STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145295	A. Building B. Wing	02/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Marseilles	578 West Commercial Street Marseilles, IL 61341

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident's dressing to a surgical wound with a history of infections was changed per physician's orders. This applies to 1 of 3 residents (R2) reviewed for wound care in the sample of 8. The findings include:On 2/7/26 at 10:15 AM, R2 was laying in bed. She stated, she had a wound to her right ankle. There was a dressing on her right ankle. The dressing was dated 2/5/26 with V3 Assistant Director of Nursing (ADON) initials. R2 stated, they are supposed to change the dressing every day, but they don't do it. It was infected for awhile and she had to have a shot. She is not getting a shot currently. On 2/7/25 at 11:26 AM, V11 R1's daughter stated, the facility's lack of care to her mom's wound on her ankle has led to it being infected. Her wound would do really good during the week until the weekend. No one would change the dressing so it would get bad again. The facility's wound report for non-pressure wounds dated 2/7/26 shows, R2 has a surgical/dehiscence wound to her right posterior ankle. On 2/7/26 at 1:20 PM, V3 ADON stated, R2's wound on her right ankle was a dehiscence from a surgical procedure. She is a daily dressing change. She does all the dressing changes during the week. She was last there on 2/5/26 and changed the dressing (last person to change R2's dressing). She started as the wound care nurse in November. She knew there was some issues with the dressing not being changed then and as far as she knew the staff had been better about changing the dressing. R2's wound was infected around the end of December and she was treated with ceftriaxone (antibiotic injection). Her infections are a chronic thing with her wound. She has poor vascularity, diabetes and doesn't follow her dietary recommendations so she is at high risk for complications. She stated, she was disheartened to hear the staff didn't change the dressing per the physician orders. R2's current treatment administration record (TAR) shows, R (right) lower leg wound. Cleanse with NS (normal saline) or wound cleanser. Pat dry. Apply medi-honey to wound bed, cover with bordered gauze daily and PRN (when needed) if saturated, soiled, or dislodged. One time a day for wound care and as needed for wound care. The same record shows, the dressing was changed and done on 2/6/26 (even though the actual dressing was dated 2/5/26 and R1 stated, it had not been changed). R2's electronic medical records (EMR) show, she had 3 cultures done to her wound in the past 3 months for symptoms of an infection: 11/25/25 was positive with a few gram negative bacilli, 12/12/25 was negative with no growth and 12/30/25 was positive with many gram negative bacilli.R2's medication administration record (MAR) for the month of November 2025 shows, she was treated with bactrim DS (oral antibiotic) twice daily for 7 days for a wound infection. R2's MAR for January 2026 shows, she was treated with ceftriaxone (antibiotic injection) once daily for 7 days for a wound infection. R2's care plan dated 3/19/24 shows, Focus: I have a dehiscence of my surgical site to my posterior right lower. Interventions: Treatment as ordered. The facility's pressure injury and skin condition assessment dated [DATE] shows, Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assuring interventions are implemented. Equipment: 19. A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible party will be notified by charge nurse. Notification will be documented in the resident's clinical record.