STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Gibson City	620 East First Street Gibson City, IL 60936

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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 0600 Level of Harm - 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. 41970 Based on interview and record review the facility failed to ensure the residents' right to be free from mental and physical abuse by staff. R2 experienced physical pain and psychosocial harm including fear, feeling unsafe, crying and mental stress/worrying. R3 experienced mental abuse through crying, being upset and scared. These failures affect two (R2, R3) residents out of four residents reviewed for abuse in a sample list of eleven residents. Findings include: The facility undated policy titled 'Abuse, Neglect and Misappropriation of Resident Property' documents Physical/mental-the facilities policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all state and federal regulations. Residents must not be subject to abuse by anyone including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the residents, family members or legal guardians, friends or other individuals. Abuse definition is documented as the willful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families. Examples of verbal abuse include but are not limited to threats of harm and saying things to frighten a resident. Physical abuse is defined as hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Mental abuse is defined as humiliation, harassment, and/or threats of punishment or deprivation. Involuntary seclusion is defined as the separation of a resident from other residents, from his or her room, or confinement to his or her room with or without roommates against the residents will or the will of the resident representative. 1.) R3's Initial Report to the State Agency dated 7/1/24 documents R3 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. (continued on next page)

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 - Actual harm Residents Affected - Few	R3's undated Abuse Investigation Form documents V1 Administrator was notified on 6/29/24 at 10:20 AM that R3 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. This report documents (R3) stated that the agency staff (V13, V14) had argued with her about how to do her care, did not get her up with a sit to stand to the bedside commode, but attempted to roll her over and clean her. This caused her pain in her leg and she wet which caused the agency staff to raise their voices, throw things on the floor and leave the room leaving her in the bed uncovered. On 6/30/24 at 9:45 AM, R3 stated Yesterday (6/29/24) two agency Certified Nurse Aides (CNA) (V13, V14) came into my room a little after 5:00 AM Saturday (6/29/24) morning to get me up for breakfast. I had asked to use the lift (partial mechanical body lift) to get me up to the commode. They (V13, V14) said they weren't going to get me up to the commode and were just going to change me in my bed. They (V13, V14) were rolling me around in bed so hard. I told (V13, V14) that my left leg hurt. I have been in the hospital twice this month for the awful pain in my left leg. They (V13, V14) grabbed my left leg and twisted my left leg and so I let out a yell. I told (V13, V14) several times to quit twisting my left leg but they just kept on. Then they (V13, V14) just left me there laying in a wet bed half dressed. I told (V16) how awful those two (V13, V14) were. I am afraid that they (V13, V14) will come back and hurt me worse. On 6/30/24 at 12:50 PM, V16 Registered Nurse (RN) stated V16 talked with R3 about 5:30 AM. V16 RN stated (R3) was crying so hard she had trouble even talking. I tried to console (R3) but she was crying so hard she was inconsolable. (R3) told me that (V13, V14) CNA's were 'very rough' with her that morning. (R3) had asked to use the bathroom and she was told no. (R3) stated (V13, V14) rolled her around so hard and rough that she had urinated in her bed because she was scared of them. On 6/30/24 at 12:30 PM, V15 Social Service Director (SSD) stated R7 (R3's roommate) reported to V15 SSD Those two Certified Nurse Aides (CNA's) (V13, V14) were mean to my roommate (R3) this morning. I heard them yelling and carrying on. They (V13, V14) just threw her blankets on the floor and walked out. V15 SSD stated R3 was still upset and crying throughout the entire conversation. On 6/30/24 at 1:40 PM, V7 Restorative Certified Nurse Aide (CNA) stated When I entered (R3's) room, she was crying. (R3) had her pants around her knees, her shirt was tucked up under her breasts, her bed was wet and she didn't have any covers on. This would have been about 5:40 AM or so. (R3) said her left leg hurt. I had to help (R3) move her left leg because it was hurting her so bad. Normally (R3) can move her own legs, slowly, but she can do it on her own. Yesterday (6/29/24) (R3) couldn't even move her left leg on her own due to the pain. On 7/1/24 at 10:05 AM, V17 Licensed Practical Nurse (LPN) stated the morning of 6/29/24 was very chaotic. V17 LPN stated R3 had reported to V16 Registered Nurse (RN) that they (V13, V14) scared her and hurt her leg. V17 LPN stated R3 has been hospitalized twice in June for left leg pain but the Physicians are not able to find a cause of the pain. V17 LPN stated It ended up that (R3) alleged physical abuse and (R2) alleged mental abuse both by (V13 and V14) CNA's. V17 LPN stated I went to (R2's) room first about 6:30 AM. (R3) told me that 'those two (V13, V14) were awful, mean to her and hurt her leg'. V17 stated R3 said 'They (V13, V14) scared me so bad I peed as they were wiping me and (V13) Agency CNA yelled out. V17 stated R3 reported that V13 and V14 Agency CNA's left her in the wet bed half dressed and crying. V17 LPN stated When I saw (R3), she was crying hysterically. It took her a long time to be able to calm down enough to talk to me and tell me what happened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2.) R2's Initial Report to the State Agency dated 7/1/24 documents R2 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. R2's undated Abuse Investigation Form documents V1 Administrator was notified on 6/29/24 at 10:20 AM that R2 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. On 6/30/24 at 10:10 AM, R2 stated There were two agency CNA's (V13, V14) that were here (facility) yesterday (6/29/24). (V13) Agency CNA pushed a washcloth in my hand and told me to wash my face. I can't do that because of my Arthritis. (R2's hands appear deformed at knuckles. R2 was unable to open both hands completely.) R2 stated (V13) kept pushing the washcloth into my hand. It hurt a bit. I told them (V13 and V14) multiple times that I just can't physically do it. I showed (V13, V14) my hands so they could see how bad they are. I pushed the washcloth back at (V13). I don't deserve that. They (V13, V14) just rolled their eyes and looked at me so mean. I have to say I was scared that morning. R2 stated later that morning after breakfast V13 and V14 agency CNA's assisted R2 from her wheelchair to her bed. R2 stated They (V13, V14) threw me into bed. (V14) CNA grabbed my hand (R2 holding onto her own Right hand) and squeezed so hard it really hurt. It didn't bruise but it sure hurt. I yelled out several times and they (V13, V14) left me laying there in my bed. On 7/1/24 at 10:08 AM, V17 LPN stated I could hear (R2) yelling from her room with her door closed four doors down in the dayroom on [NAME] hall. (V16) and I went to investigate. I didn't see (V13, V14) actually do anything to (R2) but I do know they had just been in there laying (R2) down after breakfast. (R2) told me that they (V13, V14) were just in her room and laid her down. (R2) told me 'I'm just so scared of them (V13, V14). Please don't let them back in my room'. On 7/1/24 at 11:15 AM, V13 Agency Certified Nurse Aide (CNA) stated (R2) is rude to the staff. We (staff) don't have to tolerate that. I am not helping anyone that treats me like that. (R2) was all kinds of frustrated at me and (V14) Agency CNA. (R3) was the same way. (R3) wanted to get up but she had already been incontinent so there is no reason to get somebody up after they have already been incontinent. (R3) just kept crying and wouldn't be quiet about it. There is no reason for (R3) to be crying like that. We (V13, V14) just walked out of (R3's) room. On 7/1/24 at 2:00 PM, V1 Administrator stated Our facility has a lot of great staff who are caring and knowledgeable to care for our residents. Unfortunately, these two Agency CNA's (V13, V14) did upset our residents R2 and R3 a great deal. V1 stated R2 reported physical and mental abuse to our staff and R3 reported an allegation of what could be mental abuse by (V13, V14). V1 confirmed R2 and R3 were both physically and mentally abused by V13, V14 Agency CNA's. V1 Administrator stated We (facility) take this very seriously. My staff has already been educated. Our residents have been interviewed and say they feel safe here now. You can be sure those two Agency CNA's will not return to our facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to notify the Administrator and the Administrator failed to notify the State Agency timely of allegations of staff to resident abuse for two (R2, R3) residents. This failure affects all 60 residents residing in facility. Findings include: The facility undated policy titled 'Abuse, Neglect and Misappropriation of Resident Property' documents Reporting-Elder abuse is an unfortunate situation that must be reported. If you suspect or observe a resident being abused, discuss the situation with your supervisor immediately. The facility will ensure that all allegations of abuse, neglect, mistreatment including injuries of unknown source are reported immediately to the Administrator of the facility. The Administrator and/or other officials shall notify the State Agency. The facility Daily Midnight Census Report dated 6/30/24 documents 60 residents reside in facility. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 is dependant on staff for bathing, toileting, personal hygiene, dressing, bed mobility and transfers. R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 is dependent on staff for bathing, dressing, toileting, personal hygiene, bed mobility and transfers. R2 and R3's combined Initial Report to the State Agency dated 7/1/24 documents R2 and R3 complained that V13 and V14 agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. On 6/30/24 at 12:52 PM, V16 Registered Nurse (RN) stated I should have called (V1) Administrator at 5:30 AM, the first time (R3) told me she was so upset. (R3) didn't say anything to me earlier about (V13, V14) twisting her leg. (R3) told me that they treated her horribly and made her wet the bed and cry and that her leg hurt. I should have called right then. That would have prevented (V13, V14) treating anyone else poorly. On 6/30/24 at 12:54 PM, V16 RN stated V16 RN called V1 Administrator on 6/29/24 at 10:19 AM to report R2 and R3's allegations of abuse. On 7/1/24 at 10:05 AM, V17 Licensed Practical Nurse (LPN) stated I should have just called (V1) right then when I was told about (R3) being so upset but I thought (R3) was overly upset over nothing really. (R3) told me she was scared of (V13, V14) and didn't want them back in her room. I tried to console (R3). I really should have known to call (V1). I have been inserviced on abuse, who the abuse coordinator is, and to call immediately if anything is suspected. There were 50 other things going on that morning so I left it up to (V16) RN to take the lead. I should have reported things myself. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/1/24 at 10:50 AM, V2 DON stated she received a call from V16 Registered Nurse (RN) at 9:41 AM reporting that the schedules may have to change for the day (6/29/24) due to (V13, V14) causing problems and upsetting residents. V2 DON stated V2 was not informed of any allegations of abuse at that time. V2 DON stated the staff are expected to report any allegation of abuse to the Abuse Coordinator (V1) immediately. On 6/30/24 at 10:35 AM, V1 Administrator stated two agency Certified Nurse Aides (CNA) who worked yesterday (6/29/24) were asked to leave due to their behaviors. V1 sated these two Certified Nurse Aides (V13, V14) were walked out by our management staff. I know there were customer service issues with (R2 and R3) from (V13, V14). I did not report either of those situations to the State Agency as abuse. V1 Administrator stated the staff have all been inserviced on our Abuse Prevention Policy and did not follow it. V1 stated R2 and R3's allegations should have been reported immediately to V1 Abuse Coordinator/Administrator and the two agency CNA's (V13, V14) should have been walked at after R3 made the first allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to follow their abuse policy by not immediately suspending two alleged perpetrators after mental and physical abuse allegations were made by one resident (R3). The facility failed to protect two additional residents (R2, R6) from said perpetrators after R3's allegation was made. The facility also failed to assess R2 and R3 after abuse allegations were made against two alleged perpetrators. These failures affect three residents (R2, R3, R6) and have the potential to affect all 60 residents residing in the facility. Findings include: The facility undated policy titled 'Abuse, Neglect and Misappropriation of Resident Property' documents All residents shall be assessed immediately by the attending nurse upon notification of alleged abuse, neglect or mistreatment including employee inflicted injury. When incidents involve suspected abuse, neglect or mistreatment are reported the facility shall take the following steps: remove the employee immediately, staff is to notify immediate supervisor and he/she must conduct interview, employee must be sent home immediately pending outcome of final investigation, Administrator shall be notified immediately and conduct an investigation immediately. The facility will keep evidence that all alleged violations and thoroughly investigated and will prevent further potential abuse while the investigation is in progress. The facility will provide training to staff on identifying and reporting possible victims of abuse during orientation and annually thereafter. The facility Daily Midnight Census report dated 6/30/24 documents 60 residents reside in facility. 1.) R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. On 6/30/24 at 9:46 AM R3 stated R3 reported to V16 Registered Nurse (RN) 'around 5:30 AM' on Saturday 6/29/24 that V13 and V14 agency CNA's were mean to her, made her cry and hurt her leg. R3 stated I hope they never come back. It would upset me very much. 2.) R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 is dependent on staff for bathing, toileting, personal hygiene, dressing, bed mobility and transfers. R2's Electronic Medical Record (EMR) does not document any skin assessment after R2 alleged physical abuse from agency staff on 6/29/24. R2 and R3's combined undated Abuse Investigation Form documents V1 Administrator was notified on 6/29/24 at 10:20 AM. This report documents (R3) stated that the agency staff (V13, V14) had argued with her about how to do her care, did not get her up with a sit to stand to the bedside commode, but attempted to roll her over and clean her. This caused her pain in her leg and she wet which caused the agency staff to raise their voices, throw things on the floor and leave the room leaving her in the bed uncovered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/30/24 at 10:00 AM, V10 Certified Nurse Aide (CNA) stated I had to fill out a witness statement yesterday (6/29/24) for (R2). I overheard one of them (V14) tell the other (V13) that (R2) wanted to go to bed and (V14) told the other agency CNA (V13) that (V14) left (R2) in her room, shut off the lights and closed the door. I reported both of them. On 6/30/24 at 10:10 AM, R2 stated V13, V14 agency Certified Nurse Aides (CNA) forced a washcloth into her hand when assisting R2 with morning cares before breakfast. R2 stated R2 was scared of both of them (V13, V14) that morning. R2 stated I hope they never come back but I would really be scared if they did. R2 stated the same two agency CNA's (V13, V14) assisted R2 to bed after breakfast. R2 stated (V13 and V14) grabbed my hand so tightly that it hurt. I think they did it on purpose. They (V13, V14) were so rough. On 6/30/24 at 12:25 PM, V15 Social Service Director (SSD) stated when V15 arrived at facility at 9:45 AM, V15 was 'bombarded' with staff reporting (V13, V14) Certified Nurse Aides (CNA) behaviors towards R3. V15 SSD stated V16 Registered Nurse (RN) and V15 SSD called V1 Administrator together that morning to report R3's allegation of physical abuse after it was reported to V15 SSD. V15 SSD stated V1 was called in between 10:00-10:30 AM. V15 SSD stated they were told at that time by V1 Administrator to walk V13 and V14 CNA's out of the facility. V15 stated V13 and V14 CNA's were both off the premises by 10:51 AM. On 6/30/24 at 12:53 PM, V16 Registered Nurse (RN) stated V16 RN, V17 LPN and R8 (R2's) roommate were in the dayroom at the end of [NAME] hall when they heard R2 screaming. V16 stated V13 and V14 just finished putting R2 to bed. V16 RN stated that is the same time V15 SSD reported to V16 RN that R3 had an allegation of physical abuse against V13 and V14 CNA's. 3.) R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. This same MDS documents R6 as dependent on staff for bathing, dressing, toileting, bed mobility and personal hygiene. This same MDS documents R6 requires two staff using a total body mechanical lift for transfers. On 6/30/24 at 12:58 PM, V7 Restorative Certified Nurse Aide (CNA) stated she witnessed V13 agency CNA and V14 agency CNA at 10:35 AM in R6's room helping him with incontinence care. V7 stated V13 agency CNA told V7 to go away because V14 agency CNA was helping V13. V7 CNA stated she closed the door to R6's room and left V13 and V14 agency CNA's in R6's room with him. On 7/1/24 at 8:45 AM, R6 stated Those two (V13, V14) Certified Nurse Aides (CNA) should not be helping anyone. R6 also stated, All they did was complain about how hard their job is. They (V13, V14) don't realize I am their job. They (V13, V14) were both rude to me in how they responded and acted. They (V13, V14) were both smart a**** (expletive) and I don't want them to come in my building again. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/30/24 at 12:55 PM, V16 Registered Nurse (RN) stated after reporting R3's physical abuse allegation to V1 Administrator V16 RN went to find V13 and V14 agency Certified Nurse Aides (CNA's). V16 stated V13 and V14 CNA's were in R6's room at about 10:30 AM. V16 RN stated When I walked into (R6's) room, (V13 and V14) CNA's were in the process of getting (R6) ready for the day. (V13, V14) were both rolling him over and putting the lift (total body mechanical lift) sling underneath (R6). I asked (V14) to come with me and asked (V18) agency CNA to assist (V13) with getting (R6) up. I knew both (V13 and V14) were going to be walked out but I didn't want to do that with both at the same time so I just asked (V14) to come up front with me. When (V14) and I got up front I let her know that there was an allegation against her of abuse and she needed to leave. Once (V14) was out of the facility, I went back to the hall to find (V13). I then did the same thing with (V13). V16 stated V13 and V14 were assigned to the 'back half' of west hall but would have had access to the entire resident population. V16 stated V2 DON was called at 9:41 AM about the possible staffing issues if V13 and V14 would leave. V16 stated V16 did not report R2 and R3's allegations at that time. V16 RN stated V13 and V14 agency CNA's were not supposed to be on the schedule. V16 RN stated Originally, there were two other agency CNA's that were scheduled for Saturday (6/29/24) but they didn't come and these two (V13, V14) showed up instead. On 7/1/24 at 11:25 AM, V13 agency Certified Nurse Aide (CNA) stated We (V13, V14) were trying to get some guy (R6) back into bed to change him and then get back up. Some boss lady (V16 RN) came in to that guy's (R6) room and made (V14) leave with her. I stayed and continued to do my job. Nobody is going to tell me I didn't do my job. That was probably 10:30 AM or so. Then after awhile, the same boss lady (V16 RN) came back into (R6's) room and made me go up front too. They (V16 RN) told me when I got up front that there had been an allegation brought against me and (V14) and we needed to leave. If we (V13, V14) were so bad why did they (facility) let us stay so long that morning. If someone has an allegation against them they are supposed to be walked out immediately. On 7/1/24 at 1:00 PM, V5 Human Resources Director stated the facility is unable to provide documentation of V13 and V14 agency Certified Nurse Aide (CNA) abuse training. V5 HR stated Normally the agency provides the training but the copy of abuse training they provided for (V13) was from another hospital, not our contracted agency and they (agency) were not able to find any proof of (V14) agency CNA ever having had abuse training through our facility or through our contracted staffing agency. On 6/30/24 at 10:35 AM, V1 Administrator stated two agency Certified Nurse Aides (CNA) who worked yesterday (6/29/24) were asked to leave due to their behaviors. V1 stated the two Certified Nurse Aides (V13, V14) left the facility and then they (V13, V14) came back in and took care of (R6). V1 stated they (V13, V14) were walked out by our management staff two other times because they kept coming back inside. V1 stated they (V13, V14) should not have been allowed to come back into the facility after already being walked out. V1 Administrator stated (V13, V14) agency CNA's were inside our facility and did have access to all of our residents. That put all of our residents at risk of being abused by (V13, V14) agency CNA's.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 41970 Based on interview and record review the facility failed to provide staff with Quality Assurance Performance Improvement (QAPI) training. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The Facility Daily Midnight Census Report documents 60 residents reside in facility. The Facility assessment dated Janurary 2024 documents the facility will provide QAPI training annually for all staff. On 7/3/24 at 1:15 PM, V25 Certified Nurse Aide (CNA) stated V25 has never heard of Quality Assurance Performance Improvement (QAPI) training. V25 CNA stated I have worked here (facility) for over eight years and never heard of QAPI training. They (facility) don't talk to us about that. On 7/3/24 at 2:15 PM, V1 Administrator stated the facility has not provided ongoing annual training on the topic of QAPI. V1 stated the facility is unable to provide documentation of QAPI trainings for staff for the last year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Gibson City	620 East First Street Gibson City, IL 60936

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to provide staff with Ethics training. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The Facility Daily Midnight Census Report documents 60 residents reside in facility. The Facility assessment dated [DATE] documents the facility will provide Ethics training annually for all staff. On 7/3/24 at 1:15 PM, V25 Certified Nurse Aide (CNA) stated V25 has never heard of Ethics training. V25 CNA stated I have worked here (facility) for over eight years and never heard of Ethics training. They (facility) don't talk to us about that. On 7/3/24 at 2:15 PM, V1 Administrator stated the facility has not provided ongoing annual training on the topic of Ethics. V1 stated the facility is unable to provide documentation of Ethics trainings for staff for the last year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Gibson City	620 East First Street Gibson City, IL 60936

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41970 Based on interview and record review, the facility failed to ensure continued competency for nurse aides for at least twelve hours per year including dementia training and resident abuse prevention training for four nurse aides (V3, V13, V14, V25). This has the potential to affect all 60 residents residing in the facility. Findings include: The facility's Facility Assessment Tool dated January 2024, documents all new employees must complete an orientation program covering abuse, neglect, exploitation, and Certified Nurse Assistants must receive at least 12 hours minimum of in-service training that include dementia management training and resident abuse prevention training. On 7/3/24 at 11:30 AM, V1 Administrator stated V1 does not have a log of staff training for abuse or dementia training. On 7/3/24 at 12:41 PM, V5 Human Resources stated she does not have training logs for dementia or abuse training for the last year for the staff for the on-boarding V5 completes for new hires. The facility's Daily Midnight Census dated 6/30/24, documents 60 residents reside in the facility.