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 01/29/2026
NAME OF PROVIDER OR SUPPLIER: Pearl Pavilion		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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent and supervise a resident from ingesting cannabis and failed to ensure a residents community pass privileges were re-assessed for safety. This applies to 2 of 3 residents (R1, R2) reviewed for safety in the sample of 3. The findings include: 1. On 1/28/26 at 8:25 AM, a sign posted at the reception desk Stated SAFETY AND SECURITY NOTICE To Protect the safety and well-being of all residents, personnel and visitors. To ensure the safety all reasonable inspections of personal items or property may be conducted when there is a reasonable cause or concern for the presence of prohibited or unsafe items such as weapons, illegal substances, alcohol and contraband.dated 12/2/25. R1's face sheet shows she has diagnoses including seizures, schizoaffective bipolar, post traumatic dress disorder, suicidal ideations, poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, unspecified mood (affective) disorder, and epilepsy.R1's hospital records dated 1/21/26 documents (R1) apparently seemed to be more confused and was slurring her words. She had problems with suspicious drug use in the past and has been caught using drugs at the facility within the facility on two separate occasions per report. (R1's) urine tox (toxicity) screen was positive for marijuana.(R1) says she may have taken some gummies or something which caused her mental status changes. On 1/28/26 at 9:32 AM, R1 was in her room, she said she was sent out to the hospital recently. R1 said she was getting gummies from R2. On 1/28/26 at 9:19 AM, V7 (Certified Nursing Assistant) said on 1/20/26, R1 was not acting herself, she was very lethargic and did not seem right. She notified V5 (RN) of R1's change of behavior. V7 said there are rumors of residents using illegal substances in the facility, but she hasn't seen any residents have illegal substances. V7 said management did not discuss why the sign was posted about substances or contraband in the facility. On 1/28/26 at 9:19 AM, V6 (CNA) said you hit the nail on the coffin when asked about substances in the facility. V6 said she's heard of rumors but has not seen it herself. On 1/28/26 at 10:23 AM, V2 (Director of Nursing-DON) said she was not aware of any residents using substances at the facility. V2 said R1 has history of substance abuse, she has tested positive for THC and she is not sure how she is getting the substance. R1 goes out on supervised visits. If we suspect a resident to be under the influence, we can get an order for urine drug screen. On 1/28/26 at 10:51 AM, V1 (Administrator) said R1 reported she had gotten gummies from another resident. R1 has manipulative behavior with a history of substance abuse. R2 denied giving the gummies to R1. On 1/28/26 at 12:38 PM, V5 (RN) said on 1/20/26 she was R1's nurse. R1 was not acting right, she was sent out to the hospital and tested positive for THC again. She is not sure how or who she is getting the substances from. R1 goes out on supervised visits with her mom. R1 has behaviors of manipulation and goes into R2's room. V5 said she re-directs R1 back to her room when she is trying to go into R2's room. R1 has no reason to go into R2's room. On 1/29/26 at 9:30 AM, R2 was in his room, he denied giving R1 gummies and said he goes out to the community independently. R1's Urine (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug Screen dated 1/14/25 shows she tested positive for cannabis. R1's current care plan does not include she has a history of substance abuse. R2's face sheet shows he has diagnoses including unspecified cirrhosis of liver, alcohol abuse, restless leg, insomnia, and major depressive disorders.R2's Physician Order Sheets dated January 2026 shows orders dated 12/1/25 for a urine drug screen. R2's nurses note dated 12/15/25 documents on multiple occasions (R2) was asked to provide a urine specimen for ordered urine drug screen. (R2) would either be out of the building or stated each time he was not able to urinate. R2's EHR (electronic health record) shows the urine drug screen was not collected. R2's Community Survival Skills assessment dated [DATE] shows he is capable of outside pass privileges. 2. On 1/29/26 at 9:30 AM, R2 was in his room; he said he goes out to the community independently. R2 admitted to consuming alcohol on occasion when he is out because he has problems sleeping. R2 said he can leave the facility when he pleases and denied using substances while at the facility. On 1/28/26 at 9:19 AM, V7 (Certified Nursing Assistant) said R2 does his own thing, he just does whatever he wants. R2 does not have any restrictions, he can leave the facility by himself. On 1/28/26 at 12:38 PM, V5 (RN) said R2 is young male resident, refuses some of his medications and leaves the facility when he wants. V5 said she has heard R2 goes out to the bars and drinks. On 1/28/26 at 1023 AM, V2 (DON) said R2 is independent, goes out on pass and does not need to be supervised. R2 does his own thing. Denies R2 having behaviors, she was not aware of R2 refusing medications or having any concerns with using substances at the facility. On 1/28/26 at 12:05 PM, V4 (Social Services) said she does the community assessment to determine if a resident is safe to go out on pass independently. If a resident violates the pass privileges, they should not be able to go out independently. R2 can leave the facility interpedently and she is not aware of R2 using substances while at the facility.On 1/29/26 at 1:34 PM, V8 (Psych Nurse Practitioner) said R2 has a history of alcohol abuse and confirmed he refused to be drug tested. V8 said she has shared her concerns with R2's use of substances with the facility. R2's Psychiatry Note dated 1/12/26 shows he is frustrated about insomnia. R2 is currently using illicit substances such as ETOH (Alcohol) and possibly cocaine. He has been refusing to provide a urine sample for drug screening.staff report he is exhibiting odd behaviors and been verbally aggressive towards staff. R2's Psychiatry Note dated 12/15/25 shows he is frustrated because he is still not sleeping well at night. R2 refusing his antipsychotic because he is not sure why it was ordered. The urine drug screen that was ordered since last visit due to refusal. It is possible that he has been using substances such as ETOH, cocaine and marijuana during community passes. R2's Community Survival Skills assessment dated [DATE] shows he is capable of outside pass privileges. The facility's Community Pass Policy states, A resident has the right to community overnight access with the consent of the facility and the resident's cooperation with the standards described within. If the resident refuses to adhere to the standards, he or she may be discharged from the facility in accordance with the Involuntary Discharge or Against Medical Advice Policy.Residents will be informed and educated about rules and expectations while in the community, including, but not limited to.Using alcohol or any illicit substance and/or bringing these items into the facility is prohibited and may result in forfeiture of pass privilege.Consenting to be checked at the discretion of supervisory personnel upon return if reasonable suspicion of contraband exists. Contraband is defined as any non-prescribed medication, substance or object that is not part of the treatment plan, is not ordered by the physician and has the likelihood of causing the individual or other persons direct or indirect harm.The facility reserves the right to revoke the community pass privilege of a person assessed by the IDT or physician or Social Services as a threat to him/herself or others to assure the safety of the individual resident and the neighboring community.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure social services assisted residents with discharge services. This applies to 2 of 3 residents (R1, R2) reviewed for social services in the sample of 3. The findings include: R1's face sheet shows she was admitted to the facility on [DATE] with diagnoses including seizures, schizoaffective bipolar, post traumatic dress disorder, suicidal ideations, poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, unspecified mood (affective) disorder, and epilepsy.On 1/28/26 at 9:32 AM, R1 said she would like to be discharged to a place similar where she used to live. R1 said V4 (Social Services) was trying to find a place for me but has not told me what's going on. V4 said no one will accept me if I'm lying. On 1/28/26 at 12:05 PM, V4 said she has been at the facility for less than one year. R1 was admitted from the hospital and was living at residential group home setting. V4 said R1 lost her apartment since she has been at the facility. The previous home said they would not accept her back and did not give a reason. V4 said today she called developmental disability homes for placement and said they can take R1 when she is able to walk. V4 said R1 recently started walking. V4 said discharge planning should be initiated on admission and documentation should be in the resident's record. On 1/28/26 at 12:38 PM, V5 (RN-Registered Nurse) said R1 is a young resident with mental health needs. She needs to be placed where she can receive mental health services, be involved with groups and residents her own age. R1 is walking with her walker, she wants to use a wheelchair, but she is fully capable of ambulating. The staff are not trained for taking care of psych residents. On 1/28/26 at 10:51 AM, V1 (Administrator) said R1 has a history of mental health, substance abuse, and manipulative behaviors. R1 had been in a group home prior to admission and said they are trying to find placement for her. On 1/28/26 at 1:34 PM, V8 (Psych Nurse Practitioner) said due to R1's psych history she would benefit being in environment that specializes in psych services, providing group, individual therapy and being with residents around her age. R1's Social Services note dated 12/5/25 shows R1 would like to live in a place like she did before she got sick and went to the hospital and was admitted to the facility. R1 expressed she wanted to be placed in a group-like setting where she can have her own room, and staff would help with needs and go on trips. R1's Social Service notes from September 2025 to January 27,2026 show no documentation regarding discharge planning and there is no documentation showing group homes/facilities have been contacted for discharge placement.R1's current care plan shows discharge planning needs to be continually assessed but the IDT team placement continues to be temporary as (R1) verbalizes the desire to return to community/group setting. Interventions include social service will assist to find resident/group setting as requested. 2. R2's face sheet shows he was admitted on [DATE] from acute care hospital with diagnoses including unspecified cirrhosis of liver, alcohol abuse, restless leg, insomnia and major depressive disorders.On 1/28/26 at 9:30 AM, R2 was in his room. He said he came to the facility about a year ago from the hospital. R2 said he is independent with care and walks independently. R2 said there has been discussion about finding alternative placement for him. On 1/29/26 at 12:05 PM, V4 (Social Services) said R2's plan is for him to stay at the facility. He gets defensive when asking about discharge planning. R2 is not receiving therapy and confirmed he is independent with his needs. On 1/28/26 at 10:51 AM, V1 (Administrator) said R1 is young male resident, goes out on pass independently, he has reported he is at peace and complacent here. What can we do, R2 has nowhere to go. On 1/29/26 at 2:45 PM, V3 (Regional Nurse Consultant) said discharge planning should be started on the day of admission and updated/care planned in the resident's record. V3 confirmed there was no documentation of R1 and R2's discharge (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planning or attempts to find alternative placement. R2's Social Service note dated 11/9/25 documents, he is alert and oriented, able to communicate verbally his needs, ambulated independently using a walker, is a smoker, goes out of the facility has an independent community pass. R2's Social Service notes requested from November 2025 to January 2026 shows no documentation for discharge planning. R2's current care plan shows he is here for short term rehab; he makes his own decisions and is independent with activities. R2 discharge care plan shows he has extensive care needs and requires long term care setting. R2's preference is not to be asked about discharge planning. The facility's Discharge Planning dated January 2020, states, To identify appropriate candidates for inclusion in active discharge planning, to facilitate the transition to a less structured environment/or resident/decision-maker transfer requests to another facility of choice and to coordinate adequate supportive community care services.To assure the involvement of the Social Work staff in assessing discharge potential, transfer requests, documenting significant information related to discharge and coordinating community health care services.