

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Goldwater Care Princeton		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Bureau Valley Parkway Princeton, IL 61356	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify the power of attorney for a resident with dementia of an incident for 1 of 3 residents (R3) reviewed for notification in the sample of 5. The findings include: The Nurse's Notes dated 7/3/26 at 9:40 PM for R3 showed at this time R1 was in this resident's room and had this resident pinned against the wall and was confused over room. Certified Nursing Assistant - CNA observed R1 against R3 and he was easily redirected out of the room. R3 noted to have redness to forearm and redness to shoulders. No bruising at this time. Staff to monitor residents. Administrator and Director of Nursing aware. On 7/12/26 at 3:34 PM, V9 Licensed Practical Nurse - LPN stated it was around 10:00 PM and she was at the nurse's station and heard a noise. She heard R3 yelling but wasn't sure, so her and V8 CNA went to look for the noise. R3's room was dark, the bathroom light was on, R3 was against the wall by the window and R1 was there. R1 was holding her left forearm with one hand and the bottom of her shirt with the other hand. R1 was looking for his wife, her name is the same as R3's name. R1 was easily separated from R3 and was removed from the room. V9 stated she looked over R3, checked her vital signs and contacted the doctor. V9 stated R3 went to bed and just asked for staff to check on her. On 7/12/26 at 4:36 PM, V12 (R3's power of attorney) stated the facility did not notify her of any incident between a male resident and R3. She stated the facility never called her but R3 did call her. She stated they talk on the phone every day and one day R3 told her that a man in a wheelchair came into her room, she got up and yelled. R3 told her she was backed up against a wall and she kicked him. V12 stated the facility calls her for all kinds of silly things, but they did not call her about this, and they should have notified her. On 7/12/26 at 4:53 PM, V2 Director of Nursing - DON stated for the incident between R1 and R3 she would have expected the staff to separate the residents and make sure they were safe. The administrator should be contacted right away. The doctor, family/POA should be notified of the incident as well. On 7/12/26 at 5:05 PM, V1 Administrator stated the POA/family should be notified and care plan updated. This was not handled like it should have been. The Face Sheet dated 7/12/26 for R3 showed diagnoses including St elevated myocardia infarction, cerebral infarction, asthma, dementia, insomnia, atrial fibrillation, osteoarthritis, obesity, gastroesophageal reflux disease, and hypertension. The facility's Physician-Family Notification policy (10/1/15) showed the facility will inform the resident; consult with the resident's physician or authorized designee such as nurse practitioner; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status.		

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to prevent resident to resident abuse for 2 of 3 residents with dementia (R1 & R2) reviewed for abuse in the sample of 7. The findings include: The Nurse's Note dated 6/5/26 at 7:03 AM for R2 showed the nurse documented the next morning after the incident that the certified nursing assistant observed and reported that the resident was involved in a physical altercation with another resident (R1). Both residents were immediately separated. Assessment was initiated, and no injuries were noted as a result of the incident. The Final Abuse Investigation Report dated 6/8/26 showed in the Incident Description: V3 Registered Nurse - RN reported to V1 Administrator that there was a physical abuse allegation between two residents, R1 and R2. V3 stated that when the V4 certified nursing assistant - CNA looked up from her charting and observed R1 with both hands on R2's neck. V4 separated the two without incident and immediately told the nurse. The facility's conclusion was that abuse was unfounded. On 7/12/26 at 1:00 PM, V4 CNA stated she was charting when the incident between R1 and R2 occurred. V4 said R2 had been touching the medication cart, had grabbed the pill crusher and was redirected not to do that. R1 had told R2 to stop touching the cart. Right after this R2 was in his wheelchair and R1 had his hands around R2's neck. R1 had both of his hands around R2's neck and R2's neck was red. They were separated right away. V3 was the nurse, and she was notified and the administrator was told. R1 looked frustrated; R1 is confused. V4 stated she thinks R1 was trying to make R2 knock it off. V4 stated she thought what R2 was doing just set R1 off. V4 stated again that R1 had his hands around R2's neck. V4 stated she removed R1's hands from R2's neck and told the nurse. On 7/12/26 at 1:56 PM, V1 Administrator stated, for the June 2026 abuse allegation between R1 and R2 she stated she has problems deciding if an abuse allegation is founded or unfounded. V1 stated she decided this investigation was unfounded because there was no harm and staff had intervened before it resulted in harm. V1 stated the nurse never documented any injury and she was not aware of any red marks on the resident's neck; if she had known that the findings would have been different. The Face Sheet dated 7/12/26 for R1 showed diagnoses including chronic pulmonary embolism, hyperlipidemia, gastro-esophageal reflux disease, chronic kidney disease, localized edema, insomnia, dementia, low back pain, major depressive disorder, and vitamin D deficiency. The Minimum Data Set, dated [DATE] for R1 showed severe cognitive impairment. The Face Sheet dated 7/12/26 for R2 showed diagnoses including dementia without behavioral disturbance, rhabdomyolysis, atrial fibrillation, atherosclerotic heart disease, benign prostatic hyperplasia, palliative care, hyperlipidemia, abdominal aortic aneurysm, hypertension, and non pressure chronic ulcer. The Minimum Data Set, dated [DATE] for R2 showed severe cognitive impairment. The facility's Abuse Prevention and Reporting policy (10/24/22) showed abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide dementia care for a resident with dementia and behaviors for 1 of 3 residents (R1) reviewed for dementia care in the sample of 5. The findings include: The Nurse's Notes dated 7/3/26 at 9:40 PM for R3 showed at this time R1 was in this resident's room and had this resident pinned against the wall and was confused over room. Certified Nursing Assistant - CNA observed R1 against R3 and he was easily redirected out of the room. R3 noted to have redness to forearm and redness to shoulders. No bruising at this time. Staff to monitor residents. Administrator and Director of Nursing aware. On 7/12/26 at 3:34 PM, V9 Licensed Practical Nurse - LPN stated it was around 10:00 PM and she was at the nurse's station and heard a noise. She heard R3 yelling but wasn't sure, so her and V8 CNA went to look for the noise. R3's room was dark, the bathroom light was on, R3 was against the wall by the window and R1 was there. R1 was holding her left forearm with one hand and the bottom of her shirt with the other hand. R1 was looking for his wife, her name is the same as R3's name. R1 was easily separated from R3 and was removed from the room. V9 stated she looked over R3, checked her vital signs and contacted the doctor. V9 stated R3 went to bed and just asked for staff to check on her. V9 stated R1 will wander looking for his wife and is exit seeking. V9 stated when R1 wanders they take turns watching him. V9 stated she thinks that since R1's wife and R3 have the same name that he went into that room looking for his wife. V9 stated residents behaviors are put in the care plans. On 7/12/26 at 4:36 PM, V12 (R3's power of attorney) stated the facility did not notify her of any incident between a male resident and R3. She stated the facility never called her but R3 did call her. She stated they talk on the phone every day and one day R3 told her that a man in a wheelchair came into her room, she got up and yelled. R3 told her she was backed up against a wall and she kicked him. V12 stated she feels the facility should have supervised the residents better so this kind of thing doesn't happen. On 7/12/26 at 4:53 PM, V2 Director of Nursing - DON stated for the incident between R1 and R3 she would have expected the staff to separate the residents and make sure they were safe. The administrator should be contacted right away. The doctor, family/POA should be notified of the incident as well. The residents should be assessed, and the assessments should be documented. V2 stated she is new to the facility and is not aware of all the policies yet. She stated she would have social services sit down with R3 and do a trauma assessment and then notify the doctor to see if an evaluation needed to be done. The care plan would be adjusted if necessary. V2 stated to make sure both residents were safe; monitoring would be done. V2 stated she was not aware that R3 had the same name as R1's wife. V2 stated that if the wandering was related to him seeking his wife or that he is looking at females as his wife and/or this name issue it should all be care planned. These would be triggers for him and should be care planned. On 7/12/26 at 5:05 PM, V1 Administrator stated she was not aware that the name of R3 and R1's wife are the same and that he was looking for his wife. V1 stated that should be care planned and a part of his dementia care. V1 stated they will need to do more 1:1 with him. V1 stated this was not handled as it should have been. The current Care Plan with a revised date of 12/29/25 and target date of 9/10/26 for R1 showed it was last updated on 4/4/26 for his elopement risk/wanderer, exit seeking problem. The care plan did not show that he is trying to find his wife when he is wandering and was not updated after the incident between R1 and R3 and his triggers/behaviors. R1's care plan showed he has the potential to be physically and verbally aggressive. R1's care plan did not show that it was reviewed and/or revised after the incident on (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/3/26 between him and R3. The Minimum Data Set, dated [DATE] for R1 showed severe cognitive impairment. The Face Sheet dated 7/12/26 for R1 showed diagnoses including chronic pulmonary embolism, hyperlipidemia, gastro-esophageal reflux disease, chronic kidney disease, localized edema, insomnia, dementia, low back pain, major depressive disorder, and vitamin D deficiency. The Minimum Data Set, dated [DATE] for R3 showed moderate cognitive impairment. The Face Sheet dated 7/12/26 for R3 showed diagnoses including St elevated myocardial infarction, cerebral infarction, asthma, dementia, insomnia, atrial fibrillation, osteoarthritis, obesity, gastroesophageal reflux disease, and hypertension. The facility's Dementia Unit Admission/Discharge Criteria and Program policy (10/2017) showed the goal of this program is to provide a safe environment for the individual, while offering activities that support the best quality of life possible. The program will offer a person-centered approach. Person centered care encompasses four major elements and these are identified as core values of this unit. An individualized approach, recognizing uniqueness. In order to assure the best possible outcome, a team will work together to develop plans of care that allows the resident to experience the best quality of life as possible. R1's care plan showed he has impaired cognitive function/dementia. The intervention to Cue, reorient and supervise as needed has been in place since 9/15/25.		