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	02/28/2026

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 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. Based on interview and record review the Facility failed to prevent a fall during a staff assisted transfer for one of three Residents (R4) reviewed for falls in a sample of five.Findings include:The Facility Fall Prevention Program Policy, dated 11/21/17, documents: to assure safety of all Residents in the Facility; measures which determine the individual needs of each Resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary; use and implementation of professional standards of practice; communication with direct care staff members; methods to identify risk factors and Residents at risk; safety interventions will be implemented for each Resident identified at risk; direct care staff will be oriented and trained in the Fall Prevention Program; transfer conveyances shall be used to transfer Residents in accordance with the plan of care; and nursing personnel will be informed of Residents who are at risk for falling and interventions will be identified on the care plan.The Facility Transfers-Manual Gait Belt and Mechanical Lift Policy, dated 1/19/18, documents: to protect the safety and well-being of the Staff and Residents, to promote quality of care, this Facility will use Mechanical lifting devices for the lifting and movement of Residents; mechanical lifting devices shall be used for any Resident needing a two person assist or who cannot be transferred comfortably or safely; and staff responsible for direct Resident care will be trained in the use of mechanical lifting.The Facility Incidents by Incident Type Report, dated 10/1/26 through 2/26/26, documents a witnessed fall for R4 on 1/30/26 at 1:30 pm.The Facility's Fall Investigation Report, dated 1/30/26, documents statements from V6 (Certified Nursing Assistant/CNA) while in shower room, my foot slipped while transferring (R4). (R4's) feet slid as I grabbed both arms and lowered (R4) to a seated position' and I asked available (CNA's) and was told they transfer (R4) independently without assistance and that they just put (R4) in chair.R4's Physician Order Sheet/POS, dated 2/27/26, documents diagnoses including Cerebrovascular Disease, Major Depressive Disorder, Senile Degeneration or Brain, Dementia and Adult Failure to Thrive. R4's POS documents an order for Hospice services.R4's current Care Plan documents: is totally dependent on two staff members for bed mobility, dressing, grooming, bathing, positioning; transfer using a mechanical lift device and two staff members.R4's Witnessed Fall Report, dated 1/30/26, documents R4 and V6 (Certified Nursing Assistant) were in the shower room and R4 was lowered to the floor by (V6) during a transfer.R4's Nursing Note (late entry), dated 1/31/26 at 1:29 pm, documents V6 came to this nurse to report while in shower room, (V6) slipped and lost balance during a transfer. (R4's) feet slid as (V6) grasped both upper arms of (R4) and lowered (R4) to a sitting position (on the floor).' R4 did not hit head and did not complain of any pain at time of fall. Then (R4) complained of Right Shoulder pain and a radiology test (X-ray) was ordered for the shoulder pain.R4's Nursing Note, dated 2/4/26, documents: was seen by V8 (Physician's Assistant) for a plan of care related to a fall in the shower with staff assistance and a right shoulder injury; is under Hospice care and has a history of frequent fall; and has ongoing (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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(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	soreness in R4's Right Shoulder. The Nursing Note also documents Radiology test result (X-ray) of R4's Right Shoulder was negative for a fracture.On 2/26/26 at 1:58 pm, V1 (Administrator) stated, (R4) was a mechanical lift with two-person assistance for transfers. (V6/CNA) had only been employed here for about two months. (V6) did improperly transfer (R4) and should have used two staff. I did counsel (V4) on the proper transfer technique with a (mechanical lift because (V6) transferred (R4) by herself while in the shower room.