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	05/08/2025

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure residents' right to be treated in a dignified manner for three (R8, R9, and R10) of 12 residents reviewed for abuse in the sample list of 13. Findings include: The facility's Resident Rights policy dated 8/23/17 documents Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. The facility will not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights On 5/8/25 at 10:45 AM R8 stated V3 Certified Nursing Assistant (CNA) is a b**** (expletive), she's just mean. R8 stated about six months or so ago V3 hit R8 in the stomach while rolling R8 in bed. R8 felt this was done intentionally and described V3 as being mean about it. V3 stated V1 Administrator and V2 Director of Nursing were notified. R8 stated V3 also left R8's former room mate, R10, to take herself to the bathroom. R8 stated V3 knew R10 needed the bathroom, but left her on her own. R8 stated R10 waited an hour for V3 to return prior to taking herself to the bathroom. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. The facility's daily assignment sheets dated 4/30/25-5/7/25 documents V3 worked on R8's hallway five days during this time frame. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V3's employee file was reviewed on 5/8/25. This file contained Employee Disciplinary Action Form dated 11/7/24, which documents a written warning and three day suspension was given to V3 regarding being unprofessional in language and actions with resident (identified as R9) and family (identified as V16 CNA) present. V3 was educated on Abuse and Neglect and Customer Service. This file contained Employee Disciplinary Action Form dated 2/27/25, which documents it was reported to V1 Administrator that V3 did not assist a resident (R10) with toileting assistance and walked out of the room. V3 was issued a written warning and three day suspension, and provided education on the facility's Customer Service Policy. The attached undated Customer Service policy documents the facility is dedicated in serving others to create a positive experience, and this includes responding promptly and in a positive/professional manner and being polite, interested, and respectful. This policy documents to smile, convey friendliness, avoid raising your voice in frustration or anger, have an open/friendly posture, be respectful and empathize and apologize where required. R9's Census documents R9 discharged from the facility on 2/10/25. R9's MDS dated [DATE] documents R9 has severe cognitive impairment. R10's Census documents R10 discharged from the facility on 3/17/25. R10's MDS dated [DATE] documents R10 as cognitively intact. R10's Care Plan initiated 2/12/25 documents R10 has Activities of Daily Living self care deficit with varying levels of assistance needed due to right distal femur fracture. On 5/8/25 between 10:35 AM and 1:13 PM the following staff were interviewed: V19 Licensed Practical Nurse stated V3 has a history of problems with R8, including R8 saying V3 was rough with R8. V19 stated V1 Administrator was aware and V3 was placed on suspension. V16 CNA stated V16 was R9's Power of Attorney and V3 has a history of not doing things. In regards to V3's 117/24 Disciplinary Action , V16 stated V16 entered R9's room and noted an odor. V3 entered R9's room to give V16 report and V16 told V3 that R9 needed to be checked/changed. V16 stated V3 huffed and said V3 did not have time for this while standing near R9. V16 stated V1 was notified and V16 was upset to find out that V3 continues to be employed by the facility despite having similar situations. V16 stated V3 had poked R8 in the chest causing R8 to cry. V18 Human Resources, in regards to the 11/7/24 Disciplinary Action, stated it was reported by V16 that while assisting V3 to change R9, V3 did not sound very professional, it was V3's tone of voice. V3 was placed on suspension and educated on customer service. On 5/8/25 at 11:54 AM V3 stated R8 does not like V3 and described R8 as being rude to V3, even though V3 is not rude to R8. V3 confirmed V3 still provides cares for R8. V3 confirmed receipt of abuse and resident rights training. In regards to V3's 11/7/24 Disciplinary Action, V3 stated V3 went in to provide care for R9 who was dirty/incontinent. V3 stated V3 told R9 that R9 was dirty and V3 needed to change her. V3 stated V16 was also in the room providing care for R9's unidentified room mate, and V16 told V3 that V3 shouldn't talk to R9 that way. V3 stated management talked to V3 about the situation, but didn't recall what was said or reviewed. In regards to the 2/27/25 Disciplinary Action, V3 stated R10 called to request the bathroom, V3 told R10 that V3 was in the middle of providing cares to another unidentified resident and would return. V3 stated V3 did not return to R10's room since R10's call light was no longer on. On 5/8/25 at 10:40 AM V2 Director of Nursing stated R10 was R8's room mate on 2/27/25. V1 and V2 confirmed V3's 2/27/25 Disciplinary Action form was for R10. V1 stated the concern was reported by R10 and this was addressed with V3. At 10:52 AM V1 stated R8 says a lot of people are rough with her and R8 likes to make up things. V1 stated R8 has said V3 was rough with her and we have talked to V3 about it. At 1:27 PM V1 confirmed that V3 has been allowed to continue to provide R8's cares, despite a history of abuse allegation between R8 and V3 in June 2024.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on interview and record review the facility failed to protect the residents right to be free from physical and verbal abuse by another resident. This failure affects two (R1 and R2) of 12 residents reviewed for abuse in the sample list of 13. This failure resulted in R1 abusing R2 causing R2 to experience psychosocial harm as evidenced by crying. Findings include: The facility's Abuse Prevention and Reporting Policy (revised 10/24/22) documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. R1's Face Sheet dated 5/8/25 documents the following diagnoses: Dementia with agitation and behaviors and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired. R1's Care Plan (current) documents R1 has a behavior problem and screams/curses at staff. This same record documents R1 is frequently verbally aggressive towards others and can have aggressive behaviors. A Progress Note dated 5/7/25 documents R1 still wearing the same clothing as the day before and R1 resistive to cares and very aggressive physically and verbally. R2's Face Sheet dated 5/8/25 documents the following diagnoses: Alzheimer's Disease. R2's MDS dated [DATE] documents R2 is severely cognitively impaired. A typed, undated incident narrative documents a physical and verbal altercation between R1 and R2. This same record documents R1 was witnessed by V4 Certified Nursing Assistant (CNA) hitting R2 in the back and yelling at R2 stating R2 needed a good smacking. On 5/7/25 at 12:38pm, V9 Registered Nurse stated R1 can be aggressive towards other residents. V9 stated R1 does not like other residents to be around R1. On 5/7/25 at 1:21pm, V4 CNA stated on 4/26/25, R1 was in the lobby sitting area near the table by the front window and R2 was near the front door yelling I want to go home. V4 stated this is not unusual for R2. V4 stated V4 was sitting at the nurses station charting when V4 heard R1 yelling at R2, 'I'm tired of listening to you. Why don't you shut up.' V4 stated V4 then heard what sounded like R1 smacking R2 in the back and R2 posturing like R2 had been hit in the back. On 5/8/25 at 10:45am, R8 stated R1 cusses residents out. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/8/25 at 12:21pm, V16 CNA stated the last weekend V16 worked, either Saturday or Sunday (4/26/25 or 4/27/25), V16 was told by V4 CNA that R1 hit R2. V16 stated V16 came upon R1 and R2 shortly after the incident. V16 stated R2 was crying and rubbing R2's arm and R2 said R1 hit R2.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38780 Based on interview and record review, the facility failed to implement their Abuse Prevention and Reporting Policy. This failure affects two (R1 and R2) of 12 residents reviewed for abuse in the sample list of 13. Findings include: On 5/7/25 at 9:49am, V1 Administrator stated V1 was notified on 4/26/25 by V4 Certified Nursing Assistant (CNA) of R1 hitting and yelling at R2 but did not report the incident to the State Agency or do an investigation. On 5/7/25 at 10:59am, V6 R1's Representative stated V6 was not notified of the altercation between R1 and R2. On 5/7/25 at 1:21pm, V4 CNA stated V4 notified V1 Administrator on 4/26/25 of R1 yelling at R2 and hitting R2 in the back. There is no documentation in R1's medical record of the state survey agency or V6 being notified of the incident. There is no documentation in R2's medical record of the state survey agency or V10 R2's Representative being notified of the incident. The facility's Abuse Prevention and Reporting Policy (revised 10/24/22) documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Implementing systems to promptly and aggressively investigate all reports and allegations of abuse. Filing accurate and timely investigative reports. All incidents will be documented, whether or not abuse was alleged or suspected. Any incident or allegation involving abuse will result in an investigation. When an allegation of abuse has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. The State Agency shall be informed that an occurrence of potential abuse has been reported and is being investigated.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38780 Based on interview and record review, the facility failed to timely report an allegation of resident to resident physical and verbal abuse to the state survey agency. This failure affects two (R1 and R2) of 12 residents reviewed for abuse in the sample list of 13. Findings include: R1's Face Sheet dated 5/8/25 documents the following diagnoses: Dementia with agitation and behaviors and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired. R1's Care Plan (current) documents R1 has a behavior problem and screams/curses at staff. This same record documents R1 is frequently verbally aggressive towards others and can have aggressive behaviors. A Progress Note dated 5/7/25 documents R1 still wearing the same clothing as the day before and R1 resistive to cares and very aggressive physically and verbally. R2's Face Sheet dated 5/8/25 documents the following diagnoses: Alzheimer's Disease. R2's MDS dated [DATE] documents R2 is severely cognitively impaired. A typed, undated incident narrative documents a physical and verbal altercation between R1 and R2. This same record documents R1 was witnessed by V4 Certified Nursing Assistant (CNA) hitting R2 in the back and yelling at R2 stating R2 needed a good smacking. There was no abuse investigative file for the altercation between R1 and R2 and no documentation of the incident in R1 or R2's medical record. There is no documentation that the facility reported this altercation to the state survey agency. On 5/7/25 at 9:49am, V1 Administrator stated V1 was notified on 4/26/25 by V4 Certified Nursing Assistant (CNA) of R1 hitting and yelling at R2 but did not report the incident to the state survey agency or do an investigation. On 5/7/25 at 12:38pm, V9 Registered Nurse stated R1 can be aggressive towards other residents. V9 stated R1 does not like other residents to be around R1. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 1:21pm, V4 CNA stated on 4/26/25, R1 was in the lobby sitting area near the table by the front window and R2 was near the front door yelling I want to go home. V4 stated this is not unusual for R2. V4 stated V4 was sitting at the nurses station charting when V4 heard R1 yelling at R2, 'I'm tired of listening to you. Why don't you shut up.' V4 stated V4 then heard what sounded like R1 smacking R2 in the back and R2 posturing like R2 had been hit in the back. V4 stated V4 notified V1 Administrator on 4/26/25 of R1 yelling at R2 and hitting R2 in the back. On 5/8/25 at 10:45am, R8 stated R1 cusses residents out. On 5/8/25 at 12:21pm, V16 CNA stated the last weekend V16 worked, either Saturday or Sunday (4/26/25 or 4/27/25), V16 was told by V4 CNA that R1 hit R2. V16 stated V16 came upon R1 and R2 shortly after the incident. V16 stated R2 was crying and rubbing R2's arm and R2 said R1 hit R2. The facility's Abuse Prevention and Reporting Policy (revised 10/24/22) documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Implementing systems to promptly and aggressively investigate all reports and allegations of abuse. Filing accurate and timely investigative reports. All incidents will be documented, whether or not abuse was alleged or suspected. Any incident or allegation involving abuse will result in an investigation. When an allegation of abuse has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. The State Agency shall be informed that an occurrence of potential abuse has been reported and is being investigated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 38780 Based on interview and record review, the facility failed to thoroughly investigate and document an allegation of resident-to-resident physical and verbal abuse. This failure affects two (R1 and R2) of 12 residents reviewed for abuse in the sample of 13. Findings include: The facility Abuse, Neglect and Exploitation Policy dated 12/5/22 documents the following: when suspicion of abuse or reports of abuse occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members and visitors in the area. Obtain witness statements. Document the entire investigation chronologically. Notify the attending physician and the resident's family/legal representative. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. A typed, undated incident narrative documents V1 Administrator notified by V4 Certified Nursing Assistant (CNA) of a physical and verbal altercation between R1 and R2. This same record documents R1 was witnessed by V4 hitting R2 in the back and yelling at R2 stating R2 needed a good smacking. Further documents R1 and R2 separated by nursing staff and R2 assessed for injury by V5 Licensed Practical Nurse. On 5/7/25, the above incident narrative failed to document the time of the incident between R1 and R2, failed to document the date and time of required notifications, failed to document what staff and residents were interviewed, the results of those interviews, and the date/time of those interviews. The same record failed to document the investigation chronologically and failed to document any subsequent monitoring or assessment of potential resident psychosocial outcomes following R1 and R2's incident on 4/26/25. On 5/7/25 at 9:49am, V1 stated the typed, undated incident narrative was the complete investigation for the incident between R1 and R2. The facility's Abuse Prevention and Reporting Policy (revised 10/24/22) documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Implementing systems to promptly and aggressively investigate all reports and allegations of abuse. Filing accurate and timely investigative reports. All incidents will be documented, whether or not abuse was alleged or suspected. Any incident or allegation involving abuse will result in an investigation. When an allegation of abuse has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. The State Agency shall be informed that an occurrence of potential abuse has been reported and is being investigated.