

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigations 2620938/2723216, 2620332/2712025, 25212928/2705599, 25212586/2698672, 25212525/2698576, 25212564/2697898, 25211690/2682313, 25211427/2676802, and 2620964/2724097		S0000				
S9999	Final Observations Statement of Licensure Violations: 1 of 5 300.510a) 300.510e) 300.610a) 300.1210b) 300.1210d)1)4)A)B) 300.1220b)1)7)8) 300.1410a) 300.1410b) 300.1410c)1) 300.1410g) 300.1630d) 300.3210a)2)A) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. e) The licensee and the administrator shall be familiar		S9999				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 1 with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 2 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including 1) Assigning and directing the activities of nursing service personnel. 7) Coordinating the care and services provided to residents in the nursing facility. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.1410 Activity Program a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents. b) Activity personnel shall be provided to meet the needs of the residents and the program. Activity staff time each week shall total not less than 45 minutes multiplied by the number of residents in the facility. This time shall be spent in providing activity programming as well as planning and directing the program. The time spent in the performance of other duties not related to the activity program shall not be counted as part of the required activity staff time. c) Activity Director and Consultation 1) A trained staff person shall be designated as activity director and shall be responsible for planning and directing the activities program. This person shall be regularly scheduled to be on duty in the facility at least four days per week. g) The facility shall provide a specific, planned program of individual (including self-initiated) and group activities that are aimed at improving, maintaining, or minimizing decline in the resident's			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 3 functional status, and at promoting well-being. The program shall be designed in accordance with the individual resident's needs, based on past and present lifestyle, cultural/ethnic background, interests, capabilities, and tolerance. Activities shall be daily and shall reflect the schedules, choices, and rights of the residents (e.g., morning, afternoon, evenings and weekends). The residents shall be given opportunities to contribute to planning, preparing, conducting, concluding and evaluating the activity program. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate administrative oversight to ensure the facility implemented policies for wound care, medication administration, treatment administration, quality assurance measures, and basic activities of daily resident care. These failures resulted in a facility-wide lack of supervision and care leading to residents experiencing worsening pressure ulcers, severe pain, a lack of resident care for gastrostomy tubes and pressure ulcer treatments with subsequent infections requiring hospitalization, untimely assistance with incontinent care and showers resulting in residents being left in soiled conditions			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 4 for extended periods, missed medication administrations with significant medication errors, and not providing a functional, licensed and engaged leadership team. This negligence posed a high potential for, and resulted in, actual harm to residents, and has the potential to affect all 53 residents residing in the facility. Findings include: The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility. The Facility Assessment, dated 11/1/25, documents in section three Facility Resources needed to provide competent support and care for our resident population on a daily basis and during emergencies include an Administrator, Assistant Administrator, Activity Director and other activity staff. The Administrator Job Description, dated 5/2/17, documents "Summary: The Administrator directs the day-to-day functions of the facility in accordance with current federal and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Essential Duties and Responsibilities: Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice, ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures, Assist in recruitment and selection of competent department directors, supervisors, facility non-licensed staff, consultants, etcetera, Assist department directors in the topic section, planning, conducting, and scheduling of in-service training classes and on-the-job training and orientation program to assure that current material and programs are continuously provided, ensure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints, are well established and maintained at all times, and performs other duties as assigned. Qualifications: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements below are representative of knowledge, skill, and/or ability required. Must possess a current, unencumbered, active license to practice as a Nursing Home Administrator."		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 5 The Director of Nursing Job Description, dated 5/2/17, documents "Summary: The primary purpose of the Director of Nursing position is to plan, organize, develop, and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical director, to ensure that the highest degree of quality care is maintained at all times. Essential duties and responsibilities: Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations and guidelines that govern the nursing care facilities Develop, maintain, and periodically update written policies and procedures that govern the day-today functions of the nursing service department. Make written and oral reports/recommendations to the Administrator as necessary/required, concerning the operation of the nursing service department. Develops methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. Maintain ongoing quality of assurance program for the nursing department. Participate in the facility surveys made by authorized government agencies as necessary or as may be directed. Assist the Quality Assessment and Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies. Assist with discharge planning and perform administrative duties such as completing medical forms, reports, evaluations, studies charting, etcetera. Monitor the facility's Quality Indicators and Quality Measures and survey reports. Assist in the developing plans of action to correct potential or identified problem areas. Assist in calculating the number of direct nursing care personnel on duty each shift. Assign a sufficient number of licensed practical and/or registered nurses for each tour of duty to ensure that quality care is maintained. Assign a sufficient number of certified nursing assistants for each tour of duty to ensure that routing nursing care is provided to meet the daily nursing care needs of each resident. Develop work assignments and schedule duty hours, and/or assist nursing supervisory staff in completing and performing such tasks. Delegate to nursing personnel the administrative authority, responsibility and accountability necessary to perform their assigned duties. Make daily rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments. Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 6 that such care is provided in accordance with the resident's wishes. Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled. Provide direct nursing care as necessary." R1, R2, R4, R5, R6, R7, and R9's medical records document multiple missed significant medications, wound treatments, gastrostomy (g-tube) cares, and scheduled showers from 11/1/25-2/9/26. R4 was admitted to the facility on 10/28/25 with no pressure ulcers. On 12/12/25 a stage three pressure ulcer was found on R4's coccyx. Treatment was not started for 24 hours. Sixteen treatments were not done between 12/12/25 and 1/21/26. On 1/21/26 R4 was sent to the Emergency Room with complaints of fever and lethargy. R4 was admitted to the hospital with diagnoses of Severe Sepsis and Stage IV Sacral Ulcer with concern for osteomyelitis. Radiology Report documents "Stage IV (four) sacral ulcer with ill-defined lower sacral and coccygeal posterior cortices which suggests osteomyelitis." R9 was admitted to the facility on 11/20/25 with treatment orders for a stage four pressure ulcer on his sacrum. On 12/09/25, R9 had a change in condition and was sent to a local hospital and admitted for Sepsis from stage IV sacral wound with osteomyelitis. R9 returned to the facility on 12/22/25. From 12/23/25 - 1/17/26, multiple wound treatments were not completed. On 1/1/26 R9's rectal tube was accidentally removed, and the facility did not replace it due to lack of supplies. R9's sacral wound was subsequently exposed to fecal matter for extended periods of time from 1/1/26 - 1/17/26. R9's Treatment Administration records dated from 11/20/25- 1/17/26 documents multiple g-tube site care treatments and residual checks were not completed for a total of 15 uncompleted g-tube site cleansing and 26 missed residual assessments. On 1/17/26 R9 had a change in condition and was sent to a local hospital and admitted for fever, abdominal pain, diarrhea, nausea and vomiting, toxic appearance, and a diagnosis of sepsis from multiple suspected sources including g-tube site infection with pus leaking drainage and a stage IV sacral wound with osteomyelitis. On 1/28/26 at 11:08 AM, V4 (Assistant Director of Nursing) confirmed that residents who have or are at risk for pressure ulcers should have skin assessments performed daily by nursing and those are not being documented for R4 or R9 who both have stage four pressure ulcers and multiple comorbidities. V4 stated		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 7 "Wound care and skin checks and assessments should be completed by the floor nurses." On 1/29/26 at 12:50 PM, V33 (Emergency Room Physician) stated "I saw (R9) in the hospital. He is a very sick person and it's unfortunate. When we admitted him for the second time for Sepsis (1/17) we had him in the ER for a longer period. Any tube coming out of the body has the potential to get infected. At the time of his admission, we also were concerned with his g-tube site with purulent pus like drainage which can relate to the sepsis. If you don't take care of the g-tube properly with cleansing and flushes, then you can get infection at the site. Additionally, if the feeding is going into the abdominal cavity due to becoming dislodged it also is a risk factor for that becoming infected. I believe the g-tube was removed by gastrointestinal surgeons while in the hospital." R1's (MAR) Medication Administration Record, dated 12/1/25-12/31/25, documents R1 did not receive 18 scheduled doses of physician ordered medications in December, including Eliquis (anticoagulant), Juven (nutritional wound supplement), Zonisamide (anticonvulsant), Keppra (anticonvulsant), Metoprolol (antihypertensive), Vimpat (antiepileptic) and Modafinil (stimulant). These medications were left blank or document to "see nurses notes". Follow up nursing notes for the unadministered medications document "on order, not available". R2's MAR, dated November 1st – 4th 2025 documents 100% (percent) of scheduled Norco (pain medication) (5-325mg) (milligrams) doses (12 out of 12) were not administered. R4's MAR dated December 2025 documents R4 missed four doses of scheduled Vimpat Oral Tablet 100 MG, seven doses of physician ordered Keppra Oral Tablet 750 MG, and six doses of physician ordered Hydrochlorothiazide 25 MG. R6's MAR dated January 11th – January 20th, 2026, documents R6 missed seven doses of Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3 ML (milliliter). On 1/29/26 at 1:04 PM, V30/Facility Nurse Practitioner stated she has heard there are problems with the facility not having the medications available for the residents. R1, R4, R5, R6, R7, and R9's medical records do not document evidence of R1, R4, R5, R6, R7, or R9		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 8 receiving a shower in the months of December 2025 and January 2026. On 1/29/26 at 1:10 PM, V2/DON (Director of Nursing) stated she could not provide evidence or documentation showing R1, R4, R5, R6, R7, or R9 received a shower in the months of December 2025 and January 2025. V2 confirmed that no one is overseeing that showers are being documented and completed as scheduled. On 1/26/26 and 1/27/26 between 9:00 AM and 3:30 PM, facility residents were not observed in activities, no announcements were made about activities, and no current activity calendar was observed around the facility or in resident rooms. On 1/28/26 R10, R11, R12, and R13 all stated the facility does not have activities every day. At this same time, R14 also confirmed there are no daily activities and stated, "They do not have a fulltime Activity Director." On 1/28/26 at 11:38 AM V25/Housekeeping Supervisor stated she fills in at times to perform activities with the residents since the facility does not have an Activity Director, but it's not often. V25 verified no activities were performed with the residents on 1/26/26 and 1/27/26. V25 stated, "The last two days I had to help on the floor, so I was unable to ensure activities were being done with the residents. There are no planned activities after 4:00 PM or on the weekends for the residents." On 1/28/26 at 11:45 AM, V1/Administrator in Training verified the facility does not have a current activity director, and activities are not getting one daily. On 1/26/26, the facility did have an Administrator or Director of Nursing present in the facility until after 10:30 AM (after the state agency surveyors arrived and administration was notified.) Throughout the survey from 1/26/26 through 2/3/26 multiple observations were made of V1/AIT (Administrator in Training) and V2/Interim Director of Nursing's office doors closed. V2's window on the office door remained covered throughout the survey with a dark panel, giving the appearance that the office is dark when the door is closed. On 1/27/26 at 11:20 AM V1/AIT stated "I do not have a temporary license yet. I am in the classes but not eligible to apply for the AIT licenses yet. I have worked here since July of 2025 in this role. (V14) is			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 9 the corporate vice president of operations (VPO), and she is the administrator over this building. (V14) is not here every day." On 1/27/26 at 12:02 PM V17/Ombudsman stated the biggest complaint she has heard in resident council meetings is that the residents are not getting showers on second and third shifts. V17 also stated there have been resident complaints about management not coming out of their office or management keeping their doors closed so the residents never know who to talk with about issues or concerns. V17 stated "During resident council today, the residents stated they were very bored. The facility has not been having activities going on, no calendar has been posted or passed out to the residents' rooms, and they have not been offering daily activities. Residents have told me they have to figure out their own activities to do." On 1/30/26 at 1:22 PM, V4/Assistant Director of Nursing confirmed that V1/AIT is not in the facility on this date. On 2/2/26 at 10:00 AM, Both V1/AIT and V2/Interim Director of Nursing confirmed they were not in the building on Friday (1/30/26). On 2/2/26 at 11:00 AM V14/ Regional VPO, confirmed she is the administrator over the facility and is training V1. V14 stated "I am VP of operations over eleven homes, so I travel amongst them for regional support." From entrance of this survey (1/26/26), 2/2/26 is the first time V14 was seen in the building. On 2/3/26 at 1:33 PM V2/Interim DON stated V4/LPN (Licensed Practical Nurse)/Wound Nurse/Infection Preventionist is responsible for looking at the resident's MARS and TARS (Treatment Administration Records) daily to ensure medications were being given and treatments were being provided as physician ordered. V2 stated V4 is also responsible for ensuring the wound program is implemented and followed. V2 stated, "I was not aware (V4) was not monitoring the resident's MARS and TARS daily to ensure physician orders were being followed to ensure resident's received appropriate care. I should have been aware." On 2/3/26 at 2:20PM V4/LPN/Wound Nurse/Infection Preventionist stated, "I was not educated on the process of the wounds at the facility. I tried to audit to see where things were at with wounds in this facility because no wound logs were left to show who even had wounds. In December 2025 when I started, (V5/Former Director of Nursing) didn't really know what		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 10 to tell me to do. V2/Interim Director of Nursing just showed me on 2/2/26 how to monitor MARS and TARs. I was not delegated to monitor TARS and MARS prior to 2/2/26." On 1/27/26 at 12:47 PM V35/LPN stated "In December (V1/AIT) and (V2/Interim Director of Nursing) were calling people in and stating they couldn't tell state (agency surveyors) things and couldn't chart certain things. They didn't want us to bring up any issues or let anyone know the issues. They just wanted to hide what was going on." On 2/3/26 at 12:04 AM V41/CNA stated the facility's management is not stable. They don't take care of problems or don't seem to care about the residents. Their doors are always shut. They can do better as people and better professionally. There are no scheduled activities in the evenings for the residents. V1/Administrator-in-Training and V2/Interim Director of Nursing both keep their door shut. On 2/3/26 at 12:35 PM, V43/CNA stated that she has worked on and off at the facility for 15 years but will never step a foot back in the building since they have gotten new management. The staffing is "absolutely horrible." Evenings will have two to three CNAs working. There have been times when there were only one CNA and one nurse on night shift. There are no activities in the evening. Call lights are not answered timely. It can take an hour or longer. There were several residents that did not get their pain medication as needed and would complain. Wound treatments were not being done daily. When we say we are short on staff management says, "we need to make it work." V1/AIT and V2/Interim Director of Nursing's doors are always closed. V2/Interim Director of Nursing only comes in once a week to give write-ups. I got a write up because I was not taking my lunch. I didn't have time to take lunch because we were short staffed. Just because there may be enough CNAs in the building if they are agency they are not as efficient, and we are not able to give the residents the care they deserve. On 2/3/26 at 1:00 PM, V42/CNA stated she has worked at the facility for about six months. "The facility does not have enough staff to take care of the residents. Agency is used a lot. Nurses do the best they can, but treatments do not get done as often as they should." On 1/29/26 at 12:15 PM, V22 (Facility's Medical Director) stated "The continuity of care with changes in staff and management is an issue. My communication		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 11 with (V1, AIT) has been sporadic. When I come in the Administrator (V1, AIT) and DON (V2, Director of Nursing) should make me aware of concerns and issues that are happening in the building and then we can address those things in QA (Quality Assurance) and talk about solutions. I have not been notified that there is such an issue with missing treatments, missing medications and (resident) care concerns." The facility's records did not include Annual QAPI (Quality Assurance and Performance Improvement) training for all staff, 12 hours of mandatory in-service training for (CNAs) Certified Nursing Assistants, or quarterly Quality Assurance meetings. On 1/29/26 at 2:03 PM V2/Corporate/Interim Director of Nursing stated, "I cannot provide documentation to show that we provided 12 hours of training to any CNAs in the past year." On 2/4/26 at 10:14 AM V1/AIT (Administrator-in-Training) verified that facility staff have not received the annual QAPI training. On 2/10/26 at 11:15 AM V14 stated that the facility has not had a QAA meeting since 7/2025 and prior to that she has no records to show the meetings were held. V14 stated when V1 started in July QA was addressed and meetings were to be held monthly per the facility and quarterly per the regulation requirement. V4 confirmed that she wasn't aware of the multiple failures and thought things were being managed when she was not in the building. (A) 2 of 5 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 12 consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 13 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to identify, assess, and treat a facility-acquired pressure ulcer, prevent a pressure ulcer from worsening, administer wound treatments as ordered, develop and implement pressure relieving interventions and a pressure ulcer care plan, and failed to ensure a residents (R9) fecal collection system (rectal tube) was assessed and monitored, replaced after removal and care planned to ensure optimal outcome for two of three residents (R4, R9) reviewed for pressure ulcers in the sample of 16. This failure resulted in R4 developing a facility acquired pressure ulcer and R4 and R9's wounds worsening without adequate treatment and being transferred to the hospital with lethargy, high fever and requiring extensive hospitalization for diagnoses of sepsis and a stage four decubitus pressure ulcer with osteomyelitis. Findings include: The Pressure Ulcer Prevention policy dated 1/15/18 documents "Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: 1. Maintain clean/dry skin during daily hygiene measures. 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. 5. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. 6. Employ active and passive range of motion exercises to improve circulation as			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 14 indicated (in accordance with physician order and plan of care). 12. Encourage resident to maintain proper nutrition and hydration, providing supplements as ordered and necessary assistance at mealtime as needed. 14. Moisture barrier may be applied by CNA (Certified Nursing Assistant) as needed to intact skin and may be kept at bedside." The Skin Condition Assessment and Monitoring -Pressure and Non-Pressure policy dated 6/8/18 documents "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident's chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Caregivers are responsible for promptly notifying the charge nurse of skin breakdown. At the earliest sign of the injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. Wound Assessment/Measurement: 6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. 7. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses note." The facility's Guidelines for Management of Fecal Incontinence with (flexible seal) policy, dated 2/2011, documents "Objective: To effectively divert and contain liquid and semi-liquid stool away from the body. Outcomes: Keep skin clean and dry; free from contaminants that contribute to skin breakdown. Contain infectious body waste contained within a closed drainage system to minimize risk of spread of bacteria.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 15 Protect surgical wounds and pressure ulcers from contamination by stool. Keep environmental odor to a minimum. Increase patient comfort. Notify physician if any of the following occur: persistent rectal pain, rectal bleeding, abdominal distention. As with the use of any rectal device the following adverse events could occur, excessive leakage of stool around the device, loss of anal sphincter muscle tone could lead to temporary anal sphincter dysfunction, pressure necrosis of rectal or anal mucosa, infection, bowel obstruction, perforation of the bowel. Maintenance: observe the device frequently for obstructions from kinks, solid fecal particles or external pressure." 1. R4's computerized Medical Record documents that R4 is a 60-year-old that admitted to the facility on 10/28/25 with diagnoses which included Acute Respiratory Failure with Hypoxia, Tracheostomy Status, Gastrostomy Status, and Encephalopathy. R4's Skin Condition Report dated 10/28/25 documents that R4 had no wounds. R4's MDS (Minimum Data Set) assessment dated 10/31/25 Section C (Cognitive Patterns) documents that R4 is severely cognitively impaired. Section GG (Functional Ability) documents R4 is dependent on staff for all activities of daily living/ADLs, toileting, bed mobility, and transfers. R4's Risk Assessment dated 11/7/25 documents a Braden Risk Level of 9 (nine) "Very High Risk." R4's current Care Plan does not have a care plan that R4 is at risk for pressure ulcers and does not have any interventions to prevent pressure ulcers. R4's Skin/Wound Note written by V4/Wound Nurse dated 12/12/25 at 2:08 PM, documents "Notified by CNA (unidentified) (R4) had a wound on her coccyx. Evaluated. Open area to coccyx noted with moderate serous drainage. Appears to have large amount of scarring to the area. Fax sent to MD (Medical Doctor). Placed tx (treatment) order." R4's Progress Note written by V30/Nurse Practitioner/NP dated 12/24/25 documents "(R4) is bedbound, in a vegetative state, nonverbal, and fully dependent for all ADLs. Interventions: Positioning and Skin Care: Dependent for all repositioning; staff to provide frequent turning and repositioning. Regular skin assessments; care of coccyx open wound." R4's Progress Note written by V30/NP dated 12/30/25		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 16 documents that R4's has a stage 3 (three) pressure ulcer to the sacral region. The wound measures 7 cm (centimeters) by 6.5 cm by 0.20 cm. Care Plan is for frequent turning/repositioning to off-load pressure from sacral area and dressing changes. R4's Treatment Administration Record for 12/1 - 12/31/25 documents to apply (medicated dressing) and gauze to R4's coccyx two times a day at 8:00 AM and 8:00 PM starting 12/12/25 at 8:00 PM. The treatment was not started until 12/13/25 at 8:00 PM. The treatments were not documented as being done on 12/17 at 8:00 AM, 12/18 at 8:00 PM, and 12/20 at 8:00 AM. On 12/20/25 the order was changed to apply (medicated dressing) and gauze to R4's coccyx every shift day and night starting 12/20/25 at 6:00 PM. The treatments were not documented as being done on 12/23, 12/26, 12/28 on days and 12/29/25 on nights. R4's Skin/Wound Note written by V4/Wound Nurse dated 1/9/26 at 3:15 PM, documents "Left message for (POA/Power of Attorney) to obtain consent for wound MD (Medical Doctor) evaluation of wound to coccyx as it continues to decline and should be followed by Wound MD." R4's Follow UP Note written by V30/NP dated 1/15/26 at 6:55 PM, documents "New tunneling of wound." R4's Nursing Note dated 1/18/26 at 10:21 PM, documents "Wound bed is draining copious amounts of dark yellow drainage almost constantly." R4's Progress Note written by V30/NP dated 1/19/26 documents that R4's pressure ulcer is a stage 4 (four) measuring 8 cm by 10 cm with deep tunneling, purulent, odorous drainage, with concerns for infection. R4's Nursing Note dated 1/21/26 at 7:53 PM, documents that R4 was "slightly clammy" with an increase in respirations and shortness of breath. R4's coccyx wound seems to have worsened. V22/Primary Care Physician was notified about concerns. V22 gave an order to send R4 to the hospital to be evaluated to rule out Sepsis. R4's Hospital Report dated 1/21/26 documents that "Infectious Disease consulted and requested (V34/Hospital Doctor) for evaluation and antibiotic recommendation." R4 was admitted to the hospital by V34 on 1/21/26 with admitting diagnosis of Sepsis. "Call placed to (the facility) and no one answered the phone today, 1/22/26 after multiple attempts. So unclear how long (R4) was ill at facility. ER (Emergency Room) notes indicate (R4) arrived with reports of fevers		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 17 there 104-106 (degrees) unknown measurement or how long; accompanied by lethargy." R4's Nursing Note dated 1/22/26 at 1:23 AM, documents that the hospital reported there were signs pointing to Sepsis. R4 was started on Zosyn and Vancomycin. R4's Hospital Records dated 1/22/26 at 2:49 PM, documents that R4 presented to the ER/Emergency Room from the facility with complaints of fever and lethargy. Radiology Report documents "Stage IV (four) sacral ulcer with ill-defined lower sacral and coccygeal posterior cortices which suggests osteomyelitis (this may also have a large component of volume averaging artifact)." R4's Hospital Report dated 1/23/26 at 12:21 AM, documents "(R4) has sepsis which could be from the pneumonia and/or wound infection of her chronic pressure ulcer, or both." R4's Hospital Clinical Notes dated 1/25/26 at 1:25 PM, documents that bedside surgical debridement was done. Necrotic skin bridges were sharply excised, and the wound bed was mechanically debrided. There was an area of darkened tissue over R4's sacrum that was unable to be debrided at the bedside. R4's Treatment Administration Record for 1/1 - 1/31/26 documents to apply (medicated dressing) and gauze to R4's coccyx every shift day and night. The treatments were not documented as being done on 1/2 and 1/5/26 on days, 1/8/26 on days or nights, and 1/12, 1/17, and 1/21/26 on days. On 1/21/26 at 4:00 PM, the order was changed to apply (medicated dressing) and gauze to R4's coccyx four times a day and as needed at 4:00 AM, 10:00 AM, 4:00 PM, and 10:00 PM. The dressing was done on 1/21/26 at 4:00 PM then R4 went to the hospital. On 1/27/26 at 12:47 PM V35/Licensed Practical Nurse stated that wound care could not be completed most of the time on night shift. The medication pass alone was too aggressive and then the charting had to be completed. Wound care would be the last thing we (staff) would do if we could even get to it. V35 also stated "If I was working and the treatment was left blank it would mean I didn't do it due to not having enough time." On 1/28/26 at 11:00 AM, V4/Wound Nurse stated that she started doing the wounds around 12/1/25 taking over for V23/Prior Wound Nurse. V23 did not have any wound logs or wound measurements documented. V4 stated the first time she was told about R4's wound was on 12/12/25 and		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 18 V4 would classify it as a Stage 3. The dressings were to be done twice a day then was changed to four times a day due to the amount of drainage. V4 stated "The wound was getting worse. I thought it needed debrided. I brought it up to (V30/NP) and had to order the supplies. (R4) was sent out before we got the wound debrided." V4 also stated "I check the Care Plan weekly and there was not a Care Plan for (R4's) wound as of last week. I have not put anything in yet. It is my job to do it and when it is identified it should be put in a care plan." V4 stated "If the treatment is not signed out in the treatment log it did not get done." On 1/29/26 at 1:04 PM, V30/Facility Nurse Practitioner stated that the first time she saw R4's pressure ulcer was on 12/24/25. R4 was completely dependent on staff for her care. R4's wound continued to get worse and when R4 was sent to the hospital (1/21/26) the wound was a Stage 4 and was infected. V30 also stated that the dressings need to be changed as ordered or it" absolutely" would cause a problem causing the wound to worsen. 2. R9's Admission Observation assessment, dated 12/22/25, documents R9 originally admitted to the facility on 11/20/25 with a stage four pressure ulcer wound to his coccyx and is dependent on staff for all activities of daily living, mobility and care. R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), Osteomyelitis of vertebra, Sacral and Sacrococcygeal region. This care plan documents "I have a pressure ulcer coccyx related to immobility, history of CVA (cerebrovascular accident), bowel incontinence and as evidenced by Braden (skin assessment) score. Administer treatments as ordered and monitor for effectiveness. Follow facility protocols for the prevention/treatment of skin breakdown. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. The resident requires a pressure reliving/reducing mattress on bed." R9's Physician Order sheet dated, 11/20/25-2/10/26 documents R9 has an order started on 11/20/25 to monitor placement and empty contents of rectal tube every shift for wound care and a wound treatment order to cleanse coccyx wound with (wound cleaner) and gauze. Apply skin prep to peri wound skin, foam to the wound bed and drape with wound vacuum every Monday, Wednesday and Friday. This order sheet also documents an order started on 12/23/25 to cleanse stage IV (four) coccyx		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 19 wound with wound spray, pat dry and apply (wound cleanser) wet to dry dressing and cover with padded covering two times daily and as needed (PRN) for wound care. R9's Treatment Administration Record (TAR) dated 11/20/25-11/30/25 documents two of R9's scheduled wound treatments were not administered, and zero PRN treatments were completed. R9's TAR dated 12/1/25-12/9/25 documents two of R9's scheduled wound treatments were not administered, and zero PRN treatments were completed. R9's Hospital Summary, dated 12/22/25, documents R9 was evaluated in the emergency room with altered mental status and concern for infection and admitted to the hospital on 12/9/25 for Sepsis "with suspected sources including a chronic stage IV sacral ulcer with imaging evidence of underlying abscess and sacrococcygeal osteomyelitis." This summary documents R9's deep wound cultures grew multiple bacteria including Enterococcus and Citrobacter freundii which R9 was treated for at the hospital before discharging back to the facility on 12/22/25. On 1/28/26 at 12:40 PM, V32 (R9's Family) stated that three weeks into (R9's) stay at the facility, he was re-admitted to the hospital with a wound infection. V32 stated "(R9's) wound is to the bone and the size of a plum and when staff clean R9's bowel contents up, the pad over his wound also becomes soiled. I have seen that stool-soaked wound pad sit for over four hours before a nurse changed the wound dressing." R9's TAR dated 12/23/25-12/31/25, documents R9's physician ordered coccyx wound treatment was to be completed two times daily and as needed. This record documents five scheduled treatments were not completed and zero "as needed" treatments were administered. R9's TAR dated 1/1/26-1/17/26, documents R9's physician ordered coccyx wound treatment was to be completed two times daily and as needed. This record documents seven scheduled treatments were not completed and zero "as needed" treatments were administered. This same administration record documents R9 was ordered to have Sodium Hypochlorite external solution 0.125% applied to the coccyx wound topically every 12 hours related to pressure ulcer treatment. This same record documents, ten scheduled sodium hypochlorite applications were not completed. R9's TAR's dated 11/20/25-1/17/26, do not document any		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 20 site monitoring or assessments were ever completed for R9's rectal tube. R9's electronic medical record does not document R9 was provided daily nursing skin checks throughout R9's stay in the facility. R9's nursing progress note, dated 1/1/26 at 10:23 PM, documents "Resident rectal tube fell out. Called MD (V22, Facility Medical Director) and he said to monitor and call the surgeon. This nurse could not find surgeon's number. DON (V2, Director of Nursing) notified, care ongoing." R9's progress note, dated 1/10/26 at 10:03 AM and completed by V30 (Facility Nurse Practitioner), documents "Wound MD (Medical Doctor, V54 wound physician) stated that if (R9) does not want the fecal tube in place that is okay to leave out. The wound will heal better with it in place. Asked (R9) what his wishes were and he shook his head no. Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32, R9's family) would like one re-ordered. Will verify with (R9) and re-order as needed." R9's progress note, dated 1/12/26 at 4:14 PM and completed by V30, documents "Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32) would like one re-ordered. Discussed with (R9) today that the rectal tube can help with wound healing so that it does not get contaminated. He did consent that this would be OK to re-insert. Will follow up with DON (V2) about ordering." R9's progress notes, dated 1/1/26- 1/17/26, do not document R9's gastric surgeon (unknown) was notified of the rectal tube removal and does not document that the rectal tube was ever replaced. R9's nursing progress note, dated 1/17/26 at 9:54 AM, documents V22 (Facility Medical Director) was notified of R9's gastrostomy tube (g-tube) leaking and a new order was received for CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and KUB (Kidney Ureter Bladder imaging). R9's electronic medical record does not document any laboratory results throughout R9's entire admission		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 21 11/20/25-1/17/26. R9's nursing progress note, dated 1/17/26 at 8:00 PM, documents "(V22) ordered a KUB due to leaking g-tube. KUB results came back with no clear results due to faulty imaging." This same note documents V32 (R9's family) wanted R9 to be sent to the hospital "due to no clear results from KUB imaging. (R9) sent to (local Emergency Room) per request of (V32). (V22) aware." R9's Hospital Emergency Department-Admission record, dated 1/17/26, documents R9 presented to the emergency room with fever, abdominal pain, diarrhea, nausea and vomiting and R9's appearance was "ill-appearing and toxic-appearing". This record also documents R9 was admitted with a diagnosis of Sepsis with several contributing sources including a stage four decubitus ulcer. On 1/28/26 at 11:08 PM, V4 (Assistant Director of Nursing (ADON)/ Wound Nurse) confirmed R4 and R9 do not have any documentation of daily skin monitoring. V4 stated nurses should be completing skin assessments on all residents especially when they have a high risk of skin breakdown, to identify concerns. On 1/30/26 at 1:22 PM, V4 stated R9 does not have any laboratory results in his medical record because none were completed at the facility. On 1/29/26 at 12:15 PM, V22 (Facility Medical Director) confirmed that wound treatments should be completed according to the physician orders, and the physician should be notified if there are issues completing wound treatments. V22 stated "I had no idea wound treatments weren't being completed. Stool getting into a wound would definitely cause contamination. When (R9's) rectal tube came out, I wanted him to follow up with the gastric surgeon due to the g-tube (gastrostomy tube) and worried about his bowel and possible placement issues with that. So, I did want the surgeon notified when it came out and I wasn't aware they didn't notify the surgeon." On 1/29/26 at 12:50 PM, V33 (Emergency Room Physician) confirmed seeing R9 in the emergency room on admission to the hospital (1/17/26) and confirmed that R9 has been admitted to the hospital twice with Sepsis and a Stage IV pressure ulcer with osteomyelitis. V33 stated "(R9) is a very sick person and it's unfortunate. The Sepsis could come from multiple sites. In (R9's) case he had a stage IV, very deep, decubitus ulcer. Certainly, if stool were to enter into that wound bed it can lead to infection. Even just improper care of a			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 22 wound or not completing treatments, without stool involvement, can cause it to become infected." On 1/27/26 at 12:47 PM V35 (Licensed Practical Nurse) stated wound care could not be completed most of the time on third shift. V35 stated "The medication pass alone was too aggressive and then the charting had to be completed. Wound care would be the last thing we would do if we could even get to it. If I was working and the treatment was left blank it would mean I didn't do it due to not having enough time." On 1/29/26 at 1:20 PM, V30 (Nurse Practitioner) confirmed R9's sacral pressure ulcer was to the bone and R9 had a rectal tube to keep his wound clean which was removed on 1/1/26. V30 stated "The rectal tube was never re-inserted for R9 due to it not being available." V30 also stated nurses should be assessing residents' skin daily to monitor for signs of pressure or impaired skin integrity. On 2/2/26 at 10:00 AM, V2 (Director of Nursing) stated she was not aware that R9 was not receiving wound treatments, nursing skin assessments, physician ordered labs and rectal tube monitoring. V2 confirmed when the rectal tube was unavailable from their supplier, the facility did not reach out to the hospital to purchase a replacement tube. On 2/10/26 at 1:00 PM, V4 (ADON/ Wound Nurse) confirmed that R9's rectal tube was in place to help keep his sacral pressure ulcer clean. V4 also confirmed this tube was not on his care plan and R9's electronic medical record does not contain documentation to show that it was monitored every day. V4 stated "The order for (R9's) rectal tube was not put in correctly and so there is no record that the site was monitored, including the amount of stool or nursing assessment to ensure placement was secure. He did not have a care plan in place for the rectal tube and should have." (A) 3 of 5 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3) Section 300.610 Resident Care Policies			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 23 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 24 shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide physician ordered gastrostomy care including cleansing, laboratory monitoring, flushes, residual checks and tube insertion site assessments for a resident with an internal percutaneous endoscopic gastrostomy (PEG) tube for nutritional support for one of three residents (R9) reviewed for gastrostomy tubes (G-tube) in the sample of 16. This failure resulted in R9 transferring to the emergency room and being admitted to the hospital with fever, abdominal pain, diarrhea, nausea and vomiting, toxic appearance and a diagnosis of sepsis from multiple suspected sources including a g-tube site infection with pus filled drainage. Findings include: The facility's Gastrostomy Tube- Feeding and Care policy, dated 8/3/20, documents "Purpose to provide nutrients, fluids and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach. Measurement of gastric residual is usually ordered for new g-tube placement/ feeding and before advancing the hourly feeding rate to determine resident's tolerance to feeding of to detect complications related to gastric emptying and absorption. Observe the resident for signs and symptoms of nausea, vomiting, diarrhea, abdominal distention/ cramping. Notify physician." This same policy documents "Stoma site care. Inspect the surrounding skin for redness, tenderness, swelling, irritation, purulent drainage, or gastric leakage; immediately report skin irritation or infection and provide treatment. Clean skin with soap and water or antiseptic of choice. Begin next to stoma site, using spiral pattern and moving outward, clean under skin disk with cotton swab. Dry thoroughly; leave area open to air to minimize dampness, skin irritation, and maceration; use a dressing only if ordered." R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), Osteomyelitis of vertebra, Sacral and Sacrococcygeal region. This care plan documents "I require tube feeding Osmolyte 1.5 to infuse at 70 milliliters an hour for 22 hours, starting daily at 5:00 AM. Interventions: Check for tube placement and gastric		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 25 contents/residual volume per facility protocol and record. I am dependent with tube feeding and water flushes. See Physician orders for current feeding orders. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated." R9's Physician Order Summary (POS), documents R9 was admitted to the facility on 11/20/25 with treatment orders for R9's G-tube site care to cleanse and apply split gauze every shift for infection control and a treatment to check residual before medications and feedings, if greater than 100 (milliliters) hold feeding and medications and notify physician every shift and an order. This order was not initiated until 11/25/25 (five days after admission). This summary also documents R9 has an order starting on 12/24/25 to cleanse g-tube insertion site everyday with soap and water during ADL (Activities of Daily Living) care, every shift for g-tube. R9's Treatment Administration Record (TAR), dated 11/20/25-11/30/25, documents R9 did not receive g-tube site cleaning and new gauze on 11/22/25 evening shift. This TAR also documents R9 did not have any g-tube residual monitoring from 11/20-11/25/25 prior to feeding and medication administrations. R9's Treatment Administration Record (TAR), dated 12/1/25-12/31/25, documents R9 did not receive scheduled g-tube site cleaning and new gauze on seven occasions and was not provided scheduled g-tube residual monitoring on nine occasions. This same record also documents three scheduled soap and water cleansings of R9's g-tube site were not completed from 12/24-12/31/25. R9's Medication Administration Record (MAR), dated 12/1/25-12/31/25, documents an order for enteral feed flush to "flush with 30 milliliters (ml) of water before giving medications, flush with at least five ml between medications, and flush with a minimum of 30 ml after all medications given." This MAR documents R9's g-tube was not flushed on day shift on 12/5/25 and on evening shift in 12/29/25. R9's Treatment Administration Record (TAR), dated 1/1/26-1/31/26, documents from 1/1-1/17/26, R9 was not provided g-tube site cleaning and new gauze on seven occasions, was not provided scheduled g-tube residual monitoring on seven occasions and scheduled soap and water cleansings of R9's g-tube site were not completed on six occasions.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 26 R9's nursing progress note, dated 1/1/26 at 10:23 PM, documents "Resident rectal tube fell out. Called MD (V22, Facility Medical Director) and he said to monitor and call the surgeon (unknown gastric surgeon). This nurse could not find surgeon's number. DON (V2, Director of Nursing) notified, care ongoing." R9's progress notes, dated 1/1/26- 1/17/26, does not document a gastric surgeon was notified of R9's rectal tube removal and does not document that the rectal tube was ever replaced. R9's nursing progress note, dated 1/6/26 at 9:45 AM, documents "Residents POA (Power of Attorney, V32) requested that a new rectal tube be placed. Reported to APN (Advance Practice Nurse, V30) in facility. States (V30) will check and see if we can order one and speak with (V32) about this. No concerns at this time." R9's nursing progress note, dated 1/12/26 at 9:55 AM, documents "Got in report that (R9) has had emesis last night into this AM. Feeding shut off for two hours." R9's progress note, dated 1/13/26 at 11:44 PM and completed by V30, documents "Patient has had vomiting two nights ago, last evening at 6 PM and this morning at 6 AM. Vomiting on three occasions over the past two days. Monitor for improvement in symptoms or for any worsening." R9's nursing progress note, dated 1/14/26 at 9:53 AM, documents "(R9) had emesis this (morning) at 7:35 AM. Feeding paused at this time Zofran (nausea medication) given for nausea. Will continue to monitor." R9's progress note, dated 1/16/26 at 5:41 PM and completed by V30, documents "(R9) had another episode of vomiting this AM, nursing states (R9) has had vomiting for the past three to four days. He has metoclopramide (antiemetic medication) ordered on a schedule and ondansetron (nausea medication) as needed." This progress notes also documents diarrhea is also being reported to V30. R9's nursing progress note, dated 1/17/26 at 9:54 AM, documents "G-tube leakage noted. (V22, Facility's Medical Director) notified. Orders for CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and KUB (Kidney Ureter Bladder imaging). Will continue to monitor." R9's electronic medical record does not document that R9 had a CBC or BMP drawn or laboratory (lab) results were received.			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 27 On 1/30/26 at 1:22 PM, V4 (Assistant Director of Nursing) confirmed R9 does not have results for a CBC or BMP. V4 stated "(R9) does not have any lab results because none were completed at the facility, only at the hospital." R9's Nursing Progress note, dated 1/17/2026 at 8:00 PM, documents "(V22) ordered a KUB due to leaking g-tube. KUB results came back with no clear results due to faulty imaging. (V32, R9's family) came for a visit. Resident's feed has been turned off by day-shift nurse due to leaking. (V32) came to this nurse and wanted a re-assessment. Upon assessment, tube drain and gown were soaked with feed, took tube drain off and had a slight yellow-pink color to it mixed with feed. G-tube site kept continuously leaking feed. Resident complained of no abdominal pain, or pain anywhere else. (V23) wanted (R9) sent to be evaluated due to no clear results from KUB imaging. Resident sent to (local hospital ER) per request of (V32). (V22) aware." R9's Hospital Admission record, dated 1/17/26, documents R9 was admitted to the hospital with fever, abdominal pain, diarrhea, nausea and vomiting, toxic appearance and a diagnosis of sepsis from multiple suspected sources including g-tube site infection with pus leaking drainage. On 1/28/26 at 12:40 PM V32 (R9's family member) stated "Saturday (1/17/26) when he was taken to the hospital I went in there and his belly was covered with crust. Feeding was coming out of his stomach. Then when I lifted the gauze there was yellow puss coming out of his belly. I told the nurse that he needed to go to the hospital. It was awful. (R9's) g-tube was not cared for correctly. The feeding tube was removed in the hospital due to an abscess and sepsis." On 1/29/26 at 12:15 PM, V22 (Facility's Medical Director) confirmed he wanted R9's surgeon notified when his rectal tube came out (1/1/26), due to potential concerns with the bowel. V22 stated "I wanted (R9) to follow up with the GI (gastrointestinal) surgeon (unknown) due to the G-tube and worried about the bowel and possible placement issues with that. So, I did want the surgeon notified when it came out. I have not been notified that there is such an issue (in the facility) with missing treatments, missing medications and care concerns." On 1/29/26 at 12:50 PM, V33 (Emergency Room (ER) Physician) stated "I saw (R9) in the hospital. He is a very sick person and it's unfortunate. When we admitted		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 28 him for the second time for Sepsis (1/17/26) we had him in the ER for a longer period. Any tube coming out of the body has the potential to get infected. At the time of his admission, we also were concerned with his g-tube site with purulent pus like drainage which can relate to the sepsis. If you don't take care of the g-tube properly with cleansing and flushes, then you can get infection at the site. Additionally, if the feeding is going into the abdominal cavity due to becoming dislodged it also is a risk factor for that becoming infected. I believe the g-tube was removed by gastrointestinal surgeons while in the hospital." On 2/4/26 at 9:30 AM, V2 (acting Director of Nursing) confirmed she reviewed R9's hospital admission and electronic records and stated she was unaware that R9 was not receiving adequate g-tube care. V2 stated she cannot provide documentation to show a gastric surgeon was notified after R9's rectal tube came out. (A) 4 of 5 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)1)3) 300.1630d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 29 of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 30 Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to administer prescribed opioid medications to keep a residents' pain controlled, failed to perform pain assessments and implement pain relieving interventions while the resident was not receiving their prescribed pain relieving opioid medication, and failed to notify the physician of the need for a opioid medication refill order and complaints of increased pain for one of three residents (R2) reviewed for pain in the sample of 16. These failures resulted in R2 experiencing restlessness and unrelieved excruciating pain after five days of going without her prescribed pain medication. Findings include: The facility's Pain Management Policy, dated 7/6/18, documents Purpose: To establish a program which can effectively manage pain in order to remove adverse physiological and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Guidelines: It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facility life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program. Definition: The resident's descriptive words regarding the quality, duration, and location not pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital signs change, and changes in behavior and mood will be used to determine the presence of pain. The pain management program includes the following components: Documentation of pain assessment and monitoring. Standards: 1. Pain assessment protocol will be initiated under any of the following situations: a. Any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain. c. Resident receives routine pain medication and/or pain is		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 31 controlled." The facility's Pain Assessment Policy, dated 7/6/2018, documents "Purpose: To establish guidelines for appropriate assessment and intervention to manage pain. To respect and support the residents' right to optimal pain management. To measure and document the effectiveness of the plan using objective and subjective assessment criteria. Responsibility: Licensed Nurse. Guidelines: 1. A pain assessment tool will be used as indicated as a guide in determining a resident's pain level in addition to their descriptive words, and/or physician signs and behaviors. 2. A pain assessment will be performed as part of the admission assessment. A pain assessment may be completed as indicated by diagnosis and other events during the residents' stay may initiate additional pain assessments (Example: Post falls or new diagnosis of compression fractures, etcetera.) 3. Prior to administration of PRN (as needed) pain medications, non-pharmacological interventions will be attempted if patient is responsive and willing. Medications will be administered at the specific request of the patient and when the patient refuses other such interventions." The facility's Medication Administration General Guidelines Policy, undated, documents "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Administration: 2. Medications are administered in accordance with written orders of the prescriber." R2's Physician Order Report documents R2 was admitted on 10/24/25 with the diagnoses of Age-related Osteoporosis, Restless Leg Syndrome, Anxiety Disorder, Periprosthetic Fracture around Prosthetic Left Knee Joint, Type Two Diabetes Mellitus, Fibromyalgia, Depression, Unspecified Fracture of Lower End of Left Femur, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Other Lack of Coordination, Complex Regional Pain Syndrome of Upper Limb, and Major Depressive Disorder. This same Physician Order Report documents, "Start Date: 10/28/25- Hydrocodone-Acetaminophen 5-325mg (Milligrams) one tablet every six hours for pain management." R2's Care Plan dated 10/26/25 documents "Potential for pain related to recent fracture, recent surgery, and fibromyalgia. Approach: Administer medications as		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 32 ordered. Assess for signs of pain. Notify Doctor if pain medications are ineffective." This same care plan documents R2 has a history of Periprosthetic fracture and to administer pain medications as ordered." R2's MAR (Medication Administration Record), dated October 24th, 2025, through October 31st, 2025, documents R2's scheduled Norco-Acetaminophen 5-325mg was not administered on 10/31/25 at 8:00 PM. R2's Order's Administration Note written by V37/LPN (Licensed Practical Nurse) dated 11/1/25 at 1:05 AM, documents "Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication unavailable in cart." R2's MAR, dated November 1st, 2025, through November 4th, 2025, documents R2's scheduled Norco-Acetaminophen 5-325mg were not administered for 12 out of the 12 doses ordered. R2's Order's Administration Notes, dated 11/1/25 through 11/4/25, documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication on order." R2's Health Status Note, written by V23/LPN on 11/2/25 at 10:36 AM, documents "(R2) is out of Hydrocodone, prescription faxed to (V22/R2's Physician), awaiting refill." R2's Electronic Medical Record does not include any pain-relieving interventions, physician's notification of R2 not receiving the prescribed pain medication, or comprehensive pain assessments after the 13 occasions between 10/31/25 and 11/4/25 when R2 did not receive her Norco as prescribed. On 1/27/26 at 9:29 AM R2 stated she had a fall at home around a month prior to her admission to the facility and ended up having a left leg fracture resulting in R2 being hospitalized. R2 stated, "I was in severe pain and needed therapy and pain management at the facility. When I was admitted to the facility, I was not receiving enough pain medication to control my pain. My doctor had ordered an increase in my pain medication. I received my pain medication for a few days, but at the end of October to early November 2025, the facility kept telling me I was out of my pain medication, and the doctor needed to sign some kind of script in order for my pain medication to be refilled. I was in severe pain and crying out and the staff would tell me there		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 33 was nothing they could do, so they just assigned me to an ombudsman to speak with. I could not move on my own, I was in severe pain, I could not get comfortable, and the staff did nothing during the time I had no pain medication. It messed with me psychologically and was more than what I could handle, so when I was sent out to the hospital eventually, I requested to not return to the facility." On 1/27/26 at 12:47 PM V35/LPN (Licensed Practical Nurse) stated "I was working at the facility when (R2) was a resident. (R2) was able to make her needs very known I do know (R2) was not receiving her pain medications like (R2) should have been and was always complaining of pain in her left leg especially. I know there was a change in prescription with (R2's) pain medication in the beginning, and after that change, pharmacy kept saying (R2's) Norco was on hold. I am not aware if (R2) received any other pain-relieving interventions during the time her Norco (Hydrocodone-Acetaminophen) was out." On 1/27/26 at 1:02 PM V1/Administrator-in-Training stated, "I know at one time (R2) had filed a grievance stating the facility was out of her pain medication and that she was in pain. I know at that time we were waiting for (R2's) prescription to be filled. (R2) was not happy with the response, but we (the facility) had to wait for the pharmacy to fill it. (R2) should not have gone without her pain medication." On 1/28/26 at 2:02 PM V22/Facility Medical Director stated he expects the facility to notify him if a resident's pain medication is not being refilled by the pharmacy. V22 can then prescribe an alternative pain relief. V22 stated, "(R2) should not have gone without her scheduled pain medication given (R2's) condition. The facility should have gotten ahold of me when they realized (R2's) Norco was out and the pharmacy was stating it was on hold. I am always available by phone call." On 1/29/26 at 11:43 AM V52/LPN stated, "(R2) complained of all over pain quite frequently when I worked with her." On 1/29/26 at 1:23 PM V30/Facility Nurse Practitioner stated she does recall R2 complaining of pain quite frequently and stated if the facility had an issue with getting R2's pain medication from the pharmacy she would have expected them to notify her or V22/Facility's Medical Director to get an order for something else to give R2 for the pain while awaiting the refill.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 34 On 1/29/26 at 2:03 PM V2/Corporate/Interim Director of Nursing verified that R2 missed all scheduled doses of Hydrocodone from the evening of October 31, 2026, through November 4, 2026, and did not receive any PRN (as needed) pain medication or pain interventions during that same time. V2 stated that if a resident's pain medication is unavailable, nursing staff are expected to contact the pharmacy immediately to determine the delivery schedule of the medication that is unavailable, utilize backup supplies if the delivery for the unavailable medication does not arrive the same day, and/or coordinate with the physician for a local pharmacy script if the unavailable medication is not in the facility's backup stock, ensuring there is no gap in administration. V2 verified R2's progress notes dated 10/31/25 through 11/4/25 documented R2's Norco was on hold but did not have any documentation of the nurses notifying any physician to get R2's Norco delivered the same day or get something alternative ordered. On 2/3/26 at 10:43 AM V6/Occupational Therapist stated, "I only worked with (R2) once, but she was very cooperative. (R2) complained of pain during that session. (R2) had diagnoses that supported why (R2) would be in severe pain. It seemed like (R2) was in the most pain when being moved." On 2/10/26 at 12:05 PM V3/MDS Coordinator stated, "The floor nurses are assigned to perform an electronic pain assessment on a resident when they are admitted to the facility or during any acute change in condition. I do not see where anyone performed a pain assessment at any time during (R2's) admission to the facility. That would have helped the staff respond appropriately to (R2's) pain and try alternatives to relieve (R2's) pain when (R2) was out of her pain medication." (B) 5 of 5 300.610a) 300.1210a) 300.1210b) 300.1210d)4)A) 300.3210a)2)A) Section 300.610 Resident Care Policies		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 35 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 36 physician. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents' call lights were answered promptly and residents received timely incontinence care for two of four residents (R2 and R15) reviewed for dignity in the sample of 16. These failures resulted in R2 and R15 lying in urine and feces for an extended period of time, causing R2 to feel pain, embarrassed, ashamed, disgusted, and R15 experiencing pain and burning to R15's buttocks causing R15 to feel like "H*ll and disgusted." Findings include: The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility. The facility's Dignity Policy, dated 4/23/18, documents "Guidelines: The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the residents' lifestyle and personal choices identified through the assessment process to obtain a picture of his or her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth." The Ombudsman Resident's Rights Booklet, dated 11/18,			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 37 documents "Your rights to dignity and respect: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your rights to safety: Your facility must provide services to keep your physical and mental health at their highest practical levels." The facility's Incontinence Care Policy, dated 4/20/21, documents "Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode." The facility's Call Light Policy, dated 2/2/18, documents "Purpose: To respond to resident's requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. Procedure: 1. Answer light (signal) promptly." The facility's Certified Nursing Assistant Job Description, dated 5/2/17, documents "Certified Nursing Assistant: Summary- The CNA (Certified Nursing Assistant) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare, and safety of all residents. Essential Duties and Responsibilities: Provide for resident comfort by utilizing resources and materials; answering call lights and requests; reporting observation of the residents to the nursing supervisor." On 1/27/26 at 12:02 PM V17/Ombudsman stated every month during resident council the residents complain of call light waiting times. On 2/10/26 at 12:58 PM R16 stated that the last four resident council meetings residents have complained about their call lights not getting answered timely and having to sit in urine and feces for long periods of time. R16 also stated "The resident's state that it's more on second and third shift that staffing is short. The staff will tell them they (staff) don't have enough staff to get to everyone timely." 1.R2's Admission Record documents R2 is a 71-year-old female who was admitted to the facility on 10/24/25 with the following but not limited to diagnoses: Periprosthetic Fracture around Internal Prosthetic Left			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 38 Knee Joint, Type Two Diabetes Mellitus, Unspecified Fracture of Lower End of Left Femur, Muscle Wasting and Atrophy, Restless Leg Syndrome, Fibromyalgia, Age-Related Osteoporosis without current Pathological Fracture, and Other Abnormalities. R2's MDS (Minimum Data Set) Assessment dated 10/28/25 documents R2 is cognitively intact, is dependent on staff for ADLs (Activities of Daily Living) including toileting hygiene and is frequently incontinent of bowel and bladder. R2's current Care Plan documents, R2 requires dependent assistance for toileting hygiene and requires a mechanical lift with two staff to transfer R2 from the chair to the bed. On 1/27/26 at 1:29 PM R2 stated, "I laid in poop and pee for hours before any staff would answer my call lights at the facility. I was able to use the bed pan. If staff didn't answer my call light timely, I would have an accident and lay in my own poop and pee. Sometimes I would wait more than two and a half hours before someone could clean me up. I was so embarrassed and ashamed to lay in my own poop and pee that long. If the staff did get me on the bed pan in time, the staff wouldn't come back and take me off the bed pan, leaving me sitting on the bed pan for sometimes two hours. It was very painful. I came to the facility after I had surgery and was completely helpless and relied on staff to provide me with care. They would not get me up out of bed because it took two of them and they would say they didn't have enough staff to get me up and then put me back to bed later. It caused me complete embarrassment and humiliation along with disgust. In my opinion that facility should be shut down." R2 reported staff would always say they did not have enough staff to change everyone timely on their shift. On 1/27/26 at 12:47 PM V35/LPN (Licensed Practical Nurse) stated she was working at the facility when R2 was a resident. R2 was able to make her needs very known. R2 required dependent assistance with changing her and was incontinent at times. V35 stated, "The Administration felt like the amount of CNA's we had were adequate on second and third shift, but a lot of the residents are two assist or cares in pairs, so the CNAs never had enough time to round on every resident in eight hours. There were times (R2) had to wait a while before a staff could get to her to clean (R2) up." On 1/29/26 at 11:43 AM V52/LPN stated, "I can say it's true that they have to wait longer periods of time on		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 39 nights due to the staffing. It's a constant complaint about waiting long periods of time to be changed or just not getting their call light answered timely in general. (R2) was one of them who had to wait." On 2/3/26 at 10:43 AM V6/Occupational Therapist stated, "I only worked with (R2) once, but she was very cooperative. (R2) did complain to me about having to sit on the bed pain for an extended amount of time, I believe over two and half hours." 2.R15's Admission Record documents R15 is a 66-year-old-male who was admitted to the facility on 1/8/26 with the following but not limited to diagnoses: Nontraumatic Intracerebral Hemorrhage, Acute Kidney Failure, Muscle Wasting and Atrophy, Hyperkalemia, Acute Cystitis without Hematuria, Hypertension, Pain (unspecified), Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, and other Intervertebral Disc Degeneration (Lumbar Region). R15's MDS dated 1/19/26 documents R15 is dependent on staff for ADLs including toileting hygiene, toileting transfers, is occasionally incontinent of bladder, and frequently incontinent of bowel. R15's current Care Plan documents, R15 has an ADL self-care performance deficit related to having a stroke, requiring substantial to maximum assistance with toileting hygiene and transfers. On 2/10/26 from 1:02 PM to 1:36 PM, R15's call light remained on during this time. On 2/10/26 at 1:37 PM R15 was lying in his room with the covers pulled down and had on a disposable brief. R15 stated, "A CNA (Unknown) came in around 25 minutes ago and asked what I needed. I told them I was wet and had pooped and I needed to be changed. The CNA told me she was going to go get washcloths and be right back. She never returned. This happens all the time and makes me feel disgusted and like h*ll. My call light has been on for at least thirty to forty minutes, and I have had to sit in my own poop. Last Sunday I pooped and peed in my bed, turned on my call light around 3:30 PM and sat there until 6:30 PM until a staff member came to my room. My butt was burning and sore. Staff always say, "We don't have enough staff, so you will have to wait until we get to you." On 2/10/26 at 1:38 PM V49/CNA was observed sitting in a chair in the hallway documenting on the computer. V49 stated, "I just got back to this hall a little bit ago. I didn't realize (R15's) call light had been going off			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000373		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE PEORIA HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD , PEORIA HEIGHTS, Illinois, 61614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 40 that long." V49 stated she was not the staff member who told R15 she would be right back with wash cloths to clean him up but stated, "Staff be dipping out like that on resident's all the time. Answer the call light, tell the resident they will be right back, then not go back in." On 2/10/26 at 1:42 PM V50/CNA stated, "I was the assigned CNA on (R15's) hallway. I know that (R15's) call light has been on for a while, but I was the only CNA on this side at the time. Another CNA and I were the only two passing hall trays and having to answer all the call lights. Then by time we are done with that, the residents come back from the dining room, so then they want to be laid down. It's hard to get to everyone timely." On 2/13/26 at 12:36 PM V2/Corporate Interim Director of Nursing stated the staff should answer residents' call lights as soon as they can and that thirty to forty-five minutes is too long for a call light to not be answered. (B)			S9999			