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	12/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect residents' right to be free from physical abuse by another resident. This resulted in R1's abuse by R2, R3's abuse by R2, and R7's abuse by R5. R1, R2, R3, R5, and R7 are five of eight residents reviewed for abuse in the sample list of 12. Findings include:The facility's Abuse Prevention and Reporting- Illinois policy dated 10/24/22 documents the facility affirms the residents' right to be free from abuse and prohibits abuse and mistreatment of residents. This policy documents physical abuse is the infliction of injury that occurs other than by accidental means and includes hitting, slapping, pinching, and kicking. 1.) The facility's Abuse Investigation Checklist documents on 12/10/25 at 5:00 PM an allegation of physical abuse involving R1 and R2. R2 hit R1 on the left side of R1's face while in the dining room, which was witnessed by V3 Certified Nursing Assistant (CNA). There were no injuries. V3's statement documents R2 pointed at R1 as they were seated at the same table and then R2 slapped R1 on the left cheek. V3 attempted to get to them as fast as V3 could and removed R2 from R1's table. R2 started hitting V3. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is rarely/never understood, has poor recall and memory impairment. R2's active care plan documents R2 has Alzheimer's Disease. This care plan includes a problem area dated 4/12/24 that R2 can be combative when approached and includes an intervention to be aware of R2's whereabouts and R2 should be in the dining room or lobby when up in wheelchair. R1's MDS dated [DATE] documents R1 as cognitively intact. On 12/22/25 at 9:08 AM R1 was interviewed but did not recall the incident where R1 was slapped. On 12/23/25 at 9:35 AM V3 CNA stated: R1's/R2's altercation occurred in the dining room just prior to supper. R1/R2 were seated next to each other, R2 was fidgeting with a clothing protector and pushed it towards R1. R1 pushed it back to R2 and I removed the clothing protector. Then V3 saw R2 lean over the table and put R2's finger in R1's face, but V3 could not hear what was said. R2 then put her hand next to R1's face and threatened to hit R1. V3 tried to get to them to intervene, but then R2 open handed smacked R1 on the left side of R1's face. There was no redness or injury and R1 just kind of looked at R2 like a deer in the headlights. R1 is always quiet, but R2 is like a switch that turns on/off and R2 has been involved in prior altercations with staff/residents. As V3 removed R2 from the table R2 started hitting V3. 2.) The facility's Abuse Investigation Checklist documents an allegation of verbal and physical altercation between R2 and R3, who both have dementia/Alzheimer's Disease. On 11/22/25 at 11:45 AM R3 spoke to R2 and R2 hit R3 in R3's right arm, witnessed by V14 CNA. There were no injuries. V14's statement documents V14 was pushing a resident into the dining room for lunch and came around the corner to see R2 pushing a transfer chair. V15 (R3's Family) was pushing R3 in a wheelchair through the lobby and past R2. R3 asked R2 what R2 was doing, R2 brought her fist up and hit R3 in his right upper arm. V15's statement documents R3 was very excited that V15 was visiting and R3 speaks with incorrect words at times. As they passed into the hallway from the lobby, R3 yelled at R2 something like what are you doing and a lot of times cuss words are mixed up in R3's wording. R2 responded by hitting R3's arm. R3's MDS dated [DATE] documents R3 has severe cognitive impairment and have verbal and physical behaviors directed towards others 1-3 days during the 7 day review period. On 12/22/25 at 12:19 PM V14 CNA stated V14 witnessed R2's/R3's altercation.V17 was pushing R3 through the doorway of the 200 hallway. R3 said hi to R2 as they passed. R2 took her fist and hit R3 in his right arm. V14 confirmed R3's actions were intentional and not by accident. R3 had no signs of injury. 3.) The facility's Abuse Investigation Checklist documents an allegation of verbal and physical altercation between R5 and R7, who both have Alzheimer's/Dementia. On 11/14/25 at 4:00 PM in the front lobby, R7 was yelling, R5 told R7 to shut up, and then R5 hit R7 on R7's right thigh, witnessed by V5 CNA. V5's statement documents R7 was in the front lobby yelling like R7 does, V5 heard R5 yell back and V5 went to separate R5 and R7. As soon as V5 got to them, R5 hit R7 on R7's right thigh which left a small red mark. R5's MDS dated [DATE] documents R5 has severe cognitive impairment. R5's active care plan documents R5 is at risk for abuse/neglect and R5 can have aggressive behavior. This care plan includes an intervention dated 4/26/25 documents if staff hear R5 raising her voice redirect R5 with coffee or snacks and encourage R5 to move away from whomever R5 is talking to or move the other resident away from R5. R7's MDS 9/24/25 documents R7 is rarely/never understood and has poor recall and memory impairment. On 12/22/25 at 8:54 AM R5 was self propelling her wheelchair down the 200 hallway. Attempts were made to interview R5, who became increasingly agitated with conversation and R5 cursed at the surveyor. On 12/22/25 at 3:06 PM V5

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide toileting assistance/incontinence care in a timely manner for two residents (R4, R12) of five residents reviewed for bowel and bladder in a sample list of 12. Findings Include: The facility's Call Light Policy, reviewed 2/2/18, states: Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner. All residents who have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility at the bedside or another reasonably accessible location. All staff should assist in answering call lights. Nursing staff members shall go to the resident's room to respond to the call system and promptly cancel the call light when the room is entered. Bathroom call lights should be viewed as emergencies and given immediate attention. The facility's Incontinence Care Policy, reviewed 1/16/18, states: Purpose: To prevent excoriation and skin breakdown, provide comfort, and maintain dignity. Guidelines: Incontinent residents will be checked periodically in accordance with assessed incontinent episodes or at least every two hours and will be provided perineal and genital care after each episode. 1.) R4's Care Plan, updated 10/27/25, includes the following diagnoses: Cerebral Infarction, Hyperlipidemia, Hypertension, Gastroesophageal Reflux Disease without esophagitis, Type 2 Diabetes Mellitus, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Nondominant Side, and Protein-Calorie Malnutrition. R4's Minimum Data Set (MDS), dated [DATE], documents R4 as cognitively intact and requiring staff assistance with Activities of Daily Living (ADLs). R4's Care Plan, updated 10/27/25, documents that R4 requires check and change for incontinence. Provide (R4) with good peri-care and use barrier creams as needed. On 12/22/25 at 10:00 AM, R4 stated, My family members work here and all the staff help me and treat me good. They come in as soon as they can and help me when I put on my light, but sometimes at night they are busy and it's a long wait. R4 appeared clean, with no obnoxious odors observed. R4's nails and hair appeared clean and groomed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/22/25 at 10:15 AM, V12 (R4's family member) stated that on 11/22/25, R4 went all day without being checked for incontinence or changed, and when V11, a family member, visited late in the afternoon, R4's call light was on and R4 had been incontinent of feces. V12 stated V8, Certified Nurse's Aide (CNA), and V9, Certified Nurse's Aide (CNA), answered the call light and said they would be back to clean R4. After 45 minutes, V11 cleaned R4 and assisted her to her wheelchair. V8 or V9 did not return. On 12/22/25 at 12:00 PM, V11, a Certified Nurse's Aide (CNA) and R4's family member, stated, I was called in to work on 12/1/25, and R4's call light was on. I went in to change R4, and she had dried feces all over her. I scrubbed it off, but it caused R4 pain and made her skin red and irritated. On 12/22/25 at 2:00 PM, V8 stated, I do remember that day, though I'm not sure of the exact date. By the time V9 and I got back to clean up R4, V11 had already done it. On 12/23/25 at 10:00 AM, R4 was lying in her bed looking out the window. R4 appeared clean and appropriately groomed. R4 stated, I don't want to get the staff in trouble or anything, but I do lay here sometimes all night in pee and poop. It is not their fault. I don't think they have enough help sometimes. It makes me feel uncomfortable, and it's kind of disgusting. R4 looked away and frowned. 2.) On 12/23/25 at 6:17 AM, 6:30 AM, 6:40 AM, and 6:45 AM, R12's call light was on. At 6:50 AM, R12's call light was no longer on. R12 was sitting on the side of her bed with her pants at her knees. R12 stated an unidentified housekeeper had answered her call light and told her she would get staff to help. R12 stated she had been waiting to use the bathroom, which was why her call light was on. R12 stated she has waited up to 45 minutes in the past, which has caused her to urinate in her pants due to waiting so long. At 7:00 AM, V21, Certified Nursing Assistant (CNA), entered R12's room. V21 stated she and the other CNA, V31, were in another resident's room performing a full mechanical lift transfer. R12 told V21 that her call light had been on for at least 20 minutes, which she stated was a long time to wait when needing to use the bathroom. V21 assisted R12 to the bathroom, and R12 was wearing an incontinence brief. At 7:10 AM, R12 stated she wears incontinence briefs so that when she is incontinent, her pants will not get wet. R12 stated she does not like waiting so long that it causes her to be incontinent, stating, It's awful. R12's Minimum Data Set (MDS), dated [DATE], documents R12 as cognitively intact, occasionally incontinent of bowel and bladder, and requiring partial/moderate staff assistance for toileting hygiene and supervision/touch assistance for transfers. R12's active Care Plan documents that R12 receives diuretic therapy and has diagnoses of morbid obesity and complex pain syndrome. On 12/23/25 at 7:07 AM, V21 stated that two CNAs are not enough for R12's hallway, describing it as a heavy hall. V21 stated mornings are busy completing showers, which can affect call light response times. V21 stated there are 12–13 residents on the hall who require mechanical lift transfers with two staff. V21 stated all staff are supposed to help answer call lights. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/25 at 10:38 AM, V1, Administrator, stated that call lights should be answered timely and that all staff are expected to answer call lights so assistance can be provided. V1 confirmed that a 30–45 minute response time would not be considered timely for a call light or toileting request.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to develop and implement interventions to address dementia related behaviors for four of eight residents (R2, R3, R5, R7) reviewed for abuse in the sample list of 12. Findings include: 1.) The facility's Abuse Investigation Checklist documents an allegation of a verbal and physical altercation between R2 and R3, both of whom have dementia/Alzheimer's disease. On 11/22/25 at 11:45 AM, R3 spoke to R2, and R2 struck R3 on R3's right arm. The incident was witnessed by V14, Certified Nursing Assistant (CNA).V14's statement documents that V14 was pushing a resident into the dining room for lunch and came around the corner to observe R2 pushing a transfer chair. V15 (R3's family member) was pushing R3 in a wheelchair through the lobby past R2. R3 asked R2 what R2 was doing, at which time R2 raised her fist and hit R3 on his right upper arm.The facility's Abuse Investigation Checklist also documents that on 12/10/25 at 5:00 PM, there was an allegation of physical abuse involving R1 and R2. R2 struck R1 on the left side of R1's face while in the dining room. The incident was witnessed by V3, CNA. Documentation notes that R2 has mood swings and can be aggressive, including toward family members, and that it is best for R2 to sit at a dining room table where staff are also seated.V3's statement documents that R2 pointed at R1 while they were seated at the same table and then slapped R1 on the left cheek. As V3 removed R2 from the table, R2 began hitting V3.R2's active care plan includes a problem area dated 4/12/24 identifying that R2 can be combative when approached. The care plan includes interventions dated 4/12/24 and 4/24/24 to be aware of R2's whereabouts, to have R2 remain in the dining room or lobby when up in a wheelchair, and to report behaviors to psychiatric services following any encounters with other residents. The care plan has not been updated with new interventions following R2's altercations with R1 and R3.There is no documentation indicating that R2 was evaluated by psychiatric services following these altercations.On 12/22/25 from 12:03 PM to 12:13 PM, R1 and R2 were seated next to each other in the dining room, and no staff were seated at their table. At 12:13 PM, V33, Dietary Aide, confirmed this and stated that the previous Tuesday R1 and R2 were not seated next to each other. V23, CNA, entered the dining room and told V34, Dietary Aide, that R2 was not supposed to be sitting there and moved R2 to a different table. At 12:18 PM, V34 stated she was not aware that R2 was not supposed to sit with R1 and that R1 and R2 had been seated beside each other the previous Wednesday when V34 last worked.On 12/22/25 at 12:19 PM, V14, CNA, stated she witnessed the altercation between R2 and R3. V17 was pushing R3 through the doorway of the 200 hallway. R3 said hello to R2 as they passed. R2 raised her fist and struck R3 on his right arm. V14 confirmed that R2's actions were intentional and not accidental.On 12/23/25 at 9:35 AM, V3, CNA, stated that the altercation between R1 and R2 occurred in the dining room just prior to supper. R1 and R2 were seated next to each other, and R2 was fidgeting with a clothing protector and pushed it toward R1. R1 pushed it back, and V3 removed the clothing protector. V3 then observed R2 lean over the table and place her finger in R1's face, though V3 could not hear what was said. R2 then placed her hand near R1's face and threatened to hit R1. V3 attempted to intervene, but R2 then open-handedly struck R1 on the left side of R1's face. There was no redness or injury observed, and R1 appeared startled. V3 stated R2 is like a switch that turns on and off and has been involved in prior altercations with staff and residents. As V3 removed R2 from the table, R2 began hitting V3. V3 was unsure what new interventions were implemented following the altercation, including whether dining room seating was changed.On 12/22/25 at 12:30 PM, V1, Administrator, stated R2's dining room seating was changed immediately following the altercation with R1 and confirmed R2 is not supposed to sit next to R1. At 1:20 PM, V1 stated R2's Celexa dosage was decreased on 11/12/25, when R2 was last evaluated by psychiatric services. V1 stated the primary physician would be asked to re-evaluate R2 to determine if the Celexa dosage could be increased back to the prior level due to the timing of the medication reduction and subsequent altercations. On 12/23/25 at 8:00 AM, V1 confirmed that no new interventions were implemented following the altercation between R2 and R3 and that R2's care plan had not been updated.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure resident medical records are complete/accurate by failing to document resident to resident altercations and family and physician notifications for four of eight residents (R2, R3, R5, R7) reviewed for abuse in the sample list of 12. 1.) The facility's Abuse Investigation Checklist documents an allegation of a verbal and physical altercation between R2 and R3, both of whom have dementia/Alzheimer's disease. On 11/22/25 at 11:45 AM, R3 spoke to R2, and R2 struck R3 on R3's right arm. The incident was witnessed by V14, Certified Nursing Assistant (CNA). V14's statement documents that V14 was pushing a resident into the dining room for lunch and came around the corner to observe R2 pushing a transfer chair. V15 (R3's family member) was pushing R3 in a wheelchair through the lobby and past R2. R3 asked R2 what R2 was doing, at which time R2 raised her fist and struck R3 on his right upper arm.V15's statement documents that R3 was very excited about the visit and that R3 sometimes uses incorrect words. As they passed from the lobby into the hallway, R3 yelled at R2 something like, What are you doing, with profanity sometimes mixed into R3's wording. R2 responded by striking R3's arm.R2's and R3's medical records do not include documentation of this altercation, nor documentation that their families and physicians were notified.On 12/22/25 at 1:24 PM, V16, Licensed Practical Nurse (LPN), confirmed she was the nurse for R2 and R3 at the time of the 11/22/25 altercation. V16 stated that documentation of altercations is completed at the discretion of V1, Administrator. V16 confirmed that documentation and physician/family notification would typically be recorded in a nursing note.2.) The facility's Abuse Investigation Checklist documents an allegation of a verbal and physical altercation between R5 and R7, both of whom have Alzheimer's disease/dementia. On 11/14/25 at 4:00 PM in the front lobby, R7 was yelling, R5 told R7 to shut up, and then R5 struck R7 on R7's right thigh. The incident was witnessed by V5, Certified Nursing Assistant (CNA).V5's statement documents that R7 was yelling in the front lobby, as was typical behavior. V5 heard R5 yell back and went to separate R5 and R7. As soon as V5 arrived, R5 struck R7 on the right thigh, leaving a small red mark.R5's and R7's medical records do not include documentation of this altercation, nor documentation that their families and physicians were notified.On 12/22/25 at 1:50 PM, V1 stated there should be a nursing note documenting a brief summary of the incident, including physician and family notification. V1 stated there was no incident report completed for this altercation.The facility's undated Medical Record Policy documents that progress notes will indicate significant changes in resident condition when they occur, and nurses will document nursing notes including behaviors, physician notification, and family notification.