

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053603		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/18/2026	
NAME OF PROVIDER OR SUPPLIER PEARL PAVILION				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH KIWANIS DRIVE , FREEPORT, Illinois, 61032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			03/02/2026	
	Complaint Investigation 2611721/2739103						
S9999	Final Observations		S9999			03/02/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)1)						
	300.3210t)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive						

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053603		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/18/2026	
NAME OF PROVIDER OR SUPPLIER PEARL PAVILION				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH KIWANIS DRIVE , FREEPORT, Illinois, 61032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 1 setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide effective pain management to a resident with phantom pain in all 4 amputated extremities. This failure resulted in R1 having severe pain from 1/31/26 to 2/6/26 when he missed 11 doses of medication. This applies to 1 of 3 residents (R1) reviewed for pain management in the sample of four. The findings include: On 2/11/26 at 7:32 AM, R1 was in his room in bed on his back with head of his bed elevated. R1 had all 4 extremities amputated. R1 had a tray table in front of him with personal items on it. R1 stated he was without his pain medication for 4 days and was told that they couldn't get it from the pharmacy. R2 stated he was in a lot of pain. He stated his pain was a 10/10 on the pain scale. R1 stated his amputation sites (all 4 extremities) felt like they were on fire. R1 stated he was given Tylenol, but he was still very uncomfortable, and it was very unpleasant. R1 stated he has chronic pain but when the shooting pains start and he feels			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053603		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/18/2026	
NAME OF PROVIDER OR SUPPLIER PEARL PAVILION				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH KIWANIS DRIVE , FREEPORT, Illinois, 61032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 2 like he is on fire that is the worst. R1 stated he watches to see that the nurses give him his pain medication. The Medication Administration Record dated January 2026, and February 2026 showed the last dose of his Oxycodone 5 MG that was to be given twice a day was at bedtime on 1/31/26. The next dose he received was on 2/6/26. R1 missed 11 doses of pain medication. The February 2025 Medication Administration Record - MAR for R1 was reviewed and showed on 2/1, 2/3, 2/4 and 2/5 he did not receive Oxycodone 5 MG by mouth twice a day. The MAR showed on 2/2 that V8 RN (Registered Nurse) signed off that she gave the medication in the morning and V10 LPN (Licensed Practical Nurse) gave the medication at bedtime however the medication was not available. On 2/10/26 at 3:00 PM, R1's February 2025 MAR was reviewed with V8, and she stated she signed out his Oxycodone as given on 2/2/26 in error. It was not given; he did not have any available. On 2/11/26 V7 LPN stated she worked on 2/6/26 and R1 did not have Oxycodone. V7 stated the nurse before her documented a "9" on the MAR which meant R1 did not get the medication. V7 stated she thought R1 had run out of medication, so she went to the medication dispensing machine to get a dose of the medication. V7 stated the machine will prompt you to get a code from pharmacy. V7 stated she called the pharmacy and was asked if his Oxycodone order had changed. They went over his medication order and it wasn't changed and was the same as what was on file at the pharmacy. The pharmacist told her that R1 should have 16-20 pills left. V7 stated her access was denied by pharmacy until management was notified. V7 stated she notified the Director of Nursing. V5 - Vice President of Operations was contacted and she called pharmacy, and they told her on 1/17/26 there were two Oxycodone cards sent with 30 pills in each card, so they sent 60 pills. On 2/11/26 at 9:48 AM, V5 stated on 1/16/26 R1 had 2 cards of Oxycodone delivered and each card contained 30 tablets. V5 stated they are missing one of the Oxycodone cards. On 2/17/26 at 11:56 AM, V3 Director of Nursing - DON stated they use a numeric pain scale in the facility for residents that can rate their pain. The scale is from 0-10 with zero being no pain and 10 severe pain/crying etc. It is the worst pain on the scale. V3 stated for residents that cannot give a number they		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053603		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/18/2026	
NAME OF PROVIDER OR SUPPLIER PEARL PAVILION				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH KIWANIS DRIVE , FREEPORT, Illinois, 61032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 3 look at nonverbal s/s (signs and symptoms) such as facial grimaces, moaning, squinting etc. V3 stated it was a concern for R1 to receive his medication as ordered to manage his pain. V3 stated they don't want R1's pain to become out of control because it can affect his quality of life. On 2/17/26 at 1:01 PM, V17 Nurse Practitioner - NP stated R1 has phantom pain, neuropathy, and back pain and that is why he has pain medication. It is important for him to have the medication and to receive it as ordered because it can lead to other medical problems and can affect his quality of life. R1's Minimum Data Set – MDS dated 1/28/26 showed no impairment of memory and he is cognitively intact. The Care Plan dated 1/14/26 for R1 showed resident is at increased risk for alteration in pain/discomfort. Resident has scheduled and as needed medications ordered. Administer medications as ordered. The Face Sheet dated 2/10/26 for R1 showed diagnoses including chronic obstructive pulmonary disease, major depressive disorder, alcohol abuse, hypertension, hyperlipidemia, hypothermia, superficial frostbite, traumatic ischemia of muscle, homelessness, nicotine dependence, lower leg partial traumatic amputation below knee, reduced mobility, acute post hemorrhagic anemia, hypokalemia, disorders of phosphorus metabolism, type 2 diabetes mellitus, acute respiratory failure with hypoxia, mild protein calorie malnutrition, and traumatic amputation. The facility's Pain Management and Assessment policy and procedure (1/2026) showed it is the policy of the facility to assess the resident for the presence of pain in order to determine the appropriate interventions purpose - To develop a standardized method for assessing, monitoring, evaluating and documenting pain in both cognitively intact and impaired residents. Residents will receive necessary comfort, exercise greater independence, and enhance dignity through optimizing their ability to perform activities of daily living. If pain is not relieved, give further medication as the physician ordered. If there are no orders, notify the physician of assessment results and obtain an order. (B)		S9999				