STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145239	A. Building B. Wing	12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Peoria Heights	5533 North Galena Road Peoria Heights, IL 61614

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 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. (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

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure their abuse policy was implemented when the facility failed to separate a visitor from a resident (R2) after an alleged altercation was reported for one of four residents (R2) reviewed for abuse in the sample of six.Findings include:On 12/5/25 at 2:19 PM V7/LPN (Licensed Practical Nurse) stated, The early morning of 12/3/25 I was the nurse for (R1) and (R2). Around 1:30 AM (R2) came to the nurse's station crying saying (V6/R1's family) was being mean to her. I didn't know (V6) was there at this time. I walked down to (R2's) room approached (V6) to find out what was going on. (V6) started cursing at (R2) saying Nobody cares about your def a**. The situation started escalating, so I told (V6) that this was (R2's) home and that visiting hours were over at 8:00 PM and asked (V6) to leave. (V6) was agreeable at this point. (V6) gave (R1) a kiss and looked as if she was packing up her things to leave. (V6) stated at this time that (R1) and (R2) were switching rooms in the morning anyways and would no longer be roommates. (R2) was sitting in her wheelchair watching television when I left the room. (V6) was still in (R2's) room when I left (R2's) room. Two to three minutes after I left the (R2's) room, I am believing this issue has resolved, as I was standing at the nurse's station, I had witnessed (V6) exit the building. I started drafting up an abuse report regarding the incident between (V6) and (R2) to send to our Abuse Coordinator (V1) regarding the situation that had occurred. Around 2:15 AM to 2:20 AM (R2) comes to the east side nurses station crying again. This was the first night I have even seen (R2) cry like this. (R2) said loudly she needed new sheets, that her whole bed was wet all over. I walked down to (R2's) room with (V14/CNA/Certified Nursing Assistant) and (V22/CNA). (R2's) bed was soaked wet from top to bottom, completely drenched and dripping all over. I took pictures because there was no way it was from (R2). I asked (R1) if she had seen anything and (R1) started laughing and said Did (V6) do that? Do you want me to call her? I know there was an alleged incident earlier that day of (R2) pouring water into (R1's) bed and (V6) had heard about it that day before she came in to visit so I am not sure if (V6) ended up pouring water on (R2's) bed because of it. V7/LPN verified at this time she should have ensured R2 was separated from V6 when the altercation was reported and occurred and should not have left R2 in the room with V6. V6 stated, I didn't even think about it since (V6) was packing up her things to leave the facility. I should have ensured (V6) left the room and was not left alone with (R2).On 12/5/25 at 11:36 AM V1/Administrator stated anytime there is an alleged altercation the perpetrator and the alleged victim should be immediately separated. V1 stated, (V6) should have not been left with (R2) after (R2) was crying and reported (V6) was being mean to her. Any time there is an altercation both parties should be immediately separated.The facility's Abuse Prevention and Reporting- Illinois Policy, dated 10/2/22, documents, Guidelines: The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property. Protection of Residents: The facility will take seps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. Accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of the investigation.

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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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview the facility failed to report an allegation of visitor to resident verbal abuse to the state agency for one of four residents (R2) reviewed for abuse in the sample of six. Findings include:A written communication dated 12/3/25 at 3:39 AM from V7/LPN (Licensed Practical Nurse) to V1/Administrator documents, Resident abuse report. 1:30 AM (R2) approached nurses station crying that her roommate's daughter (V6) was being mean to (R2). (V7) entered (R2) rooms to assess situation. (V6/R1's family) stated, (R2) is just mad because she doesn't want me in here. (V7) replied this is (R2's) home as well as (R1's), but visiting hours are over at 8:00 PM. At this time (V6) was agreeable to leave but started to swear at (R2) saying things like yo deaf a**! This nurse requested that (R2) and (V6) no longer interact with each other. This same written communication documents, (V6) exited the facility. At 2:15 AM (R2) approached (V7) again. Visibly upset and crying explaining that she now needed new bed lines because when she went to get into her bed, (R2's) bed was wet. (V7) entered room to assess the scene. (R2's) bed was completely drenched, liquid clear and cold, from pillows to foot of bed. (R1) began to chuckle and asked Did (V6) do that? Would you like me to call her. Pictures were also sent from (V7) to (V1) of (R2)'s bed being wet from the top of (R2's) bed to the bottom of (R2's) bed.On 12/5/25 at 2:19 PM V7/LPN stated, The early morning of 12/3/25 I was the nurse for (R1) and (R2). Around 1:30 AM (R2) came to the nurse's station crying saying (V6/R1's family) was being mean to her. I didn't know (V6) was there at this time. I walked down to (R2's) room approached (V6) to find out what was going on. (V6) started cursing at (R2) saying Nobody cares about your def a**. The situation started escalating, so I told (V6) that this was (R2's) home and that visiting hours were over at 8:00 PM and asked (V6) to leave. (V6) was agreeable at this point. (V6) gave (R1) a kiss and looked as if she was packing up her things to leave. (V6) stated at this time that (R1) and (R2) were switching rooms in the morning anyways and would no longer be roommates. (R2) was sitting in her wheelchair watching television when I left the room. Around two to three minutes after I left the (R2's) room, I am believing this issue has resolved, as I was standing at the nurse's station, I had witnessed (V6) exit the building. I started drafting up an abuse report regarding the incident between (V6) and (R2) to send to our Abuse Coordinator (V1) regarding the situation that had occurred. Around 2:15 AM to 2:20 AM (R2) comes to the east side nurses station crying again. This was the first night I have even seen (R2) cry like this. (R2) said loudly she needed new sheets, that her whole bed was wet all over. I walked down to (R2's) room with (V14/CNA/Certified Nursing Assistant) and (V22/CNA). (R2's) bed was soaked wet from top to bottom, completely drenched and dripping all over. I took pictures because there was no way it was from (R2). I asked (R1) if she had seen anything and (R1) started laughing and said Did (V6) do that? Do you want me to call her? I know there was an alleged incident earlier that day of (R2) pouring water into (R1's) bed and (V6) had heard about it that day before she came in to visit so I am not sure if (V6) ended up pouring water on (R2's) bed because of it. I ended up reporting the abuse allegation between (V6) and (R2) around 3:40 AM via text message to the Abuse Coordinator (V1).As of 12/5/25 at 10:05 AM, the facility's reports to the local State Agency did not contain documentation of an alleged verbal abuse altercation from V6/R1's family to R2 on 12/3/25 as being reported.On 12/5/25 at 11:36 AM V1/Administrator stated V7/LPN did report the allegation between V6 and R2 in the early morning hours of 12/3/25. V1 stated, I did not see that alleged incident was reported to me until late in the morning. I called (V7) on the way in to work and discussed the situation with her. I did not report it to the State Agency (Illinois Department of Public Health) because it was chaotic that morning and I didn't get to it. Normally we (the facility) would report it. I would report it within 2 hours of being notified of alleged abuse. V1 verified at this time she should have notified the state agency within 2 hours of the alleged abuse allegation.The facility's Abuse Prevention and Reporting-Illinois Policy, dated 10/2/22, documents Internal Reporting Requirements and Identification of Allegations: Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse.