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	06/29/2026

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to promptly refund an overpayment of monthly charges for one resident (R2) of three residents reviewed for management of funds in a sample list of six. Findings Include: The facility's census documents R2 was admitted to the facility on [DATE]. At that time R2 was admitted to a private room with a shared bath. R2's signed contract with the facility dated 6/10/22 documents R2 was being charged for a semiprivate room with a shared bath. On 2/28/24 R2's representative paid $12,650.00 for R2's room and board. R2's Transaction Report documents R2's room and board was billed for that month at $9,920.00. The facility also provided a cancelled check signed by V13, R2's representative in the amount of $12,650.00. This supports the information on the Transaction report as above. This constituted an overpayment of $2,720.00. On 6/17/26 at 10:50AM V13, R2's representative stated I was not aware of the overpayment until I went to do the taxes, and I realized I had overpaid. I have repeatedly requested (R2's) overpayment be returned. The corporate people told me the facility made a mistake and undercharged me for the type of room (R2) is in. I have paid the amount I was billed every month since (R2) came to the nursing home. I have called the ombudsman. I was never notified of the of a rate increase. On 6/17/26 at 1:00PM V1, Administrator stated In May we did an audit of room rates and found two residents who had the wrong rate in the system. (R2) was one of those residents. I was told by corporate to apply the overpayment to the billing mistake made by our business office. The facility's resident funds policy revised 4/29/19 states. The resident may designate a representative to manage his/her personal funds. This policy further states The resident and/or representative are provided with a quarterly accounting report of his or her funds on deposit with the facility, and upon request.

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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure timely post-fall assessment and physician notification, and failed to follow a physician order to obtain a post fall x-ray for two of six residents (R1 and R3) reviewed for falls on the sample of six.Findings include: 1.R1's Progress Note written by V2 Director of Nurses dated 5/27/2026 at 12:41 PM documents R1 experienced a witnessed fall on 5/27/2026 at approximately 5:56 AM while staff were assisting with activities of daily living in R1's room. The note documents R1 stated he was getting ready for breakfast, stood from his bed, lost his balance, and hit his head. The note further documents that neurological checks were initiated and that R1's physician and Power of Attorney (POA) were called at 11:15 AM. There was no documentation indicating successful physician contact or receipt of physician orders at that time. The note further documents R1 was assisted back to bed using a full-body mechanical lift and that physical and occupational therapy evaluations were requested. The Neurological Assessments Documentation from 5/27/2026 documents neurological checks were completed at 10:30 AM, 10:45 AM, 11:00 AM, 11:15 AM, 11:45 AM, 12:15 PM, 12:45 PM, 1:15 PM, and 5:15 PM.The facility's undated Neurological Assessment Policy, directs staff to complete neurological assessments following head injuries every 15 minutes for one hour, every 30 minutes for two hours, every four hours for 24 hours, and then every shift for 48 hours.R1's Risk Management Form completed by V2, Director of Nursing, documents R1 was with staff preparing for breakfast, stood from the bed, began walking with a walker, and fell. The form documents the physician was notified on 5/27/2026 at 11:24 AM and STAT (immediately) imaging was ordered.On 6/23/2026 at 12:16 PM, V1, Administrator, stated that V5 Agency Licensed Practical Nurse failed to report R1's fall to facility management and was no longer permitted to work in the facility.On 6/23/2026 at 1:02 PM, V2 stated V5, agency Licensed Practical Nurse, did not assess R1 following the fall and did not report the incident to V4, the nurse working the following shift. V2 stated V5 denied having knowledge of the fall. V2 further stated that R1 later informed V4 of the fall, and V4 reported the incident to V2 during the morning of 5/27/2026. V2 stated she then assessed R1, notified the physician and POA, and completed the facility's incident investigation. V2 further stated that R1 had attempted to get up from the floor following the fall and that V3 assisted R1 from the floor using a mechanical lift.On 6/29/2026 at 11:37 AM V3, Certified Nurses Assistant, stated that (on 5/27/26) R1 rang to get up. V3 reported she was assisting R1 with a gait belt while R1 was using a walker. V3 stated R1 removed one arm from the walker to wipe his nose, his foot slid out of his slipper, and he lost his footing. V3 stated she initially held the gait belt but released it as R1 was falling so she would not fall on top of him. V3 stated she did not recall whether R1 hit his head but confirmed that R1 hit his back. V3 stated she reported the fall to V5, agency nurse, who did not come to R1's room. V3 stated she then obtained assistance from V8, Certified Nurses Assistant, and both waited for V5 to respond. V3 stated she notified V5 a second time and V5 stated he was giving another resident medication and again did not come to the room. V3 stated that while waiting, R1 attempted to get up from the floor, and V3 and V8 transferred him with a mechanical lift. V3 stated R1 denied pain and was able to move his arms and legs. V3 stated she notified V5 again, and V5 stated he would pass it on in report. V3 stated she did not notify the other nurse in the building.On 6/29/2026 at 11:25 AM V14, Physician stated there should not be a delay in treatment, and if a resident is not on a blood thinner neurological checks would need to be completed for 72 hours. V14 also stated that contact with a provider should have happened immediately. V14 or the facility Nurse Practitioner could have been notified.2. R3's Progress Note dated 5/8/2026 at 9:00 PM documents R3 attempted to strike a staff member while staff were assisting him, resulting in both R3 and the staff member losing their balance. The note documents R3 landed on his right elbow and complained of pain to his right lower back following the fall.R3's Progress Note dated 5/9/2026 at 3:05 AM documents V11, Licensed Practical Nurse, assessed R3 and R3 complained of pain in the lower right rib cage area.R3's Progress Notes document R3's physician was notified on 5/9/2026 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:19 AM and provided an order for hip and rib x-rays. Documentation further shows (x-ray Company) was notified of the x-ray order on 5/9/2026 at 6:20 AM.Review of the medical record does not document the ordered hip and rib x-rays were completed.On 6/23/2026 at 12:51 PM, V2, Director of Nursing, stated the x-ray ordered to be completed in the facility was never performed. V2 further stated that if ordered x-rays cannot be completed in a timely manner, the physician should be notified for further direction and orders.

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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	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 thoroughly investigate falls and document a root cause for two of six (R1, R3) residents reviewed for falls in a sample size of six. Findings include:R1's Progress Note dated 5/27/2026 at 12:41 PM documents R1 experienced a witnessed fall on 5/27/2026 at approximately 5:56 AM while staff were assisting with activities of daily living in R1's room. R1's Risk Management Form dated 5/27/2026, completed by V2, Director of Nursing, documents R1 was with staff preparing for breakfast, stood from the bed, began walking with a walker, and fell. However, the Risk Management Form does not include a witness statement from V3, Certified Nurse Aide, who was identified as assisting R1 at the time of the fall. In addition, the form does not include documentation of the possible cause or root cause analysis of the fall.R3's Progress Note dated 5/8/2026 at 9:00 PM documents R3 attempted to strike a staff member while staff were assisting him, resulting in both R3 and the staff member losing their balance. R3's Risk Management Form completed by V10, Registered Nurse, does not include complete staff statements or documentation of the possible cause or root cause of the fall.The facility's Incident and Accidents-Illinois policy, reviewed 4/7/2019, states an incident/accident report is to include a full written statement and the possible cause of the incident.On 6/29/2026 at 2:48 PM, V2, Director of Nursing, verified that there was no documented root cause analysis identified on the Risk Management Form for either R1 or R3 following their falls. V2 also verified that there were no Fall Interdisciplinary Progress Notes documented in the electronic medical record for either resident. V2 provided the facility's Post Fall Huddle form, which includes designated sections for documenting the root cause of the fall. Review of the Post Fall Huddle forms for R1 and R3 document that the sections for root cause had been left blank.