		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 05/16/2024	
		IL6005573				
IAME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
OLDWAT	ER PONTIAC NURSING	HOME	OUTH EWING DRIVE			
-			C, IL 61764			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Health Certific	cation Licensure				
S9999	Final Observations		S9999			
	Statement of Licensure Violations					
	300.1210b) 300.1210c)					
	Section 300.1210 Ge Nursing and Persona	eneral Requirements for I Care				
	and services to attain practicable physical, well-being of the reside each resident's comp plan. Adequate and p care and personal ca	rovide the necessary care or maintain the highest mental, and psychological dent, in accordance with orehensive resident care properly supervised nursing re shall be provided to each total nursing and personal ident.				
		iving staff shall review and out his or her residents' are plan.				
	These Requirements evidenced by:	were NOT MET as				
	review, the facility fail health services to ma practicable mental we diagnosed with major affects one of two res behavioral health ser	n, interview and record led to provide behavioral intain the highest ell-being for a resident depression. This failure sidents (R53) reviewed for vices on the sample list of ed in R53 being tearful,				
	nent of Public Health DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE

6899

If continuation sheet 1 of 4

Illinois Department of Public Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	BER: A. BUILDING:		COMI	COMPLETED	
		IL6005573			05/16/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
GOLDWA	TER PONTIAC NURSING	G HOME	OUTH EWING DRIVE	E			
		PONTIA	AC, IL 61764				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From page 1		S9999				
	visibly shaking, and	expressing despair.					
	Findings Include:						
	R53's ongoing diagnosis listing documents the following diagnoses: Vascular Dementia without Behaviors, Anxiety Disorder and Major Depression.						
	ml (milliliter) to the in area prn (as needed anxiety or agitation b						
	wheelchair in the doc became tearful and t about having to com facility. R53 stated R was not taking care of initially put R53 into a now R53 is in long te crying, explained R5 R53 owned stating, ' stated, "they tell me feel I am adjusting, I	AM, R53 was sitting up in a brway of R53's room. R53 began to shake when talking e to the long term care (53's family told R53 that R53 of R53's self or dog, so they an assisted living facility and erm care. R53, while still 3's family sold everything that 1' have nothing now". R53 (R53) I'm adjusting but I don't just want to run away and nning with no place to go."					
	R53's Care Plan date has a psychosocial v R53's medical diagn Major Depressive Di include: allow R53 tin to verbalize feelings	ed 3/25/24 documents R53 vell-being problem related to osis of Anxiety Disorder and sorder with interventions that me to answer questions and perceptions, and fears as urage R53 to set realistic					

9IW611

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         IL6005573			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		11 0005572				
			7/0.0005	05	5/16/2024	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
SOLDWAT	TER PONTIAC NURSING	S HOME	C, IL 61764	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMF O THE APPROPRIATE DA	
S9999	Continued From pag	e 2	S9999			
	environment; and ex Treatments, Medicat Condition, All change Care Plan also docur will work cooperative ensure R53's spiritua physical and social n	s about care and living plain all procedures and ions, Results of labs/tests, es, Rules, and options. This ments R53 is on hospice and ly with the hospice team to al, emotional, intellectual, eeds are met.				
	documentation that F	vices to assist R53 in coping				
	Service Director) stat any type of psychotro behavioral health ser when started on med not do to being on ho to manage their own explained that when facility, R53 was unre however R53 has im being taken off of hos	am, V10 SSD (Social ted any resident who takes opic medication is referred to vices upon admission, or lication however R53 was ospice and hospice wanting medication. At this time, V10 R53 was admitted to the esponsive and non-verbal proved so much, R53 is spice. V10 was not aware of emotionally about being at the ent events.				
	- 9 on R53 and stated indicates possible de V10 called V32 (R53 after completing the okay for R53 to be se services and V32 gas stated that R53 had b	atient Health Questionnaire) d R53 scored a 12, which pression. V10 stated that 's POA (Power of Attorney)) assessment to see if it was een by behavioral health ve permission and actually				

STATE FORM

6899

9IW611

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 05/16/2024	
		II 6005573				
			ADDRESS, CITY, STATE,		5/10/2024	
		1225 S				
OLDWA		PONTI	AC, IL 61764			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pag	e 3	S9999			
	11/3/23 documents t individual who is bot patient of Hospice, a Facility normally wou absence of Hospice Facility's policies, pro required by State an	e Service Agreement dated he facility will furnish to the h a resident of Facility and a ll of those services which lld have provided in the Program, as provided for the ocedures, and protocols as d Federal Law and resident and the resident's				

9IW611