| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145234 | A. Building<br>B. Wing | 06/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl Pointe Nursing Rehab & Care | 900 South Kiwanis Drive<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a paraplegic resident was provided with a call light according to his needs to 1 of 9 (R1) residents reviewed for accommodation of needs in the sample of 9. The findings include:R1's facility assessment dated [DATE] show R1 has a BIMS of 15-no cognitive impairment.On 6/30/26 at 8:45 AM, R1 was lying in bed. R1 showed this surveyor a regular call light tied to his right hand and placed near his mouth and chin. R1 said he uses his mouth or tongue or chin to push his call light when he needed something. R1 said this was hard. R1 said he had been here since 6/19/26. R1 said the facility knew his condition as paraplegic, and they should have provided a soft touch call light he can easily access since he cannot move his hands due to paraplegia.On 6/30/26 at 11:30 AM, V2 (Nurse Manager) said she had noticed R1 needed an easily access call light like (soft touch call light) due to his limited mobility. R1 is paraplegic. V2 said she thought this was taken care of at the time of R1's admit by V13 (previous Director of Nursing). V2 said she had instructed V4 (Maintenance Director) to order a soft touch call light for R1. V2 said it was important that all residents' needs were met in accordance with their rights. On 6/30/26 at 12PM, V4 showed this surveyor an electronic mail (email) document showing R1's soft touch call light was ordered last 6/25/26 (six days after R1's admit). V4 said it had arrived yesterday and will be provided to R1 today. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident that is totally dependent on staff for Activities of daily living (ADL) care received showers and personal hygiene care. This failure effects 1 of 5 residents (R1) reviewed for ADL care in the sample of 9. The findings include:R1's face sheet shows he was admitted to the facility on [DATE], with diagnosis that includes paraplegia due to injury to C4 and C5 cervical spinal cord.R1's care plan dated 6/22/26 show, R1 has an alteration of neurological status related to quadriplegia/paralysis, self-care deficit, resident is dependent with ADL care, with intervention to provide total care for showers and hygiene.On 6/30/26 at 8:45 AM, R1 was in his room lying in bed. R1 said he was supposed to get a shower yesterday (6/29/26 Monday) and his hair washed but it was not done. R1 said he had been here at the facility since 6/19/26 and his hair had not been washed. R1 said his hair was so itchy. R1's hair was unkempt, greasy, oily with several white flaky substances noted throughout his hair.On 6/30/26 at 11:AM, V3 Certified Nursing Assistant (CNA) said R1's scheduled showers including hair wash were Friday PMs and Mondays PMs. V3 said R1's hair was so greasy consistent with not having been washed in days. V3 (CNA) said showers should be done as scheduled for the residents' cleanliness and comfort.On 6/30/26 at 3:45 PM, V2 (Nurse Manager) said residents should be provided with care including hair washed/showers. The Facility Policy entitled Resident shower (undated) shows it is the practice of this facility to assist residents with bathing to maintain proper hygiene stimulate circulation and help prevent skin issues as per current standard of practice. |