STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145413	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Toluca	101 East via Ghiglieri Toluca, IL 61369

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to conduct quarterly Quality Assurance/QA Performance Improvement meetings with the required Committee Members present. This failure has the potential to affect all 61 Residents who currently reside in the facility. Findings Include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Centers for Medicare and Medicaid Services/CMS 671) form, dated 9/23/25, documents 61 residents reside in the facility. The Facility Quality Assurance Performance Improvement (QA)/QAPI Policy, revised 10/24/22, documents: to ensure the organized quality assessment and improvement process program that includes performance measurement, performance assessment and performance improvement; Committee shall meet at least quarterly to assure activities are performed and identified problems have corrective actions taken or action plan developed; Minutes, related reports and attendance of the Committee members shall be maintained on file in the Administrator's office.The QAPI Meeting Minutes (dated 12/4/24, 2/12/25, 4/9/25, 5/27/25, 6/11/25, 7/9/25 and 9/11/25) do not document V3's (Medical Director's) attendance. The Facility could not provide documentation of QA Meeting Minutes for March 2025. On 9/24/25 at 9:54 am, V1 (Administrator) stated, I hold QA meetings every month. When (V3/Medical Director) is in the building, I try and fill (V3) in on our meeting agenda, because it is hard to coordinate the days that (V3/Medical Director) is here in building and the days that we hold our QA meetings.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to test for presence of Legionella throughout the facility's water system. This failure has the potential to affect all 61 residents in the facility.Findings include:On 9/23/25 at approximately 9:20am, V1/Administrator provided the facility's Resident Roster, dated 9/23/25, documenting 61 residents residing in the facility.The facility's Water Management Program for Prevention of Legionella Growth, revised on 6/27/23, documents: The following will be verified and documented at least once weekly: The domestic hot water boiler, storage tanks, verified to be set between 140 - 160 degrees F (Fahrenheit). Thermostat indicating the temperature of water entering the circulating system at the mixing valve is 120 F or above. 9/25/25 at 1:10pm, V11, Maintenance employee, stated the facility does not have a boiler and utilizes a hot water heater to heat the facility's incoming water. V11 stated the Maintenance Department does not keep a weekly log documenting the hot water heater temperatures.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review, the facility failed to justify the use of an antipsychotic medication for one of five residents (R10) reviewed for unnecessary medications in the sample of 28.Findings include:R10's medical record documents R10 was admitted to the facility on [DATE], with a diagnosis of Severe Vascular Dementia with Agitation.The facility's Psychotropic Medication policy documents the following, under Purpose: To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per standards of practice.R10's POS/Physicians Order Sheet includes the following order by V3, Medical Director: Quetiapine Fumarate (antipsychotic primarily used to treat schizophrenia and bipolar disorder) Oral Tablet 150 MG: Give 1 tablet by mouth at bedtime related to Vascular Dementia, Severe, with Agitation.R10's monthly MAR/Medication Administration Records for past 3 months include documentation that Quetiapine has been administered as ordered.R10's medical record includes Progress Notes from the facility's contracted psychiatric provider documenting R10's order for quetiapine for the diagnosis of Severe Vascular Dementia with Agitation.On 9/25/25 at 11:40am, V2, DON/Director of Nursing, verified R10's diagnosis of Severe Dementia with Agitation does not justify the use of Quetiapine, an antipsychotic.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the Facility failed to notify Resident Representatives of transfers/discharges and the reason for discharge and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for two of 15 Residents (R4 and R8) reviewed for transfer and discharge in a sample of 28.Findings include:Facility Bed Hold and Return to Facility Policy, revised 9/26/17, documents: to ensure that Residents and/or Representatives are notified of the Facility Bed Hold Policy and conditions for return to Facility upon admission and at the time of a transfer from the Facility; bed hold policies apply to all Residents; and the Bed Hold Policy will be given to the Resident/Resident Representative at the time of a transfer from the Facility.1.R4's Un-Witness Fall Report, dated 5/24/25, documents R4 was sent to the local Emergency Department for evaluation after a fall.R4's Bed Hold Policy Notice, dated 5/24/25, documents R4 was transferred out of the Facility on 5/24/25. The Notice does not document reason for discharge or notification to Resident Representative.2.R8's admission Record Face Sheet, dated 9/24/25, documents an admission date of 12/8/24 and R8's diagnoses including: Left Femur fracture, Epilepsy, Anxiety, Depression, Chronic Obstruction Pulmonary Disease, Acute Respiratory Failure and Peripheral Vascular Disease.R8's Interdisciplinary Fall Progress Note, dated 5/19/25, documents R8 was sent to the local Emergency Department for a post fall evaluation.R8's Census List, dated 9/24/25, documents R8 discharged to the local hospital on 5/11/25.R8's Bed Hold Policy Notice, dated 5/11/25, documents R8 unable to sign at time of transfer and does not document copy mailed to Representative. The Notice does not document reason for discharge or notification to Resident Representative.The Facility Ombudsman Notification of Discharge/Transfer Log (4/1/25 through 4/30/25), submitted 5/5/25 and Discharge/Transfer Log (5/1/25 through 5/31/25), submitted 6/3/25, do not document R8's 5/11/25 discharge.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a care plan for one of 15 residents (R9) reviewed for care planning in a sample of 28.Findings include:The Comprehensive Care Plan policy, revised 11/17/17, documents the Care Plan must describe the services that are being furnished, reviewed and revised by the interdisciplinary team on an ongoing basis to reflect changes in the resident's care.R9 was admitted on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory Failure, Chronic Pain, Neuropathy, Vascular Dementia, Seizures, Contracture Bilaterial foot and ankles, Dysphagia, Bipolar, and Depression. The Census report documents R9 returned to the facility from a hospitalization on 8/8/25, with Hospice services and was discharged from Hospice services on 8/27/25.R9's current care plan documents on 8/12/25 R9 requires communication and contact assistance with Hospice, staff is to notify the Hospice of any changes in R9's condition and R9 needs a discharge plan and bereavement care.On 9/24/25 at 1:30 PM, V2 (Director of Nursing) confirmed R9 was discharged from Hospice and the care plan should have been updated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received a nursing assessment and timely provider notifications to ensure medical interventions were received during an acute change of condition for one of three (R28) residents reviewed for change of condition, and failed to ensure wound care was provided as ordered for one of three residents (R6) reviewed for wounds in a sample of 28.Findings include: 1.The Physician-Family Notification-Change in Condition policy, revised on 11/13/18, documents the facility will inform the resident, resident's physician and the resident's representative when there is a significant change in the resident's physical status in either life-threatening conditions or clinical complications and/or transfer or discharge from the facility.R28 was admitted on [DATE], with diagnoses including but not limited to Dyspnea, Hypertension, Anemia, Myocardial Infarction, Ventricular Tachycardia, Major Depressive Disorder Congestive Heart Failure, Atrial Fibrillation, Sleep Apnea, Renal Dialysis and Type II Diabetes Mellitus. R28's Progress Note, dated 9/23/25 at 7:41 PM, documents hosp. (hospital). The notes do not indicate what time R28 was transferred to the hospital, assessment of R28's condition, and interventions that resulted in the transfer or if the physician and/or resident's representative was notified. On 9/24/25 at 11:07 AM, V9 (Registered Nurse/RN) stated, I don't know what happened to him (R28). I think someone said they found him unresponsive. He just got back from the hospital on Sunday. I know he refused to go to dialysis yesterday because he hurt so bad from the broken ribs. Last time he went to the hospital, they had to shock him because he was in full cardiac arrest by the time he got there. That's when he got his ribs broken. On 9/26/25 at 1:00 PM, V2 (Director of Nursing) stated she did not know if the facility had a policy for transfers to the hospital. V2 confirmed the Hospital Transfer Form should be completed by the nurse who provided cares and assessed the resident with all the pertinent details and agreed R28's record did not include an assessment of R28's condition and interventions that resulted in the transfer or if the physician and/or resident's representative was notified. 2.The (State) Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, dated 11/28/18, documents: You (Residents) have the right to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. The facility's Medication Administration General Guidelines Policy (Undated) documents: Documentation (including electronic): 1. The individual who administers the medication dose records the administration on the resident's MAR/Medication Administration Record directly after the medication is given. 2. Current medications, except topicals used for treatments, are listed on the Medication Administration Record (MAR). 3. Topical medications used in treatments are listed on the Treatment Administration Record (TAR). R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a BIMS (Brief Interview of Mental Status) score of 15. (MDS indicates that on a scale of 0 – 15, 13 to 15 cognitively intact; 8 to 12 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderate impairment; and 0 to 7 severe impairment.) R6's current Care Plan documents: I have a chronic wound. Site: right groin. (Interventions include: Keep wound site clean/dry. Monitor site for signs/symptoms of infection (i.e.: increased drainage, foul odor, redness, warmth, etc.) Treatment as ordered by MD/medical doctor.) R6's Physician Order dated 9/19/25 and Treatment Administration Record/TAR (September 2025) document: Clindagel External Gel 1%/percent (Clindamycin Phosphate (Topical)); Apply to right groin topically every day and night shift for wound care. (Start Date 9/19/25 6:00pm). R6's Progress Note dated 9/21/25 documents: Clindagel not available. R6's Order Administration Note dated 9/21/25 documents: Waiting for med (Clindagel) to be delivered. R6's Order Administration Note, dated 9/22/25, documents: (Clindagel) on order. R6's Order Administration Note dated 9/22/25 also documents: Unavailable; (Physician/Nurse Practitioner) notified. R6's TAR (Dated 9/2025) documents staff signature on 9/20/25 and 9/22/25 to indicate staff treated R6 with the Clindagel External Gel. On 9/25/24 at 2:00pm, V4 Licensed Practical Nurse/LPN stated that R6's Clindagel External Gel treatment medication did not arrive at the facility until 9/22/24. R6's TAR (Dated 9/2025) also documented signature for V4, Licensed Practical Nurse/LPN, to indicate she had completed R6's treatment on 9/24/25 on the day shift. On 9/24/25 at 12:50pm, V4, LPN, stated she was the nurse for R6. V4 stated she signed R6's TAR for his wound treatment but had not provided the treatment for R6. V4 stated, No, we are not supposed to document and sign off in the TAR before the treatment is done. On 9/24/25 at 12:40pm, R6 stated: They (nursing staff) are supposed to do my treatments (to groin area) twice a day on the day and night shifts; most of the time they (treatments) don't get done. When they have other things to do, my treatments get pushed back. They have run out of my treatment meds; they do not let me know it is out. On 9/25/25 at 10:40am, V2, Director of Nursing/DON, stated regarding staff signature documentation, that it is expected that nurses wait until the treatment is done and then document, just as with the protocol with medications; sign when the medication is given.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure daily weights were obtained, notify the physician of weight gains per physician orders, and monitor for discrepancies of weights for one of three residents (R1) with daily weights and failed to clarify diet orders prior to feeding for one of three residents (R9) reviewed for diets in a sample of 28.Findings include: The Weight policy, revised 10/17/19, documents re-weights should be obtained if there is a difference of five pounds or greater (loss or gain) since the previous recorded weight.1. R1 was admitted on [DATE], with diagnoses of Hypertension, Depression, Anxiety, Lymphedema, Obstructive Sleep Apnea, Diabetes Mellitus, and Congestive Heart Failure. R1's Physician Order, dated 11/12/24, documents to weigh R1 daily and to notify the physician if R1's weight gain is greater than three pounds (lbs.) in a day or five pounds in a week.R1's Weight Summary, dated 7/1/25 to 9/24/25, has no documentation of R1's daily weights being obtained for 32 out of the 77 days while R1 was in the facility during the time span of 7/1/25 to-9/24/25. R1's Weight Summary also documents daily weight gain fluctuations varying from 3 lbs. (pounds) to 13 lbs. (7/11-7/13, 13 lbs.; 7/24-7/25, 7 lbs.; 7/25-7/26, 7 lbs.; 8/13-8/14, 10 lbs.; 8/18-8/20, 5 lbs.). R1's current medical record has no documentation of R1's physician being notified of R1's weight gains of more than three pounds in a day and/or five pounds in a week. R1's current medical record has no documentation that R1 was re-weighed with greater than a five-pound loss or gain.On 9/26/25 at 2:40 PM, V2 (Director of Nursing) confirmed R1's daily weights were not obtained as ordered, the physician was not notified of R1's gains of more than three pounds in a day or five pounds in a week per R1's physicians order, nor were R1's weights monitored for discrepancies. V2 reviewed the Weight Summary and confirmed significant weight losses should have also been reported.2. R9 was admitted on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory Failure, Chronic Pain, Neuropathy, Vascular Dementia, Seizures, Contracture Bilateral foot and ankles, Dysphagia and Bipolar and Depression. R9's Care Plan, initiated 2/12/25, documents R9 has no teeth and does not wear dentures. Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. R9's revised Care Plan dated 8/22/25 documents R9 is at increased nutritional risk requiring a therapeutic diet, NAS (No Added Salt) diet, mechanical soft texture, thin liquid consistency and that R9 often complains he is unable to chew the mechanical soft vegetables and meats. The Hospital's discharge instructions, dated [DATE], documents R9 was ordered a general diet without restrictions. R9's Hospital Discharge summary, dated [DATE], documents R9 was admitted for Aspiration Pneumonia, failed his swallow evaluation, refused a feeding tube and to return to the facility with Hospice and continue to eat. R9's census report indicated R9 returned to the facility on 8/8/25 with Hospice services and revoked Hospice services on 8/27/25. The Hospice Plan of Care, dated 8/8/25, documented R9 was ordered a Regular Diet as tolerated. R9's Physician's order, dated 10/23/24, documents R9 was ordered a no added salt mechanical soft textured and thin liquids diet. The orders had not been clarified and/or updated post swallow function test and discharge from Hospital and/or Hospice. On 9/23/25 at 10:00 AM, R9 stated he wants to talk with the Speech Therapist and said, Something is wrong. They make me eat Dog Food. They make me eat a mechanical soft diet because I don't have teeth, but I want to eat egg salad, tuna salad, ham salad, ravioli and meatloaf. I made them a list but (V14/Dietary Manager) refuses to provide food other than what's on the menu for that day. On 9/25/25 at 1:00 PM, V14 (Dietary Manager) stated she has spoken with R9 multiple times. R9 wants egg salad, ham salad and tuna salad. R9 should be on a pureed diet because he does not have teeth and can't chew. Plus, the facility does not have the requested food all the time. V14 stated I will try to get him stuff he likes but I just can't make him what he likes, every meal just for him. Yes, he can eat bread and technically he could eat egg salad and ham salad. On 9/26/25 at 1:15 PM, V1 (Administrator) confirmed R9's diet order should have been clarified so that food preferences could be honored and provided as requested.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was maintained per physician's order for one of three residents (R1) reviewed with oxygen in a sample of 28. Findings include:The Oxygen and Respiratory Equipment Changing and Cleaning policy, dated 9/8/16, documents the handheld nebulizer should be changed weekly and on as needed basis. R1 was admitted on [DATE], with diagnoses of Hypertension, Depression, Anxiety, Lymphedema, Obstructive Sleep Apnea, Diabetes Mellitus, and Congestive Heart Failure. R1's Physician Order, dated 10/26/23, documents to change out, date, and label nebulizer mask and tubing weekly and on an as needed basis when in use. R1's Medication Administration Record (MAR), dated 7/21/25, documents R1 receives nebulizer treatments daily between 9/1/25 to 9/25/25.On 9/23/25 at 10:45 AM, R1's Nebulizer mask and tubing were not labeled with a date as to when they were changed.On 9/25/25 at 2:00 PM, V13 (Licensed Practical Nurse) confirmed oxygen equipment should be dated.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to log, track and justify the prophylactic use of an antibiotic with no stop date for one of five residents (R39) reviewed for antibiotic use in the sample of 28.Findings include:R39's medical record documents R39 was admitted to the facility on [DATE], with the following diagnoses: Cerebral Palsy; Type 2 Diabetes; Morbid Obesity; Schizophrenia; Follicular Disorder, and Idiopathic Progressive Neuropathy.The facility's Infection Prevention and Control Program policy, last revised on 11/28/17, documents the following: Purpose: To comply with the core elements of Antibiotic Stewardship to reduce the unnecessary use of antibiotics. This policy also documents: Antibiotic use will be logged and tracked to ensure prescribing practices and outcomes are monitored for trends. Prophylactic long-term use of antibiotics will be discouraged unless clinical rationale is provided for ongoing use. R39's current POS/Physicians Order Sheet includes the following antibiotic order by V3, Medical Director, dated 01/25/25: Doxycycline Monohydrate Tablet 100 MG: Give 1 tablet by mouth one time a day for infection related to follicular disorder, unspecified. Prophylactic No stop date.There is no documentation of R39's ongoing prophylactic antibiotic use noted in the facility's monthly Infection Logs for July/2025; August/20265 and September/2025.On 9/25/25 at 11:40am, V2 DON/Director of Nursing stated she was aware of the prophylactic antibiotic order for R39. V2 verified there was no documentation in the monthly Infection Logs tracking the daily prophylactic antibiotic ordered, nor was there Physicians justification provided for the open-ended use of the prophylactic antibiotic.