies that R1 fell during his shift.</p> <p>On 02/11/2026 between 2:09 to 2:17pm, V34 NP (Nurse Practitioner) stated in part that she has been following him (R1) since last year. V34 said on the day he was sent out, the nurse called me to say that he was having severe pain in the left side unable to move so I told them (nurse) to send him to the (Hospital) for workup (evaluation and treatment) to rule out stroke. The work up came out that R1 has multiple fractures, bleeding in the brain and abdomen. The surveyor asked V34 whether it is possible for R1 to walk independently, get up from the bed or dangle feet exercising. V34 explained that R1 has not being able to walk since admission to</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b>                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                        | <p>Continued from page 7<br/>the facility (February 2025). Movement to lower extremity is slow and weak, the right side has been weaker. The nurse (referring to V19) did not say R1 fell, and V2 DON (Director of Nurse's) told me that R1 did not fall.</p> <p>During this investigation V31 LPN (Licensed Practical Nurse) was contacted via telephone without success. V2 DON (Director of Nurse's) stated that she had tried to contact V31 several times without success.</p> <p>The facility as at 3:00pm on 2/11/2026 could not present any fall incident report. V2 stated that because the staff that worked did not report any fall incident and that none of the staff knows what happened to R1 and the cause of injury.</p> <p>According to facility investigation, the facility staff interviewed on 1/27/2026 and 1/28/2026 V5, V18, V28, V29, V30, V32, V35, V36, V38, V39, V40, V43, V44, V48, V49, Certified Nursing Assistants, V13, V14, V31, V47, Licensed Practical Nurses, and V37, V41, V46, V50, Registered Nurses did not know what happened to R1 and denied that R1 fell and was picked up off the floor.</p> <p>On 02/11/2026 at 10:34am, V5 stated that (R1) cannot sit on the edge of the bed or scoot down the bed. R1 can only turn to side with the (staff) assistance because we (staff) must help him move his legs and feet. He (R1) lays on the bed playing with his phone. V5 stated R1 speaks only Spanish language.</p> <p>On 02/11/2026 at 10:36am, V12 stated that (R1) only move in bed by sitting up and turning with incontinent care with staff assistance. I have never seen R1 get up or stand up. (R1) needs 2 people's assistance if he must get up. We (nursing staff) just raise the head of the bed up. He (R1) cannot scoop to the edge of the bed, and I have never seen him done that. V12 stated that I have not seen him even trying to get off the bed.</p> <p>On 02/11/26 at 12:25pm, V1 stated in part that none of the staff interviewed knows what happened to R1. When pictures of the night CNAs on 01/26/2026 were shown to R1, R1 identified (V29) that it was him who picked him off the floor.</p> <p>Facility Abuse prevention policy presented under definitions documents in part that the federal and state laws and regulations mandate that a nursing home resident has the right to be free from abuse. Injury of unknown source are injuries for which both of the following condition are met one the source of injury</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                 |                                                                         |  |                                                                                                      |                                                                                                                          |                                                 |                            |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0056903</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                 |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>PEARL OF HILLSIDE,THE</b> |                                                                                                                                                                                                                                                                                                 |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4600 NORTH FRONTAGE ROAD , HILLSIDE, Illinois, 60162</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                    |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                        | Continued from page 8<br>was not observed by any person, or the source of injury<br>could not be explained by the resident and two the<br>injury is suspicious because of the extent or location<br>of the injuries observed at one point, or the incidence of<br>injuries overtime.<br><br>(A) |                                                                         |  | S9999                                                                                                |                                                                                                                          |                                                 |                            |