STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Pontiac Nursing Home	1225 South Ewing Drive Pontiac, IL 61764

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review the facility failed to protect a resident's right to be free from misappropriation of money for one of 10 residents (R86) reviewed for misappropriation of property in the sample list of 38. On 8/18/2025 at 10:40 AM, R86 stated R86 thought her money was in her purse, but when she went to get her hair done there were only singles left, and the large bills were gone, which was $80. R86 stated R86 had gotten $40-$50 from V10 Business Office Manager and had some money left over from a prior withdrawal. R86 stated R86 keeps her purse in her room and does not leave her room, so the only time someone could have taken it was during the night when R86 was asleep. R86 stated the facility replaced the $80. On 8/19/25 at 9:30 AM R86 stated R86 is unsure what happened to her missing $80 but is certain R86 did not misplace it. R86 stated R86 always keeps her purse in her closet but now is keeping it with her at all times. R86 stated there was only one time, over six months ago, when an unidentified person was going through R86's closet during the night and asked R86 how many pairs of jeans R86 had. R86's Nursing Note dated 7/28/25 documents R86 as alert and oriented to person, place, and time. The facility's investigative file of R86's allegation of misappropriation of money contained the following information: The Initial Abuse Investigation Report dated 7/1/25 documents on 7/1/25 at 3:00 PM R86's Family, V23, reported to V1 Administrator that $80.00 was missing from R86's room. The facility's Final Abuse Investigation Report dated 7/3/25 documents resident and staff interviews were conducted, and R86's room, laundry, and common areas were searched and were unable to locate the missing funds which would be replaced by the facility. This report documents R86 stated R86 never goes out to activities or the dining room, R86 is always in her room, and was unsure where the missing funds could have gone. R86's Cash Disbursement Forms dated 5/14/25 and 6/10/25 document R86 made a cash withdrawal of $50 on these dates from her resident trust fund account and was signed by both R86 and V10. On 8/19/25 at 12:51 PM, V1 Administrator stated R86 was not sure of the exact day that the money went missing. Stated R86 goes out on Mondays to get her hair done and R86 stated on Monday 6/30/25 R86 realized R86's cash was no longer in her purse. V1 stated R86's $80 was unable to be located.On 8/19/25 at 2:46 PM, V23 stated R86 went to get her hair done on 6/30/25 and didn't have money to pay. V23 confirmed R86 was missing $80. V23 stated R86 keeps money in her purse to pay for her hair appointments, and V23 knows that R86 did not misplace the money. V23 stated V23 believes someone took R86's money during the night while R85 was asleep. On 8/19/2025 at 2:07 PM, V10 confirmed R86 made $50 cash withdrawals on 4/2/25, 5/14/25, and 6/10/25. V10 stated the largest bill she gives out is a $20 bill and typically would give two $20 bills and one $10 bill. On 8/19/25 at 2:30 PM, V6 Licensed Practical Nurse confirmed R86's credibility. V6 also stated R86 is alert and oriented to person, place, time, and situation; has never been dishonest; and has no history of prior accusations or behaviors. The facility's Abuse Prevention and Reporting-Illinois policy dated 10/24/22 documents the facility affirms the resident's right to be free from misappropriation of property, which means the deliberate misplacement, exploitation, or wrongful use of a resident's belongings or money without the resident's consent.

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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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 observation, interview, and record review the facility failed to conduct a thorough investigation of an allegation of misappropriation of funds for one of ten residents (R86) reviewed for misappropriation of property in the sample list of 38. On 8/18/2025 at 10:40 AM R86 stated R86 thought her money was in her purse, but when she went to get her hair done there were only singles left, and the large bills were gone, which was $80. R86 stated R86 had gotten $40-$50 from V10 Business Office Manager and had some money left over from a prior withdrawal. R86 stated R86 keeps her purse in her room and does not leave her room, so the only time someone could have taken it was during the night when R86 was asleep. R86 stated the facility replaced the $80. On 8/19/25 at 9:30 AM R86 stated R86 is unsure what happened to her missing $80 but is certain R86 did not misplace it. R86 stated R86 always keeps her purse in her closet but now is keeping it with her at all times. R86 stated there was only one time, over six months ago, when an unidentified person was going through R86's closet during the night and asked R86 how many pairs of jeans R86 had. On 8/18/25 during general intermittent observations between 9:30 AM and 4:15 PM there were video surveillance cameras located throughout the 300 unit, including on R86' hallway. R86's Nursing Note dated 7/28/25 documents R86 as alert and oriented to person, place, and time. The facility's investigative file of R86's allegation of misappropriation of money contained the following information: The Initial Abuse Investigation Report dated 7/1/25 documents on 7/1/25 at 3:00 PM R86's Family, V23, reported to V1 Administrator that $80.00 was missing from R86's room. The facility's Final Abuse Investigation Report dated 7/3/25 documents resident and staff interviews were conducted, and R86's room, laundry, and common areas were searched and were unable to locate the missing funds which would be replaced by the facility. This report documents R86 stated R86 never goes out to activities or the dining room, R86 is always in her room, and was unsure where the missing funds could have gone. This report documents the floor nurse and nurse aides were interviewed but were not aware funds in R86's room but does not identify that video surveillance was reviewed or which specific staff were interviewed. R86's Cash Disbursement Forms dated 5/14/25 and 6/10/25 document R86 made a cash withdrawal of $50 on these dates from her resident trust fund account and was signed by both R86 and V10.On 8/19/25 at 2:46 PM, V23 stated R86 went to get her hair done on 6/30/25 and didn't have money to pay. V23 confirmed R86 was missing $80. V23 stated R86 keeps money in her purse to pay for her hair appointments, and V23 knows that R86 did not misplace the money. V23 stated V23 believes someone took R86's money during the night while R85 was asleep. On 8/19/25 at 12:51 PM, V1 Administrator stated R86 was not sure of the exact day that the money went missing. V1 stated R86 goes out on Mondays to get her hair done and R86 stated the following Monday (6/30/25) R86 realized R86's cash was no longer in her purse. V1 stated R86's $80 was unable to be located and it is hard to say if R86's money was lost in the facility or while out in the community. On 8/19/25 at 1:53 PM V1 confirmed the entire investigative file for R86's allegation was provided. V1 stated V1 did review video surveillance for night shift and interviewed staff but has no documentation of this. V1 stated since R86 wasn't able to identify a specific date that the money went missing, V1 didn't have a certain date to review video surveillance. V1 stated video surveillance is only kept for 30 days.On 8/19/2025 at 2:07 PM, V10 confirmed R86 made $50 cash withdrawals on 4/2/25, 5/14/25, and 6/10/25. V10 stated the largest bill she gives out is a $20 bill and typically would give two $20 bills and one $10 bill. On 8/19/25 at 2:30 PM, V6 Licensed Practical Nurse confirmed R86's credibility. V6 also stated R86 is alert and oriented to person, place, time, and situation; has never been dishonest; and has no history of prior accusations or behaviors. The facility's Abuse Prevention and Reporting-Illinois policy dated 10/24/22 documents the facility affirms the resident's right to be free from misappropriation of property, which means the deliberate misplacement, exploitation, or wrongful use of a resident's belongings or money without the resident's consent. This policy documents the administrator, or designee will initiate an incident investigation, and will at a minimum attempt to interview the person who reported the incident, anyone likely to have knowledge of the incident, the resident, and any employees with whom the accused has regularly worked with.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain physician orders for the use and care of a CPAP (continuous positive airway pressure) for one of two residents (R6) reviewed for respiratory care on the sample list of 38. On 8/18/2025 at 10:08 AM there was a CPAP machine on R6's desk in R6's room. R6 stated R6 is suppose to use it, but has had problems getting parts for it. R6 removed the filter from the machine to show the filter was dirty, covered in gray debris/dust. R6 stated R6 has talked to facility staff about needing parts for the machine. R6's Minimum Data Set, dated [DATE] documents R6 has severe cognitive impairment. R6's active physician orders and active care plan do not document the use or care of R6's CPAP machine as of 8/18/25. On 8/18/2025 at 3:54 PM V6 Licensed Practical Nurse stated R6 sleeps in her recliner and uses the CPAP machine, at least for the last five months that V6 has worked in the facility. V6 stated there should be physician's orders for use and care that would prompt to document on the Treatment Administration Record (TAR). V6 confirmed R6 did not have any physician's orders regarding the use of the CPAP. On 8/19/25 at 4:54 PM V21 Registered Nurse stated V21 works night shift and R6 has used a CPAP for about 5-6 months, R6 applies and cares for the machine herself. On 8/19/2025 at 12:08 PM V2 Director of Nursing stated CPAPs should be rinsed/washed on Mondays, and need filled with distilled water. V2 stated there should be physicians orders for use and documented on the TAR. V2 stated V2 would have to look at the facility's policy regarding changing filters on CPAPs. V2 stated V2 just found out about R6's CPAP yesterday and obtained orders for use/care. V2 stated it probably isn't care planned since we just found out about it yesterday. The facility's undated CPAP Therapy policy documents to verify physician orders, if ordered connect humidifier to CPAP unit, fill humidifier with distilled sterile water, and adjust the ramp to prescribed time if ordered. This policy documents to use a soft cloth and gently wash th3 mask or pillows with a solution of warm water and mild detergent, rings, and allow to air dry; wash/rinse/dry tubing as necessary; clean and inspect all components regularly. This policy documents that disposable filters should be replaced according to manufacturer's instructions, and reusable filters should be rinsed of dust and allowed to air dry. The User Manual dated 2021 for R6's CPAP machine, documents the device should only be used as instructed by a physician, including correct pressure settings, device configurations, and accessories. This user manual documents the device uses a reusable blue pollen filter that can be rinsed and includes an automatic reminder every 30 days to check and replace filters as directed.