

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Pearl Pointe Nursing Rehab & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 900 South Kiwanis Drive Freeport, IL 61032	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident was free from misappropriation for 1 of 3 residents (R1) reviewed for theft in the sample of 5. The findings include: On 11/24/25 at 9:30 AM, R1 was sitting at the bedside in her room. R1 said she woke up one morning and her ring was missing. R1 pointed to her left hand, ring finger. R1's left hand ring finger had a visible indentation of where a ring had been worn. R1's skin in this area was lighter in color. R1 said it was a tight-fitting ring and it just wouldn't slide off. R1 said she was very upset and told the first person that came in the room when she noticed. R1 said she never took the ring off. R1 said it was a large ring and went from her knuckle to the base of her finger. R1 said it had numerous diamonds with two large diamonds and it was yellow gold. R1 stated I miss it a lot. R2 (R1's room mate) said R1 always wore the ring and both herself and R3 sat with R1 at meals saw R1's ring. R2 said R1 came to breakfast one day and told herself and R3 that the ring was missing. R2 said R1's ring fit snugly. On 11/24/25 at 10:00 AM, R3 said R1 wore a wedding band on her left hand that she always had on. R3 said R1 told them one morning at breakfast that she lost her ring. R3 said R1 was very upset and said V4 Housekeeping was looking for it. On 11/24/25 at 11:25 AM, V9 (R1's Power of Attorney/sister) said R1 had a ring when she came to the facility from the hospital. V9 said R1's daughter visited R1 at the facility on 10/13/25 and confirmed that R1 had her ring on her finger. R1's Inventory of Personal Effects dated 9/25/25 shows Jewelry-1 ring. R2's Minimum Data Set, dated [DATE] shows R2 is cognitively intact. R3's MDS dated [DATE] shows R3 is cognitively intact. The facility's Abuse Prevention Policy dated 1/24 shows Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview, and record review the facility failed to follow their Abuse Policy when a resident reported missing property for 1 of 3 residents (R1) reviewed for abuse in the sample of 5. The findings include: On 11/24/25 at 9:30 AM, R1 was sitting at the bedside in her room. R1 said she woke up one morning and her ring was missing. R1 pointed to her left hand, ring finger. R1's left hand ring finger had a visible indentation of where a ring had been worn. R1's skin in this area was lighter in color. R1 said it was a tight-fitting ring and just wouldn't slide off. R1 said she was very upset and told the first person that came in the room when she noticed. R1 said she never took the ring off. R1 said it was a large ring and went from her knuckle to the base of her finger. R1 said it had numerous diamonds with two large diamonds and it was yellow gold. R1 stated I miss it a lot. R2 (R1's roommate) said R1 always wore the ring and both herself and R3 sat with R1 at meals saw R1's ring. R1 said some staff had helped her look for it. R2 said R1 came to breakfast one day and told herself and R3 that the ring was missing. On 11/24/25 at 10:00 AM, R3 said R1 wore a wedding band on her left hand, that she always had on. R3 said R1 told them one morning at breakfast that she lost her ring. R3 said R1 was very upset and said V4 Housekeeping was looking for it. On 11/24/25 at 10:09 AM, V4 Housekeeping Manager said she was in R1's room one morning and R1 told her she was missing her ring and was very upset about it. V4 said she looked under R1's bed, in R1's wheelchair, and shook out R1's pajama pants. V4 said she told another housekeeper that when R1 got up for breakfast to strip R1's bed and look in the covers. V4 said R2 reported to her that R1's ring was missing, and she told R2 that she was looking for it. V4 said she did not report R1's missing ring to anyone, but she should have. On 11/24/25 at 12:43 PM, V12 Certified Nursing Assistant (CNA) said R1 told her about her ring missing awhile back when R1 was on the south hallway. V12 said she told the nurse on duty at that time and talked about it with V13 CNA. On 11/24/25 at 12:01 PM, V1 Administrator said she became aware of R1's missing ring on 11/17/25 when R1's POA and nephew came into the facility and reported it to her. V1 said staff are to report a resident's missing item right away to the administrator or supervisor according to their abuse policy. The facility's Abuse Prevention Program Policy dated 1/24 shows Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an allegation of misappropriation of resident property was reported immediately for 1 of 3 residents (R1) reviewed for theft in the sample of 5. The findings include: On 11/24/25 at 9:30 AM, R1 was sitting at the bedside in her room. R1 said she woke up one morning and her ring was missing. R1 pointed to her left hand, ring finger. R1's left hand ring finger had a visible indentation of where a ring had been worn. R1's skin in this area was lighter in color. R1 said it was a tight-fitting ring and just wouldn't slide off. R1 said she was very upset and told the first person that came in the room when she noticed. R1 said she never took the ring off. R1 said it was a large ring and went from her knuckle to the base of her finger. R1 said it had numerous diamonds with two large diamonds and it was yellow gold. R1 stated I miss it a lot. R2 (R1's roommate) said R1 always wore the ring and both herself and R3 sat with R1 at meals saw R1's ring. R1 said some staff had helped her look for it. R2 said R1 came to breakfast one day and told herself and R3 that the ring was missing. R2 said R1's ring fit snugly and R1 always had it on. On 11/24/25 at 10:00 AM, R3 said R1 wore a wedding band on her left hand, that she always had on. R3 said R1 told them one morning at breakfast that she lost her ring. R3 said R1 was very upset and said V4 Housekeeping was looking for it. On 11/24/25 at 10:09 AM, V4 Housekeeping Manager said she was in R1's room one morning and R1 told her she was missing her ring and was very upset about it. V4 said she looked under R1's bed, in R1's wheelchair, and shook out R1's pajama pants. V4 said she told another housekeeper that when R1 got up for breakfast to strip R1's bed and look in the covers. V4 said R2 reported to her that R1's ring was missing, and she told R2 that she was looking for it. V4 said she did not report R1's missing ring to anyone, but she should have. V4 said this occurred when R1 was in a room on the south hall. On 11/24/25 at 12:43 PM, V12 Certified Nursing Assistant (CNA) said R1 told her about her ring missing awhile back when R1 was on the south hallway. V12 said she told the nurse on duty at that time and talked about it with V13 CNA. V12 said R1 was upset and had her things on her floor looking for the ring. V12 said she helped R1 look for her ring and put R1's things back in order. On 11/24/25 at 1:21 PM, V13 CNA said R1 told her that her ring was missing at breakfast one morning. V13 said V12 had reported it. On 11/24/25 at 12:01 PM, V1 Administrator said she became aware of R1's missing ring on 11/17/25 when R1's POA and nephew came into the facility and reported it to her. V1 said staff are to report a resident's missing item right away to the administrator or supervisor. R1's Census list shows R1 resided in the south hallway room (Room Number) from admission on [DATE] to 11/11/25, when she was moved to room (Room Number). The facility's Abuse Prevention Program Policy dated 1/24 shows Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator.		