| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145239 | A. Building<br>B. Wing | 06/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Goldwater Care Peoria Heights | 5533 North Galena Road<br>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.

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| F 0578<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to formulate a desired advanced directive for one resident (R2) of three residents reviewed for Advanced Directives. This failure resulted in R2 receiving CPR (Cardiopulmonary Resuscitation) when he did not wish to. This past non-compliance occurred [DATE] through [DATE].The Facility's Advanced Directives policy dated [DATE] documents At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law. The resident, the legal representative, or the individual who has been authorized as the resident's health care representative will be asked if an Advanced Directive, as recognized under the state law, has been executed. Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making this inquiry. This information shall be included in the resident's medical record. The Facility's Advanced Directives policy dated [DATE] documents Copies of the resident's Advanced Directive shall be made and maintained in the resident's clinical record and financial folder. If a resident or health care representative indicates as Advanced Directive regarding CPR or Scope of Treatment (POLST or POST form), the appropriate forms will be completed. R1's Medical Record documents he was admitted on [DATE] with diagnosis to include but not limited to Acute Respiratory Failure with Hypoxia, Ventilator Dependent, Tracheostomy status and Gastronomy tube status. R1's Medical Record documents that he was alert and oriented and able to make his needs known via text message, mouthing words or gestures. On [DATE] V16 (Licensed Practical Nurse-LPN) stated on [DATE] around 8:00 AM that R2 was pulseless and not breathing. V16 (LPN) stated that V6 (R2's Spouse) was at bedside and told her that R2 was a DNR (Do Not Resuscitate) but V6 could not provide a signed Physician Order to not resuscitate R2 so she began CPR. V16 (LPN) stated that R2 was worked by facility staff and paramedics when they arrived giving full life saving cares with chest compressions and ventilation and medications. R2 was then transported to the hospital. V16 stated she looked everywhere to include Electronic Medical Record and all loose paperwork from hospital and could not locate any paperwork or documentation of R2's Advanced Directive. On [DATE] V6 (R2's Spouse) stated that when she entered R2's room on [DATE] around 7:50 AM or 8:00 AM he was pulseless and had no respirations. V6 stated she began yelling for help and staff responded. V6 stated she told anyone who would listen that R2 was a DNR but she did not have the paperwork. V6 stated (R2) would have never wanted to have CPR or any of that other stuff done. Since he has gotten sick, he has been very clear that he did not want CPR done. No one asked me for any paperwork when he was admitted . They should have asked him, he would have told them, he probably did, he was very sure on this, I hate that this happened to him. He ended up being declared brain dead and we turned everything off in the hospital and he died. R2's admission Note dated [DATE] at 2:20 PM documents Resident is a No CPR. R2's Hospital Referral packet documents that R2's status at the hospital prior to admission to the facility was No CPR Full Arrest: Do Not Attempt Resuscitation. On [DATE] V17 (Regional Nurse Coordinator) confirmed that R2 should have had a POLST form indicating his desire to not receive any life saving measures if found pulseless and<br>(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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| F 0578<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | without respirations. We should have obtained a copy of his DNR immediately when he said he wanted to be a DNR. Prior to the survey date of [DATE] the facility took the following actions to correct the non-compliance: Social Service Director and admission team was educated on the facility's Advanced Directives guidelines, including but not limited to ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and at the resident's option, formulate an advance directive by Director of Nursing/Designee or Administrator on [DATE]. Licensed staff who are on FMLA (Family Medical Leave of Absence) or vacation will be in-serviced prior to returning to the facility by the Director of Nursing/Designee or Administrator.Social Service Director and admission team was educated on providing copes of state statutes, regulations, and information regarding Advanced Directive (s), to resident, legal representatives upon admission, and also to families who wish to receive such information and assistance regarding Advanced Directive(s) and decisions regarding life sustaining measures and in no event shall give legal advice on the need for medical care directives by Director of Nursing/Designee or Administrator on [DATE]. Licensed staff who are on FMLA or vacation will be in-serviced prior to returning to the facility by the Director of Nursing/Designee or Administrator.All licensed staff were educated on the facility's Advanced Directive guidelines, including but not limited to ensure that all residents and/or representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive by Director of Nursing/designee or Administrator on [DATE]. Licensed staff who are on FMLA (Family Leave Act) or vacation will be in-serviced prior to returning to the facility by the Director of Nursing/Designee or AdministratorFacility wide audit was conducted by the Social Services Director to ensure copies of advanced directives are uploaded into each resident's chart, physician order is accurate, and care plan have been reviewed and updated accordingly.The Director of Admissions and Marketing was in-serviced on ensuring POLST form will be uploaded prior to admission by the [NAME] President of Operations on [DATE].The Director of Marketing and Admissions or admission Group will obtain current POLST form from referring hospital or facility prior to admission to (the facility.) a. The Director of Marketing and Admissions/Admissions Group will obtain the POLST from referring hospital (Electronic Medical Record) system and upload into (Electronic Medical Record). If POLST cannot be obtained prior to admission to (the facility), the Director of Marketing and Admission/admission Group will notify the Facility admission email group that there is no POLST on file. a. The Social Service Director will meet with resident, POA (Power of Attorney)/Guardian, to obtain a new POLST form. For weekend and after-hours admissions, the Manager on Duty will be obtain POLST form from Resident or POA/Guardian.The Social Service Director of Manager on Duty will scan and upload POLST into resident's chart. Social Service Director or Manager on Duty will ensure the Nurse Management team is aware of POLST or Code Status. The Nurse Managers will ensure the correct code status order is entered into the resident's chart in (Electronic Medical Record).Nursing Management will be responsible for the updating the clinical staff on the resident's current code status. An Impromptu QAPI (Quality Assurance Performance Improvement) was held with medical director and staff IDT team to discuss deficiency and facility action plan. The facility will conduct audit (5 days per week for 6 weeks) to ensure all admission and readmissions have copies of advance directives are uploaded into each resident's chart, physician orders are accurate, and care plan have been reviewed and updated accordingly. A QA tool will be completed to verify this practice has occurred by the Director of Nursing/Designee, 5 days per week for 6 weeks. There will be oversight of the QA tool by the Administrator. Completed date: [DATE] |

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| F 0620<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly screen a resident prior to admission for one (R1) of three residents reviewed for admission/discharge/transfers in a sample of five. This failure resulted in R1's behaviors not being properly controlled to where R1 was involuntarily discharged to the hospital, and currently waiting placement for a long term care facility. Findings include:Facility admission of Resident, undated, documents To facilitate smooth transition into a health care environment. To gather comprehensive information as a basis for planning individualized therapeutic care. Conduct head to toe nursing assessment of body systems, parts, and surfaces identifying functional status abilities, needs, or problems. Findings from the assessment required to meet the resident's needs, which can in turn be conveyed to the physician.R1's medical record documents he was admitted on [DATE] from another hospital, and discharged on 6/4/26 to a local hospital. R1's pre-admission notes, sent to the receiving facility on 4/14/26, documents a note dated 4/12/26 by V22 MD/Medical Doctor of transferring hospital Neurologically reserve Lorazepam for clearly documented seizures or severe agitation. These pre-admission notes document PRN/as needed medications of Lorazepam 0.5mg/milligrams every four hours and Lorazepam 2mg every 15 minutes as needed. This pre-admission paperwork further documents to the receiving facility that R1 was in bilateral mittens, full side rails, and a bed alarm.R1's admission progress note at the receiving facility, dated 4/28/2026 at 7:39PM by V13 LPN/Licensed Practical Nurse documents Resident arrived with mittens on both hands. When assessing resident, resident became combative trying to hit both nurses.R1's Involuntary Discharge delivered to R1 and signed by V1 Administrator on 6/3/26 documents This facility seeks to transfer or discharge you. The reason for this proposed transfer or discharge is the safety of individuals in this facility is endangered.On 6/17/26 at 8:43AM, V5/R1's wife stated via phone The (facility) was aware of (R1's) behaviors before admission, and they served me with involuntary discharge paperwork when (R1) was sent to the hospital. (R1) is feisty, irritable, and combative with staff. (R1) is still at the hospital until we can find a placement for him that has a trach/vent unit.On 6/17/26 at 2:03PM, V2 Acting DON (Director of Nursing)/CNO (Chief Nursing Officer) stated they have a team of three for admissions, do not always lay eyes on a person before admission, but reviews paperwork before admission, and RT/Respiratory Therapy evaluates the resident if a new admit for the trach/vent unit.On 6/17/26 at 2:15PM, V19 admission Director stated, I asked if (R1) was clinically ok and (V1) and (V20) both said yes. (V1) and (V20) reviewed (R1's) file for the clinical side; and I reviewed for the financial side. I leave the clinical side up to the nursing facility because they are the ones that know if they have the capability of taking care of the resident.On 6/17/26 at 2:31PM, V1 Administrator stated via phone she was part of the admission screening for R1 along with V20 prior DON, and RT since he was to be admitted to the respiratory unit due to his trach/vent status. V1 stated she is a nurse and looked at R1's medications before admission; knew R1 was a TBI/Traumatic Brain Injury; left the clinical nursing decisions to her V20 DON; RT looks at the resident needs to make sure they can meet their needs; stated I did not review R1's current medications prior to admit because that was left up to V20 DON; doesn't recall reading where R1 had mittens on at the hospital in the hospital notes; and stated I was aware the wife brought mitts to the nursing home for (R1). Any time a resident is admitted to their facility they are reviewed by her and V20, and if to therespiratory department their RT reviews. Then after their decision to admit or not it then goes to the head of their admission team located in [NAME], IL. We reviewed his paperwork, no one laid eyes on R1 prior to admit. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to monitor, provide adaptive smoking materials, and a smoking apron for one resident (R3) of three residents reviewed for smoking in a sample of five. These failures resulted in R3 burning his second and third fingers resulting in third degree burns, which required the wound doctor to order treatment to the burned areas. Findings include:Facility Smoking safety, dated 11/28/12, documents To provide a safe and healthy living environment. Appropriate safety devices including smoking aprons shall be readily available. A smoking safety assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store smoking materials, and if a smoking apron is indicated. R3's final report to state, dated 5/21/26, documents on 5/15/26 at 3PM the following: Diagnosis: Diabetes Mellitus. Occurrence/Injuries: Resident has a burn to the right second and third fingers. Actions: Wound Doctor treated and new orders received. Resident is a smoker, independent with smoking, smokes the cigarette all the way down to the filter. R3's Wound Evaluation and Management Summary report, dated, 5/15/26, documents Patient has wounds to his right second and third finger. Right third finger wound size 3x1.3cm/centimeters. Light Serous Exudate. 100% necrotic tissue. Third degree burn. 4-6 months estimated time to heal. Xerofoam gauze daily and as needed. The wound was surgically excised of devitalized tissue and necrotic periosteum. Right second finger wound size 4x1cm. 100% necrotic tissue. Third degree burn. 4-6 months estimated time to heal. Skin prep daily and as needed. R3's medical record documents the following diagnoses: Diabetes Mellitus, and Peripheral Vascular Disease. R3's medical record has a smoking safety assessment screen last done on 4/1/25, no further assessments completed until R3's incident on 5/15/26. The 4/1/25 smoking screen indicates R3 is a daily cigarette smoker, severe difficulty handling cigarettes, requires assistance and supervision with smoking, requires a smoking apron, and has burns on his fingers and clothing from not using finger grips. R3's smoking care plan initiated on 1/19/24 and current care plan documents (R3) expresses the desire to smoke and will be monitored/supervised smoking program to fully assess compliance and ability to smoke independently. (R3) exhibits the physical ability to smoke with the use of adaptive equipment when smoking. Adaptive device: finger guards, Clothes pin; extendable cigarette holder as resident will allow initiated on 5/18/26. Monitor resident to ensure he is using the cigarette clip correctly and safely initiated on 7/19/24. Utilize smoking apron initiated on 1/19/24.On 6/17/26 at 12pm, R3 was alert and oriented, stated he smokes independently, and showed surveyor his right hand second and third fingers that were burned black at the middle knuckles. R3 stated the black burns were from smoking, he does not use a smoking apron, can handle smoking materials but has limited feeling in his fingers, smokes out front where the secretary lets him out to smoke; and he is diabetic. On 6/17/26 at 2:31PM, V1 Administrator stated via phone (R3) is an independent smoker and nobody monitors independent smokers, and smoking assessments are to be done quarterly (verified R3's last smoking assessment was on 4/1/25 and should have been done since then prior to the smoking incident on 5/15/26 where R3 was smoking independently and burned his fingers). (R3) was seen by our wound doctor for treatment to his fingers, and R3 was to use adaptive devices for his cigarettes due to his limited feeling in his fingers. On 6/17/2026 at 2:56 PM V21 Receptionist stated There is no official list of who can go out and smoke. I have a mental list of cognitively intact residents. Only person who does anything different is (R3) where sometimes he uses a clothes pin so that when the cigarette gets low he doesn't burn himself. I know that because I have seen him with it and asked him but no one has told me he needs to do that. Other than that residents are considered independent to smoke. |