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	05/27/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely assessment, physician notification, documentation, and implementation of treatment interventions for pressure ulcers for one resident (R2) of five residents reviewed for pressure ulcers in the sample list of five. These failures resulted in delayed treatment implementation for pressure ulcers identified on admission and resulted in R2 developing two stage two pressure ulcers and one stage three pressure ulcer to the coccyx while residing in the facility.Findings include: The facility's policy titled Skin Condition Assessment & Monitoring - Pressure and Non-Pressure, revised 6/8/18, documents a skin assessment and pressure ulcer risk assessment would be completed upon admission/readmission. The policy further documents when pressure injuries or skin conditions were identified, a wound assessment would be initiated and documented, changes would be promptly reported to the charge nurse, and at the earliest sign of pressure injury the resident, legal representative, and attending physician would be notified. The policy further documents interventions would be implemented to address skin breakdown and prevent worsening.R2's census line documents R2 was admitted to the facility on [DATE] and discharged from the facility on 3/18/26.R2's Medical Diagnosis List documents Acute Respiratory Failure with Hypoxia, Nontraumatic Intracerebral Hemorrhage, Encephalopathy, Gastrostomy Status, Tracheostomy Status, and Diabetes Type 1.R2's Minimum Data Set (MDS) assessment dated [DATE] documents R2 is severely cognitively impaired and dependent on staff for activities of daily living. This MDS further documents R2 had one stage two pressure ulcer upon discharge from the facility.R10's Skin Condition Report dated 3/10/26 documents R10 has an open pressure ulcer to the right rear thigh, redness to the right buttocks, redness to the left buttocks, and a recurring rash to the right front thigh. This assessment did not contain wound measurements, detailed descriptions of the identified skin concerns, and did not contain notification to R2's Physician that any skin issues were present. R2's admission Braden assessment dated [DATE] documents R2 is at Moderate risk for Pressure Ulcers. R2's Wound Note dated 3/13/26 documents R2 has a stage two pressure ulcer to the right buttocks measuring 4 centimeters (cm) x 2 cm x 0.1 cm, a stage two pressure ulcer to the left buttocks measuring 3 cm x 1.5 cm x 0.1 cm with serosanguinous drainage, and a stage three pressure ulcer to the coccyx measuring 1.5 cm x 0.8 cm x 0.3 cm with serosanguinous drainage. This note further documents a new treatment was initiated on 3/13/26 for all three pressure ulcers to have hydrocolloid (moisture retentive) dressing to be applied three times a week and as needed if saturated or dislodged. R2's Care Plan did not contain Pressure Ulcer prevention or Pressure Ulcer relieving interventions until 3/13/26.R2's Treatment Administration Record (TAR) dated March 2026 documents a treatment order initiated 3/16/26 for a stage two pressure ulcer to the left buttocks to cleanse with wound cleanser, pat dry, and apply hydrocolloid dressing every Monday, Wednesday, Friday, and as needed if soiled or dislodged. The TAR documented the treatment order was discontinued on 3/17/26. R2's TAR dated 3/16/26 documented a new order for wound care for a stage three pressure ulcer to the coccyx to cleanse with wound cleanser, pat dry, and apply hydrocolloid dressing every Monday, Wednesday, Friday, and as needed if soiled or dislodged with a start date of 3/20/26. R2's TAR dated 3/16/26 documented a new order for wound care for a stage (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 0686 Level of Harm - Actual harm Residents Affected - Few	two pressure ulcer to the right buttocks to cleanse with wound cleanser, pat dry, and apply hydrocolloid dressing every Monday, Wednesday, Friday, and as needed if soiled or dislodged beginning 3/16/26.R2's Physician Orders did not contain a treatment for R2's pressure Ulcer's until 3/13/26.R2's Nurse Progress Note dated 3/17/26 documents the hydrocolloid dressings became dislodged and were not staying in place appropriately. The note documents treatment was updated to silicone foam dressing three times weekly and as needed if soiled or dislodged. The physician and responsible party were notified.R2's Nurse Progress Note dated 3/18/26 at 8:48 PM, documents R2 experienced an abrupt drop in oxygen saturation levels ranging between 60% (percent) and 74% despite interventions including repositioning, elevation of the head of the bed, suctioning, nebulizer treatments, oxygen administration up to 40%, Venturi mask application, and respiratory therapy interventions. The note documents R2's oxygen saturation levels remained unstable and continued fluctuating between 78% and 90%. V9 Assistant Director of Nursing was notified and agreed R2 should be transferred to the hospital for further evaluation and treatment. The record further documented emergency medical transport transferred R2 to the hospital, and the party responsible and V10 (Medical Director) were notified.R2's hospital records dated 3/18/26 documents R2 had an unstageable pressure injury present on admission located at the coccyx extending into the sacrum. The wound assessment documents measurements of 8 cm x 6 cm with no undermining or tunneling present. The wound base consisted of 50% pink tissue, 40% purple tissue, and 10% brown tissue. The assessment further documents intact peri wound skin, scant serosanguinous drainage, no visible structures, and no odor present.On 5/26/26 at 9:50 AM, V8 (R2's Family Member) stated R2 was admitted to the facility from the hospital on 3/10/26. V8 stated after approximately one week at the facility, R2 became dehydrated and was transferred to the emergency room by ambulance. V8 further stated R2 developed a coccyx wound that became significantly deep during R2's stay at the facility and that R2's wound was deep enough to place two eggs inside. V8 stated the staff at the facility did not notify V8 that R2 had pressure ulcers until a couple of days after he was admitted to the facility and that staff were not very good about turning or repositioning R2.On 5/27/26 at 9:00 AM, V9 (Assistant Director of Nursing/Wound Nurse) stated she was not made aware of R2's pressure ulcers until 3/13/26 because she had been on vacation prior to that date. V9 stated she completed a skin assessment with wound measurements on 3/13/26 and confirmed R2's electronic medical record did not contain a prior skin assessment with wound measurements or detailed descriptions of the pressure ulcer sites. V9 further confirmed R2 did not have treatment orders in place for the pressure ulcers until 3/13/26. V9 stated when she assessed R2 on 3/13/26, R2 had a stage two pressure ulcer to the right buttocks, a stage two pressure ulcer to the left buttocks, and a stage three pressure ulcer to the coccyx.On 5/26/26 at 2:00 PM, V2 (Director of Nursing) stated residents should receive a skin assessment upon admission to the facility and if skin concerns were identified, measurements and descriptions of the wounds should be documented. V2 further stated treatment interventions should be initiated upon admission. V2 confirmed there was no treatment order in place for R2's wounds until 3/13/26 and there is no documentation in R2's medical record that a physician was contacted for treatment orders.On 5/27/26 at 9:30 AM, V10 (Medical Director) stated the facility should contact the physician any time abnormal findings or new concerns are identified with a resident. V10 stated he did not receive notification regarding R2's wounds on admission and further stated if V10 had been notified upon admission, treatment orders would have been implemented to prevent worsening of the wounds.