

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Goldwater Care Toluca		STREET ADDRESS, CITY, STATE, ZIP CODE 101 East via Ghiglieri Toluca, IL 61369	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to protect Residents' Rights to be free of Mental Abuse and Verbal Abuse from a Facility staff perpetrator that caused mistreatment, emotional distress, and mental anguish for one of three Residents (R1) reviewed for Abuse in a sample of three. Findings include: The Facility Abuse Prevention and Reporting Policy, dated 10/24/22, documents: the Facility affirms the right of our Residents to be free from abuse; the Facility prohibits abuse and mistreatment of Residents; the Facility has established a Resident sensitive and secure environment; the policy assures the Facility is doing all that is within its control to prevent occurrences of abuse; the Facility will establish an environment that promotes Resident sensitivity, security and prevent mistreatment; identify occurrences and patterns of potential mistreatment; implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment; filing accurate and timely investigative reports; abuse means any mental injury other than by accidental means; abuse is the willful infliction of intimidation, punishment or mental anguish to a Resident; and willful in the definition of abuse means the individual must have acted deliberately; mental abuse is verbal/non-verbal conduct which causes or has the potential to cause the Resident to experience humiliation, intimidation, fear, shame, agitation or degradation; verbal abuse is a type of mental abuse and includes oral or gestured communication to Residents within hearing distance such as harassing a Resident, insulting, yelling or hovering over a Resident with the intent to intimidate and threatening a Resident; and orientation/training of employees includes sensitivity to Resident rights/needs, what constitutes abuse, how to assess/prevent/manage aggressive/violent/catastrophic reactions in a way to protect both Residents and staff and an employees obligation under the law for reporting a suspected crime to the facility, state survey agency and local law enforcement. The Facility Resident Rights Policy, dated 1/4/19, documents: to promote the exercise of rights for each Resident, including any who face barriers (communication problems, hearing problems and cognition limits) in the exercise of these rights; a Resident even though determined to be incompetent, should be able to assert these rights based on his/her degree of capability; to have autonomy to the maximum extent about how they wish to live their everyday lives and receive care, subject to the Facility's rules and regulatory requirements; and the Facility will not hamper, compel, treat differentially or retaliate against a Resident for exercising his/her rights. The Facility Final Abuse Investigation, dated 9/17/25, documents an incident on 9/15/25, between V4 (former Social Service Director) and R1. On 9/15/25, V2 (Director of Nursing/DON) reported to V18 (former Administrator/Abuse Coordinator) an inappropriate conversation/language between V4 and R1. The Final Abuse Investigation documents V4 used profane language during a conversation with R1 and that the profane language was not directed towards R1. The Facility unsubstantiated the allegation. The Facility's Social Service Director Job Description, dated 5/2/17, documents: purpose to assist in planning, organizing,</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145413	Facility ID: 145413 If continuation sheet Page 1 of 11

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>implementing, evaluating and directing the overall operation of our Facility's Social Service Department in accordance with federal, state and local standards, guidelines and regulations, our established policies and procedures, as may be Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis; review Facility policies and procedures as part of the Facility's Interdisciplinary team to assure compliance with state and federal regulations; ensure and provide therapeutic interventions to assist Residents in coping with their transition and adjustment to a long-term care Facility, including social, emotional and psychological needs; and provide clinical interventions to address catastrophic events that occur during the Resident's stay in the Facility/V4's Termination Notice, dated 9/18/25, documents V4's last day worked as 9/15/25. V4's reason for termination is documented that on 9/15/25, a complaint was received from a Resident regarding conduct during an interaction. Specifically, that profane language was used during a conversation and that the behavior was found to be inconsistent with Facility policy which requires staff to treat Residents with courtesy, professionalism and respect at all times. The Employee Conduct Standards which list the use of profane, discourteous or unprofessional language toward Residents is grounds for immediate dismissal. R1's admission Record, dated 12/27/25, documents R1's current age of [AGE] years old and an admission date to the Facility as 9/23/25. R1's current Care Plan documents R1's diagnoses including Anxiety Disorder, Diabetes Type Two, Vertebral Disc Degeneration, Discogenic Back Pain, Heart Failure, Psychoactive Substance Abuse, Liver Disease, Depression, Age Related Nuclear Cataract, Hepatic Encephalopathy, Fall History, Abnormal Gait, Lack of Coordination and Abnormal Posture. R1's Care Plan also documents: Activities of Daily Living performance deficit; risk for falls; at risk for abuse/neglect and will be cared for in a safe manner and verbalize to staff any incidences of abuse or neglect and impaired visual function. The Final Abuse Investigation, dated 9/17/25, documents a written statement from V17 (Certified Nursing Assistant/CNA) wherein V17 was delivering R1 a lunch tray and R1 requested a salad. V17 went to request a salad for R1 from the kitchen and the kitchen was closed. R1 told V17 to Get out of my room. Go. V17 removed R1's lunch tray and exited R1's room. V17 notified V4 (former Social Service Director) that V17 did not want to go back into R1's room by V17's self. V4 went to R1's room to talk to R1 and, V4 told V17 that V4 told R1, He can get up to the dining room and ask for extra things when he wants extra things. V17 stated that prior to that incident, R1 stated R1 was not getting discharge planning help from V4. The Final Abuse Investigation, dated 9/17/25, documents a written statement from V2 (Director of Nursing/DON) that V13 (Certified Occupational Therapy Assistant/COTA) overheard in R1's room. V13 told V2 that V4 (former Social Service Director) told R1 do not be a f***** a***** to my staff. V2 immediately notified V18 (former Administrator).The Final Abuse Investigation, dated 9/17/25, documents a written statement from V13 (Certified Occupational Therapy Assistant/COTA). V13 was in R1's room providing therapy services with shaving at sink level, to R1's roommate. V13 overheard V4 approach R1's bedside and said, You have to quit being an a***** to my staff. V4 proceeded to argue and have a bad attitude with (R1). V4 stated to R1, You can go get your own salad next time and I know you are leaving in a few days, but you cannot yell at the staff, she is the only CNA down here today. V13 stated R1 remained calm during the conversation.The Final Abuse Investigation, dated 9/17/25, documents a typewritten statement, signed by V18 (former Administrator) from V4 (former Social Service Director). V4 was overheard telling R1 do not be an a***** to my staff. The statement documents verbal abuse did not occur, however, V4 displayed unprofessional conduct by cursing during the conversation with R1. The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from V4 (former Social Service Director). V17 (CNA) reported to V4, that R1 called V17 a</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>piece of s*** and some other names. R1 called V17 a liar and threw a tray at V17 after V17 returned from the kitchen and said the kitchen did not have a side salad. V4 stated, (V13, COTA) was in R1's bathroom and we could ask (V13) as well. The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from R1. R1 stated R1 was frustrated with V17 (CNA) over lunch, when V4 entered R1's room. R1 stated R1 did not like the way V4 approached R1 about R1's discharge from the Facility. R1 stated V4 called R1 a f***** a***** during the conversation. R1 continues to state frustration with V4. On 12/27/25 at 11:02 am, V11 (Therapy Director) stated, (V13/COTA) came to me and told me (V13) overheard (V4) cussing in (R1's) face and (V13) was concerned because (V13's) behavior was inappropriate. Honestly, (V4) was not all the way there and was very weird. (V4) was degrading to even me and I even heard other Residents complain about (V4). On 12/27/25 at 11:30 am, R4 (Resident Council President) stated, I heard people talking about (V4) getting fired for cursing at (R1). I did not surprise me because (V4) had issues. On 12/27/25 at 12:17 pm, V13 (Certified Occupational Therapy Assistant/COTA) stated, I was doing occupational therapy with (R1's) roommate. We were in (R1's) bathroom, because we were practicing shaving. I saw (V4) enter (R1's) room, and (V4) even saw me. (V4) walked in and immediately had an attitude and pretty much got right into (R1's) face and was very aggressive and rude to (R1). (V4) was berating (R1) and called (R1) an a***** , and a lot of other bad words. (R1) was so upset. The sad thing is (V4) knew I was in that room and could hear (V4), and (V4) still treated (R1) like that. I immediately reported it, because I thought it was really bad. On 12/27/25 at 9:47 am, R1 stated, (V4) ignored me all the time. I just wanted (V4's) help with my discharge, but (V4) was always too busy for me. I have an explosive attitude, and I cannot help it. I am not going to lie; I was not very nice to (V17). When (V17) came into my room and I asked (V17) for a salad, then (V17) told me that (V17) could not get me one, I got very mad and angry because all I wanted was a salad. Other people heard her talking to me and they all admitted that she did. (V4) ended up getting fired over it. (V4) came into my room right after I got into it with V17 (CNA), (V4) got right in my face, inches from my face, and was cussing and screaming at me. (V4) was telling me to f*** off and called me an a*****. (V13/COTA) was in here and heard everything. (V4) belittled me and made me feel terrible. I thought it was totally inappropriate, and it made me even more upset, and (V4) was supposed to be someone that was helping me, but instead (V4) degraded me. I cannot do some things for myself, and I felt so humiliated, helpless, and like an idiot. How do you think I feel if I cannot even go the one person who is supposed to me helping me. It still makes me mad, I cannot even think about it. On 12/27/25 at 9:35 am, V2 (Director of Nursing/DON) stated, (V18/former Administrator) is no longer employed here. I was involved in the incident between (V4) and (R1) and helped with the investigation. (V13/COTA) came to me because (V13) overheard (V4) cursing and yelling at (R1) in R1's room. (V13) reported that (V4) told R1 do not be a f***** a***** to my staff. V2 immediately notified V18 (former Administrator).</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to identify Abuse for one of three Residents (R1) reviewed for Abuse investigations in a sample of three. Findings include: The Facility Abuse Prevention and Reporting Policy, dated 10/24/22, documents: the Facility affirms the right of our Residents to be free from abuse; assures the Facility is doing all that is within its control to prevent occurrences of abuse; identify occurrences and patterns of potential mistreatment; implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment; filing accurate and timely investigative reports; abuse means any mental injury other than by accidental means; and willful in the definition of abuse means the individual must have acted deliberately; mental abuse is verbal/non-verbal conduct which causes or has the potential to cause the Resident to experience humiliation, intimidation, fear, shame, agitation or degradation; verbal abuse is a type of mental abuse and includes oral or gestured communication to Residents within hearing distance such as harassing a Resident, insulting, yelling or hovering over a Resident with the intent to intimidate and threatening a Resident; and orientation/training of employees includes sensitivity to Resident rights/needs, what constitutes abuse, how to assess/prevent/manage aggressive/violent/catastrophic reactions in a way to protect both Residents and staff and an employee's obligation under the law for reporting a suspected crime to the facility, state survey agency and local law enforcement. The Facility Final Abuse Investigation, dated 9/17/25, documents an incident on 9/15/25, between V4 (former Social Service Director) and R1. On 9/15/25, V2 (Director of Nursing/DON) reported, to V18 (former Administrator/Abuse Coordinator), an inappropriate conversation/language between V4 and R1. The Final Abuse Investigation documents V4 used profane language during a conversation with R1 and that the profane language was not directed towards R1. The Facility unsubstantiated the allegation. The Final Abuse Investigation, dated 9/17/25, documents a signed and written statement from V17 (Certified Nursing Assistant/CNA) wherein V17 was delivering R1 a lunch tray and R1 requested a salad. V17 went to request a salad for R1 from the kitchen and the kitchen was closed. R1 told V17 to Get out of my room. Go. V17 removed R1's lunch tray and exited R1's room. V17 notified V4 (former Social Service Director) that V17 did not want to go back into R1's room by V17's self. V4 went to R1's room to talk to R1 and, V4 told V17 that V4 told R1 he can get up, to the dining room and ask for extra things when he wants extra things. V17 stated that prior to that incident, R1 state R1 was not getting discharge planning help from V4. The Final Abuse Investigation, dated 9/17/25, documents a signed and written statement from V2 (Director of Nursing/DON) that V13 (Certified Occupational Therapy Assistant/COTA) overheard in R1's room. V13 told V2 that V4 (former Social Service Director) told R1 do not be a f***** a***** to my staff. V2 immediately notified V18 (former Administrator). The Final Abuse Investigation, dated 9/17/25, documents a signed and written statement from V13 (Certified Occupational Therapy Assistant/COTA). V13 was in R1's room providing therapy services with shaving at sink level, to R1's roommate. V13 overheard V4 approach R1's bedside and said, You have to quit being an a***** to my staff. V4 proceeded to argue and have a bad attitude with (R1). V4 stated to R1, You can go get your own salad next time and I know you are leaving in a few days, but you cannot yell at the staff, she is the only CNA down here today. The Final Abuse Investigation, dated 9/17/25, documents a signed typewritten statement from V18 (former Administrator) that was made from V4 (former Social Service Director). V4 was overheard telling R1, Do not be an a***** to my staff. The statement documents verbal abuse did not occur, however, V4 displayed unprofessional conduct by cursing during the conversation with R1. The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from V4 (former Social Service Director). V17 (CNA) reported to V4, that R1 called</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V17 a piece of s*** and some other names. R1 called V17 a liar and threw a tray at V17 after V17 returned from the kitchen and said the kitchen did not have a side salad. V4 stated, V13 (COTA) was in R1's bathroom and we could ask V13 as well. The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from R1. R1 stated R1 was frustrated with V17 (CNA) over lunch, when V4 entered R1's room. R1 stated R1 did not like the way V4 approached R1 about R1's discharge from the Facility. R1 stated V4 called R1 a f***** a***** during the conversation. R1 continues to state frustration with V4. V4's Termination Notice, dated 9/18/25, documents V4's last day worked as 9/15/25. V4's reason for termination is documented that on 9/15/25, a complaint was received from a Resident regarding conduct during an interaction. Specifically, that profane language was used during a conversation and that the behavior was found to be inconsistent with Facility policy which requires staff to treat Residents with courtesy, professionalism and respect at all times. The Employee Conduct Standards which list the use of profane, discourteous or unprofessional language toward Residents is grounds for immediate dismissal. On 12/27/25 at 11:02 am, V11 stated, (V13/COTA) came to me and told me that (V13) overheard (V4) cussing in (R1's) face and (V13) was concerned because (V13's) behavior was inappropriate. Honestly, (V4) was not all the way there and was very weird. (V4) was degrading to even me and I even heard other Residents complain about (V4). On 12/27/25 at 11:30 am, R4 (Resident Council President) stated, I heard people talking about (V4) getting fired for cursing at (R1). I did not surprise me because (V4) had issues. On 12/27/25 at 12:17 pm, V13 (Certified Occupational Therapy Assistant/COTA) stated, I was doing occupational therapy with (R1's) roommate. We were in (R1's) bathroom, because we were practicing shaving. I saw (V4) enter (R1's) room, and (V4) even saw me. (V4) walked in and immediately had an attitude and pretty much got right into (R1's) face and was very aggressive and rude to (R1). (V4) was berating (R1) and called (R1) an a***** and a lot of other bad words. (R1) was so upset. The sad thing is that (V4) knew I was in that room and could hear (V4), and (V4) still treated (R1) like that. I immediately reported it, because I thought it was really bad. On 12/27/25 at 9:47 am, R1 stated, (V4) ignored me all the time. I just wanted (V4's) help with my discharge, but (V4) was always too busy for me. I have an explosive attitude, and I cannot help it. I am not going to lie; I was not very nice to (V17). When (V17) came into my room and I asked (V17) for a salad, then (V17) told me that (V17) could not get me one, I got very mad and angry because all I wanted was a salad. Other people heard her talking to me and they all admitted that she did. (V4) ended up getting fired over it. (V4) came into my room right after I got into it with V17 (CNA), (V4) got right in my face, inches from my face, and was cussing and screaming at me. (V4) was telling me to f*** off and called me an a*****. (V13/COTA) was in here and heard everything. (V4) belittled me and made me feel terrible. I thought it was totally inappropriate, and it made me even more upset, and (V4) was supposed to be someone that was helping me, but instead (V4) degraded me. I cannot do some things for myself, and I felt so humiliated, helpless and like an idiot. How do you think I feel if I cannot even go the one person who is supposed to me helping me. It still makes me mad, I cannot even think about it. On 12/27/25 at 9:35 am, V2 (Director of Nursing/DON) stated, (V18/former Administrator) is no longer employed here. I was involved in the incident between (V4) and (R1) and helped with the investigation. (V13/COTA) came to me because (V13) overheard (V4) cursing and yelling at (R1) in R1's room. (V13) reported that (V4) told R1, Do not be a f***** a***** to my staff. V2 immediately notified V18 (former Administrator). I am not sure why (V18) did not substantiate the abuse because (V4) did talk to (R1) by cussing and degrading (R1), and there are statements from employees that even witnessed it. I would have considered that to be abuse. (V4) was fired over it. V2 verified the information/statements collected in the investigation proved V4 did</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>mentally and verbally abuse R1 and V18 could have concluded a more thorough determination by substantiating the abuse investigation.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on observation, interview, and record review, the Facility failed to staff a certified Food Service Manager/Dietary Manager. This failure has the potential to affect all 63 Residents Residing in the Facility. Findings include: The Facility Resident Census Roster, dated 12/24/25, documents 63 Residents residing in the Facility. The Facility Assessment Tool, undated, documents: the purpose of the Assessment is to determine what resources are necessary to care for Residents competently during day-to-day operations; to provide services to the Residents of your Facility; focuses on ensuring each Resident is provided care that allows the Resident to maintain/attain their highest practicable physical, mental and psychosocial well-being; Resident population that must be taken into account when determining staffing and resources needed for daily schedules and food; and identified staff needed to care for the Facility Resident population includes a Food Service Manager/Dietary Manager (Food and Nutrition Services). The Facility Dietary Manager Job Description, dated 3/23/17, documents: is responsible for partnering with the Dietician to plan, organize, develop and direct the overall operation of the Food and Nutrition Services Department in accordance with current federal, state and local standards, guidelines and regulations; participate in survey inspection; assists in planning, developing, organizing, implementing, evaluating and directing the Food Services Department; ensure that the menu's are maintained; knowledgeable on laws, regulations and guidelines; and possess as Food Service Sanitation Manager Certification. Resident Council Minutes, dated 11/17/25, document Dietary looking for a new Dietary Manager, V2 (Director of Nursing/DON) is handling all questions with staff at this time and that no Food Committee Meeting today due to no Manager. Resident Council Minutes, dated 12/15/25, documents still looking for a new Dietary Manager. On 12/27/25, 12/28/25, and 12/29/25, the Facility could not provide/identify a Food Service Manager/Dietary Manager employed in the Facility. The Facility Employee Contact Numbers Report, updated 12/4/25, documents Dietary Manager none. On 12/27/25, 12/28/25, or 12/29/25, a Dietary Manager was not available, and the Facility could not provide a contact person for the Food Service Manager/Dietary Manager. On 12/27/25 at 11:30 am, R4/Resident Council President (alert and oriented) stated, They have not had a kitchen manager for a long time. I used to run kitchens back in my day, and that kitchen is run terrible, we have so many issues with food. The menu is never right compared to what they serve, and the food is cold and undercooked. It would help if they had someone in charge in there. I could do a better job than these people do. On 12/27/25 at 9:20 am, V12 (Minimum Data Set/MDS Registered Nurse/Manager on Duty) stated, (V3/former Dietary Manager) is no longer employed here. We have not had a Dietary Manager for about two months now. The Director of Nursing is overseeing the Dietary department, and everyone just helps out when they need it. On 12/27/25 at 9:40 am, V7 (Dietary Cook) stated, We do not currently have a Dietary Manager. We all just pitch in and do what we can. On 12/27/25 at 9:38 am, V8 (Dietary Aide) stated, We have not had a manager in quite a long time. (V7/Dietary [NAME] and V11/Dietary Cook) handle a lot of the kitchen stuff. On 12/27/25 at 11:02 am, V9 (Dietary Cook) stated, I pretty much do everything I can in the kitchen because we have not had a Dietary Manager since (V3) left a couple months ago. On 12/27/25 at 9:47 am, R1 (alert and oriented) stated, I am on a special diet, and the food absolutely sucks here. I never get what they say I am supposed to get, and they do not want to help when I ask for something. They are always running out of coffee and milk too; heck I cannot even get a turkey sandwich when I want one. I ask to talk to the Dietary Manager, and they tell me that they do not have one. On 12/27/25 at 10:00 am, R2 (alert and oriented) stated, Fifty percent of the time, they never follow the menu, it is messed up quite a bit. For Christmas breakfast I got two dried up pancakes and one piece</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>of toast, no meat, and no fruit. They do not always have milk either. The salad is always brown, and when I say brown, it is not just a little bit brown, it is mushy and slimy brown; it is rotten. I just do not understand how they do not even see that before they serve that. On 12/27/25 at 11:16 am, R3 (alert and oriented) stated, The food is horrible, and they do not even give you a choice. They do not even give you what is on the menu. You just get what you get. On 12/27/25 at 10:10 am, R5 (alert and oriented) stated, The food is not edible. It sucks and they do not follow the menu. We cannot get any salads, and if we do, they are not edible. Also, there is never enough food. The food is undercooked or cold. One night we had all carbohydrates like mashed potato and macaroni and cheese together with no fruit or vegetable. Some people are starving after dinner, and the kitchen is all locked up and we cannot get anything. I am diabetic and graham crackers at night for a snack just does not cut it. On 12/27/25 at 10:08 am, R6 (alert and oriented) stated, Sometimes we do even get what is on the menu. They run out of coffee and milk all the time. I like chocolate milk, and I do not even get that half the time. On 12/27/25 at 9:20 am, V12 (Minimum Data Set/MDS Registered Nurse/Manager on Duty) stated, (V3/former Dietary Manager) is no longer employed here. We have not had a Dietary Manager for about two months now. The Director of Nursing is overseeing the Dietary department, and everyone just helps out when they need it. I have heard some of the residents complain that the food is terrible and that they do not follow the posted menu. On 12/27/25 at 9:40 am, V7 (Dietary Cook) stated, We do not currently have a Dietary Manager. We all just pitch in and do what we can. On 12/27/25 at 9:38 am, V8 (Dietary Aide) stated, We have not had a manager in quite a long time. (V7/Dietary [NAME] and V11/Dietary Cook) handle a lot of the kitchen stuff. On 12/27/25 at 11:02 am, V9 (Dietary Cook) stated, I pretty much do everything I can in the kitchen because we have not had a Dietary Manager since (V3) left a couple months ago. On 12/29/25 at 10:43 am, V16 (Registered Dietician) stated, When I was at the Facility this last month, they were still looking for a Dietary Manager and had not hired one yet. On 12/29/25 at 10:37 am, V14 (Ombudsman) stated, I attended last month's Resident Council meeting, and everyone told me that the Dietary Manager had been fired. I do not think that they have hired anyone yet, but they are still looking for one. On 12/29/25 at 10:00 am, V10 (Contracted Dietary Supplier) stated, They have not had a Dietary Manager here for a couple of months. (V7/Dietary Cook) and myself usually do the ordering together because there is no Dietary Manager, I think that the staff just do not have any management in that kitchen. On 12/27/25, V2 (Director of Nursing) stated, 'We do not currently have a Dietary Manager. I help out when I can in there.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Goldwater Care Toluca		STREET ADDRESS, CITY, STATE, ZIP CODE 101 East via Ghiglieri Toluca, IL 61369	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, and record review, the Facility failed to follow the Facility menu. This failure has the potential to affect all 63 Residents residing in the Facility. Findings include: The Facility Resident Census Roster, dated 12/24/25, documents 63 Residents residing in the Facility. The Facility Assessment Tool, undated, documents: the purpose of the Assessment is to determine what resources are necessary to care for Residents competently during day-to-day operations; to provide services to the Residents of your Facility; focuses on ensuring each Resident is provided care that allows the Resident to maintain/attain their highest practicable physical, mental and psychosocial well-being; Resident population that must be taken into account when determining staffing and resources needed for daily schedules and food; and identified staff needed to care for the Facility Resident population includes a Food Service Manager/Dietary Manager (Food and Nutrition Services). The Facility Off Versus Serve Meal Service Policy, dated 2020, documents: keeping with the rights of individual Residents, including person-centered care, planned meals will be offered versus served; and that Residents will be offered items from the planned menu. The Facility Dietary Manager Job Description, dated 3/23/17, documents: is responsible for partnering with the Dietician to plan, organize, develop and direct the overall operation of the Food and Nutrition Services Department in accordance with current federal, state and local standards, guidelines and regulations; participate in survey inspection; assists in planning, developing, organizing, implementing, evaluating and directing the Food Services Department; ensure that the menus are maintained; knowledgeable on laws, regulations and guidelines; and possess as Food Service Sanitation Manager Certification. Resident Council Minutes, dated 9/15/25, document alternative meals available during the week. Resident Council Minutes, dated 10/20/25, documents an apology made to Residents for taking all available off the menu. Resident Council Minutes, dated 11/17/25, document Dietary looking for a new Dietary Manager, V2 (Director of Nursing/DON) is handling all questions with staff at this time and that no Food Committee Meeting today due to no Manager. Resident Council Minutes, dated 12/15/25, documents still looking for a new Dietary Manager and substitutes should not be regular meals. The Facility Dining Manager Western Egg Bake (ground ham) recipe documents seven and a half ounces of diced ham per 15 servings. The Facility Week-at-Glance Menu, dated 12/21/25 through 12/27/25, documents on 12/27/25, western egg bake at breakfast and a baked potato with sour cream and margarine at lunch. On 12/27/25 at 9:05 am, the Western Omelet did not have ham. On 12/27/25 at 12:20 pm, all Residents in the dining room had a sweet potato; no baked potatoes were observed. On 12/27/25 at 11:30 am, R4/Resident Council President (alert and oriented) stated, They have not had a kitchen manager for a long time. I used to run kitchens back in my day, and that kitchen is run terrible, we have so many issues with food. The menu is never right compared to what they serve, and the food is cold and undercooked. It would help if they had someone in charge in there. I could do a better job than these people do. On 12/27/25 at 9:47 am, R1 (alert and oriented) stated, I am on a special diet, and the food absolutely sucks here. I never get what they say I am supposed to get, and they do not want to help when I ask for something. They are always running out of coffee and milk too; heck I cannot even get a turkey sandwich when I want one. I ask to talk to the Dietary Manager, and they tell me that they do not have one. On 12/27/25 at 10:00 am, R2 (alert and oriented) stated, Fifty percent of the time, they never follow the menu, it is messed up quite a bit. For Christmas breakfast I got two dried up pancakes and one piece of toast, no meat and no fruit. They do not always have milk either. The salad is always brown, and when I say brown, it is not just a little bit brown, it is mushy and slimy brown, it is rotten. I just do not understand how they do not even</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>see that before they serve that.On 12/27/25 at 11:16 am, R3 (alert and oriented) stated, The food is horrible, and they do not even give you a choice. They do not even give you what is on the menu. You just get what you get.On12/27/25 at 10:10 am, R5 (alert and oriented) stated, The food is not edible. It sucks and they do not follow the menu. We cannot get any salads and if we do, they are not edible. Also, there is never enough food. The food is undercooked or cold. One night we had all carbohydrates like mashed potato and macaroni and cheese together with no fruit or vegetable. Some people are starving after dinner, and the kitchen is all locked up and we cannot get anything. I am diabetic and graham crackers at night for a snack just does not cut it.On 12/27/25 at 10:08 am, R6 (alert and oriented) stated, Sometimes we do even get what is on the menu. They run out of coffee and milk all the time. I like chocolate milk, and I do not even get that half the time.On 12/27/25 at 9:20 am, V12 (Minimum Data Set/MDS Registered Nurse/Manager on Duty) stated, (V3/former Dietary Manager) is no longer employed here. We have not had a Dietary Manager for about two months now. The Director of Nursing is overseeing the Dietary department, and everyone just helps out when they need it. I have heard some of the Residents complain that the food is terrible and that they do follow the posted menu.On 12/27/25 at 9:40 am, V7 (Dietary Cook) stated, We do not currently have a Dietary Manager. We all just pitch in and do what we can. We have had problems with getting all the ingredients ordered so we can follow the menus that are posted. A lot of times we have to improvise for stuff that we do not have. We always here that 'they' are trying to cut the budget or stay under budget.On 12/27/25 at 9:38 am, V8 (Dietary Aide) stated, We have not had a manager in quite a long time. (V7/Dietary [NAME] and V11/Dietary Cook) handle a lot of the kitchen stuff. I hear the Residents complain that they are not getting the right food, but we do the best we can.On 12/27/25 at 11:02 am, V9 (Dietary Cook) stated, I pretty much do everything I can in the kitchen because we have not had a Dietary Manager since (V3) left a couple months ago. We have had major issues with getting all of our supplies; the corporate people always review our order and make us cut corners, and it makes it hard to make things according to or menu. They will not let us get everything we need because they are trying to cut the budget. This morning, we were supposed to put ham in the Western Omelet according to the recipe and we were not even able to put ham in it, because we did not have any ham, so the residents did not get any meat. At lunch today, we have to substitute sweet potato for baked potato because we do not have any regular potatoes. We are constantly having to re-do the menu because we do not always have what we need to make the food that is supposed to me made. The Residents complain a lot, but there is nothing we can do, and this has been going on for quite a long time. It is very frustrating. Every week we run out of supplies and always run out of milk by the weekend, and our order does not come until Monday, so we go without milk for a day or so.On 12/29/25 at 10:43 am, V16 (Registered Dietician) stated, When I was at the Facility this last month, they were still looking for a Dietary Manager and had not hired one yet.On 12/29/25 at 10:37 am, V14 (Ombudsman) stated, I attended last month's Resident Council meeting, and everyone told me that the Dietary Manager had been fired. I do not think that they have hired anyone yet, but they are still looking for one. The Resident's had complaints about not getting what was on the menu and the alternate food selection.On 12/29/25 at 10:00 am, V10 (Contracted Dietary Supplier) stated, They have not had a Dietary Manager here for a couple of months. (V7/Dietary Cook) and myself usually do the ordering together because there is no Dietary Manager, but I think that the staff just do not have any management in that kitchen, and that is how the menu gets messed up and how they run out of food. We get milk delivered on Mondays and Wednesdays, and our food order comes on Wednesdays. This Facility is always running out of milk; I have never seen a Facility go through so much milk. We ordered 36 pounds of ham on last week's purchase</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>order and received 18 pounds. They did a Christmas potluck on 12/22/25 for the entire staff and residents and served ham, so they ran out of ham for the Denver Omelet on 12/27/25. The kitchen staff do not know how to portion out all the ingredients when they are preparing meals, so a lot of times they run out of product that they need. We could not get bagged lettuce for like 4 weeks, because there were issues with our supplier and if we ordered single heads of lettuce, they would generally just get stuck in the back of the refrigerator and go bad, because no one would cut them up. I do try and stay within or under budget on the food, but the kitchen staff does not follow the correct recipes or serving portions for the food. On 12/27/25, V2 (Director of Nursing) stated, 'We do not currently have a Dietary Manager. I help out when I can in there (kitchen).</p>		