STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146076	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Clinton	1 Park Lane West Clinton, IL 61727

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42702 Based on interview and record review the facility failed to ensure the dignity of one (R1) of three residents reviewed for dignity from a total sample list of seven residents. Findings include: The facility provided Dignity Policy dated 4/23/18 documents that the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and a respect in full recognition of his or her individuality. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. R1's undated diagnosis sheet documents R1's diagnoses include: Epilepsy, Primary Hypertension, and Venous Thrombosis with Embolism. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact. On 4/30/25 at 11:33AM, R1 stated there have been several times when she doesn't receive her medications and that it is usually from an agency nurse who she doesn't know. R1's physician order dated 2/3/25 documents Keppra (anti-seizure) 1000 milligram (MG), twice daily. R1's physician order dated 2/18/25 documents Oxcarbazepine ((anti-seizure) 150MG, twice daily. On 4/30/25 at 11:33AM, R1 stated, Sunday evening I am supposed to get my medicines between 4-8. I didn't get them until 1:00AM. When I asked the nurse about getting my seizure medications, she said, Well, I guess you will just have to have a seizure. On 5/5/25 at 1:20PM, V14 Licensed Practical Nurse (LPN) stated that she was incredibly overwhelmed that Sunday night and that she had been told in report that R1 had asked for her medications all day. I was very curt to R1 because I was overwhelmed and was trying not to make a medication error. Her medications were late. (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 - Few	On 5/5/25 at 1:00PM, V2 Director of Nursing stated that he expected staff to treat residents professionally at all times and that it was unacceptable and rather harsh to tell someone that they would just have to go ahead and have a seizure. On 5/5/25 at 12:45PM, R1 stated that when (V14 LPN) told her that she would just have to have a seizure because she hadn't had her medications, I thought it was very disrespectful and unprofessional and it made me feel uncared for and undignified.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview, and record review the facility failed to have linens and incontinence briefs for three of seven residents (R5, R6, R7) reviewed for resident preferences from a total sample list of seven residents. Findings include: 1.) On 5/5/25 at 9:37 AM R5 stated the facility ran out of her size briefs the weekend of April 26-27, 2025. R5 stated that they gave her a smaller size to use which was uncomfortable. R5's Minimum Data Set, dated dated dated [DATE] documents R5 is cognitively intact. On 5/5/25 at 9:40 AM R6 stated about a week or so ago they ran out of several sizes of briefs. They gave her a smaller size and she wasn't able to fasten them. R6's Minimum Data Set, dated dated dated [DATE] documents R6 is moderately cognitively intact. The facility provided purchase order dated 4/25/25 documents a rush order submitted at 9:20AM for extra large briefs, large briefs, ultra size briefs, and medium size briefs. On 4/30/25 at 9:35AM V4 Certified Nursing Assistant (CNA) stated that she worked on Friday (4/25/25) and she knew they ran out of briefs from Saturday until Sunday. On 4/30/25 at 1:00PM, V7 CNA stated, I worked this weekend and we ran out of bariatric briefs, double extra large and extra large briefs. On 4/30/25 at 10:00AM, V2 Director of Nursing (DON) stated that he knew that they were low on brief supplies, but he didn't know that they had run out. On Friday 4/25/25, (V2) tried to use the corporate credit card but that it had a negative balance so he could not go to (store name) or anywhere else for the supplies. The DON stated that he was ordering the supplies because the regular supply person was off. V1 Administrator confirmed that they had tried to use the credit card unsuccessfully and that they worked together to try to get a rush order to go through because the big order could not be approved. When asked if there was a system or mechanism for obtaining supplies in a situation such as this, V1 Administrator stated that a system needed to be developed for supply management. 40385 2.) The facility's Resident Council Meeting Minutes dated 4/9/25 document a new concern regarding if there are enough linens and an ongoing concern regarding the use of wipes. R7's Minimum Data Set, dated dated dated [DATE] documents R7 is cognitively intact. On 5/5/25 at 10:14 AM R7 stated the facility has run out of washcloths since the facility stopped using incontinence wipes, and currently R7's hallway (100 hall) does not have any washcloths. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/5/25 at 10:28 AM V11 Certified Nursing Assistant (CNA) stated since the change in ownership the facility no longer provides wipes, and they have run out of washcloths for the last two to three weeks. V11 stated V11 thinks staff are throwing the wash clothes away instead of using the hopper to rinse prior to laundering. V11 stated this has been an ongoing issue that has been brought to laundry's attention. V11 stated V11 does not currently have any washcloths on the 100 hallway and V11 uses bath towels when washcloths are unavailable. The linen carts on the 100 hall/shower room and clean linen closet were viewed with V11, and V11 confirmed these carts/rooms did not contain a supply of washcloths. On 5/5/25 at 10:34 AM V10 CNA stated V10 only had a few wash clothes this morning on the 200 hallway, and the supply was used up. The clean linen room on the 200 hall was viewed with V10, who confirmed there was no supply of washcloths. On 5/5/25 at 10:36 AM V12 CNA stated there are frequently not enough washcloths for resident use. There were four washcloths on the 300 hall, confirmed with V12. On 5/5/25 at 10:37 AM The laundry room was viewed with V9 Laundry Aide. There were no washcloths readily available in the laundry room. V9 stated there have been times that the CNAs come to laundry because they have run out of washcloths, and the CNAs get upset when they don't have any washcloths to give them. V9 stated there are washcloths currently in the washer, but none readily available at this time. On 5/5/25 at 10:42 AM the clean linen carts on the 400 hall were viewed with V13 CNA, who confirmed there were seven washcloths. V13 stated the facility frequently runs out of washcloths since changing from wipes to washcloths.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to provide ordered dressing changes and failed to accurately document worsening pressure wound staging for three (R2, R3, and R4) of four residents reviewed for pressure wounds from a total sample list of seven residents. Findings include: The facility provided Pressure Injury and Skin Condition assessment dated [DATE] documents the facility policy is to assess, monitor, and document the presence of skin breakdown, pressure injuries, and other ulcers and to insure that interventions are implemented. Pressure and other ulcers will be assessed and measured at least every seven days and documented in the resident's clinical record. Physician ordered treatments shall be initialed by the staff on the treatment administration record after each administration. 1.) R4's wound report dated 2/1/25-4/30/25 documents R4 has a facility acquired skin tear on the right outer ankle, identified on 4/10/25. On 4/30/25 at 1:20PM, V3 Wound Nurse stated that the wound began as a skin tear and that is how it is being treated. R4's physician wound evaluation and treatment dated 4/17/25 documents that after debridement, R4's wound was documented as a stage three wound. R4's physician order dated 4/16/25 documents to cleanse the right ankle and above the ankle with wound wash, cover with a single layer of Xeroform, apply an abdominal dressing and secure it daily. R4's treatment administration record dated 4/22/25 documents the dressing change was not completed. On 4/30/25 at 1:15PM, V3 Wound Nurse performed R4's wound dressing on her right ankle. The wound is the size of a dime and oval in shape. No slough or infection is noted. On 5/5/25 at 1:15PM, V3 Wound Nurse stated that she did not realize that V8 Wound Physician had identified R4's wound as a stage three wound and that changes would be made to ensure that she was aware of the development and plan for wounds based on the wound physician's rounds. 2.) R2's wound report dated 1/30/25-4/30/25 documents R2 was admitted to the facility on [DATE] with a right heel pressure wound. R2's physician order dated 4/16/25 documents the treatment for the right medial heel includes cleaning the area with wound wash, applying a thick coat of Santyl, apply Dakin soaked gauze, cover with a gauze dressing, wrap with gauze wrap and then securing, daily. R2's April 2025 treatment administration record documents that the dressing was not completed on 4/25/25, 4/26/25 and 4/27/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) R3's March physician order dated 2/28/25-3/7/25 documents an order to cleanse the left hip with normal saline, pack loosely with Iodoform gauze and cover with an abdominal pad twice daily. R3's March physician order dated 3/7/25-3/28/25 documents an order to cleanse the left hip with normal saline and then pack with one single long strand of gauze, covering with an abdominal pad twice daily. R3's March 2025 treatment administration record dated: 3/2/25 PM, 3/17/25 PM, 3/18/25 PM, 3/19/25PM, 3/20/25PM, 3/21/25PM, 3/23/25PM, 3/24/25PM, 3/25/25PM and 3/26/25 PM document that R2 did not receive her evening (PM) wound dressing change. On 4/30/25 at 1:30PM, V3 Wound Nurse stated that if a dressing change isn't documented, it wasn't done.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to administer medications according to physician orders for two of three residents (R1, R2) reviewed for medication administration in the sample list of seven. Findings include 1.) The facility provided Medication Preparation and General Guidelines Policy dated December 2019 documents that it is the policy of the facility to administer medications as prescribed. Medications are administered within 60 minutes of scheduled times. Current medications are listed on the Medication Administration Record (MAR) and the MAR is initialed by the person administering the medication, in the space provided under the date. If a scheduled medication is not given, an explanation is documented. R1's April/May 2025 medication administration record documents orders for Amiloride (potassium sparing medication) 10 Milligrams (MG) daily, Celexa (antidepressant) 20 MG daily, Cranberry tablets (urinary health) 400MG daily, Fiber-Lax (constipation preventative) 625MG daily, and Famotidine (acid reducer) 20 MG twice daily. R1's April medication administration record documents the following medications were not administered as ordered on the following dates: Amiloride 5MG on 4/22/25, Celexa on 4/22/25, Cranberry 400MG on 4/22/25 & 4/23/25, Fiber-Lax 625MG on 4/22/25, 4/28/25 and 4/29/25, Famotidine 20MG 4/22/25 AM, 4/23/25 AM and PM, and 4/26/25 AM. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as cognitively intact. On 4/30/25 at 11:33AM, R1 stated that there have been several times when she hasn't received her medications, usually in the evening and usually from an agency nurse with whom she is not familiar. 2.) R2's April/May 2025 medication administration record documents orders for Aspirin 81MG, 75MG, CoQ-10 (enzyme) 100MG, Daily Multivitamin, Fenofibrate (decreases cholesterol) 160MG, 100MG daily, Miralax (constipation preventative) 17 Grams, Myrbetriq (bladder activity) 25 MG daily and Rosuvastatin (decreases cholesterol) 40MG all daily. R2's April/May 2025 medication administration record documents the following medications were not administered as ordered on the following dates: Aspirin 81MG on 4/25/25 and 5/4/25 daily, CoQ10 on 4/25/25 and 5/4/25 daily, Multivitamin on 4/25/25 and 5/4/25 daily, Fenofibrate 160MG on 4/25/25 and 5/4/25 daily, Rosuvastatin 40MG on 4/24/25 daily, Myrbetriq 25MG on 4/25/25 and 5/4/25 daily. On 4/30/25 at 12:00PM, V2 Director of Nursing stated that he did not know why R1 and R2's medications were not given as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 11:36AM, V2 Director of Nursing stated that he would expect medications to be given as ordered, if they weren't documented, they weren't given, and the failure to give medications as ordered can be harmful to a resident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to administer medications as ordered resulting in repeated significant medication errors for two (R1, R2) of three residents reviewed for significant medication errors from a total sample list of seven. Findings include: The facility provided Medication Preparation and General Guidelines Policy dated December 2019 documents that it is the policy of the facility to administer medications as prescribed. Medications are administered within 60 minutes of scheduled times. Current medications are listed on the Medication Administration Record (MAR) and the MAR is initialed by the person administering the medication, in the space provided under the date. If a scheduled medication is not given, an explanation is documented. R1's undated diagnosis sheet documents R1's diagnoses include: Epilepsy, Primary Hypertension, and Venous Thrombosis with Embolism. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact. On 4/30/25 at 11:33AM, R1 stated there have been several times when she doesn't receive her medications and that it is usually from an agency nurse who she doesn't know. R1's physician order dated 2/3/25 documents Keppra (anti-seizure) 1000 milligram (MG), twice daily. R1's physician order dated 2/18/25 documents Oxcarbazepine (anti-seizure) 150MG, twice daily. R1's physician order dated 11/28/24 documents Chlorthalidone (diuretic) 12.5MG daily. R1's physician order dated 3/29/24 documents Eliquis (platelet inhibitor) 5MG twice daily. R1's physician order dated 4/17/25 documents Amlodipine (blood pressure) 5MG daily. R1's April/May 2025 medication administration record documents that Keppra 1000MG was not given on 4/22/25 for the AM dose and on 4/23/25 for the PM dose. Chlorthalidone 25MG was not given on 4/22/25 or 4/26/28 daily doses. Eliquis 5MG was not given on 4/22/25 AM dose, 4/23/25 AM dose and 4/23/25 PM dose. Amlodipine 5MG was not given on 4/19/21 and 4/21/25 daily doses. R2's undated diagnosis sheet documents the following diagnoses include: Diabetes, Ocular Hypertension, Primary Hypertension, Peripheral Vascular Disease, and Heart Disease. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's April/May 2025 medication administration record documents physician orders for Clopidogrel (antiplatelet) 75MG, Glimepiride (anti-diabetic) 1MG, Hydrochlorothiazide (blood pressure) 12.5MG, Lisinopril (blood pressure) 20MG, Metoprolol Succinate (blood pressure) 100MG daily, Metformin Extended Release (anti-diabetic) 750 MG twice daily, Cephalexin (antibiotic) 500 MG three times daily, and Pregabaline (anti-seizure) 25MG daily. R2's April/May 2025 medication administration record documents the following medications were not administered as ordered on the following dates: Clopidogrel 75MG on 4/25/25 and 5/4/25 daily, Glimepiride 1MG on 4/25/25 and 5/4/25 daily, Hydrochlorothiazide 12.5MG on 4/25/25 and 5/4/25 daily, Pregabaline 25MG on 4/23/25 daily, Lisinopril 20MG on 4/25/25, 5/4/25 daily, Metoprolol Succinate 100MG on 4/25/25 and 5/4/25 daily, Metformin 750MG on 4/25/25 and 5/4/25 both the AM doses, and Cephalexin 500MG on 4/19/25 at the 4:00PM dose. On 4/30/25 at 12:00PM, V2 Director of Nursing stated that he did not know why R1 and R2's medications were not given as ordered. On 5/5/25 at 11:36AM, V2 Director of Nursing stated that he would expect medications to be given as ordered and the failure to do so can be harmful to a resident.