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	06/03/2025

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide consistent quality care for five of eight residents (R1, R2, R5, R6, R7) reviewed for nursing care on the sample list of eight. Findings Include: The Facility assessment dated [DATE] documents all medical and non-medical supplies needed and ordered by the physician will be provided to the resident in a timely manner. If equipment is not in the facility, it will be ordered and provided, borrowed from a sister facility or rented to endure the needs of the residents are met. Staffing is adjusted based on resident census and acuity. Resident preferences and suggestions are elicited during resident council meetings and will be taken into consideration. Concerns will be addressed as appropriate and the need for additional staff will be considered to meet the needs of the residents in the facility. The facility's March 2025 Grievance Log and Resident Council Minutes document resident concerns with not getting scheduled showers. The summary of findings, documents showers were indeed not being completed due to use of agency staff not completing assigned tasks. The facility's April 2025 Grievance Log and Resident Council Minutes document resident concerns with call light response times, not enough staff on resident units, staff being on their phones while on the clock, ice water not being passed, staff being loud in the hallways at night, and scheduled showers not being provided. The summary of findings, documents showers were indeed not being completed due to increased use of agency staff who are not completing assigned tasks/cares. The facility's May 2025 Grievance Log and Resident Council Minutes document resident concerns with staff being on their phones while on the clock, ice water not being passed, staff being loud in the hallways at night, and two-hour checks not being done. 1. R1's Medical Diagnoses List dated June 2025 documents R1 is diagnosed with Hemiplegia and Hemiparesis post Stroke, Chronic Obstructive Pulmonary Disease, Muscle Atrophy, Dysphagia, and Reduced Mobility. R1's Minimum Data Set, dated [DATE] documents R1 is cognitively intact and requires max assist for activities of daily living and is dependent on staff for transfers. R1 requires the use of a motorized wheelchair for mobility. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/25 at 12:30 PM V4 R1's Daughter stated on 5/17/25 R1 called her about 7:30 PM to tell her she could not find any staff to help her get ready for bed. V4 stated she came to the facility and assisted R1 to bed and then walked through the facility to find staff. V4 stated she walked through the entire facility two times and did not see any staff. V4 stated she finally found one male staff member (unknown) sleeping in a dark area at the end of one hall and then found another staff member, V3 Licensed Practical Nurse (LPN), who attempted to help her find others. V3 and V4 walked around the facility two more times without finding any other staff members. V4 stated she asked V3 LPN to call V2 Director of Nurses (DON) and let him know that staff were not available to meet the needs of the residents. V4 stated as she and V3 walked around the facility they observed many resident call lights on and some residents asleep in their wheelchairs in the common areas. V4 stated when she spoke with V2 DON the next day he told her they have had issues with some of the agency Certified Nursing Assistants (CNAs) they have had working in the building. On 5/27/25 at 2:35 PM V3 LPN confirmed that V4 approached her looking for staff on the night of 5/17/25. Both V3 and V4 searched the building twice and could not find anyone else. V3 confirmed V4 was very upset and worried that there was no one there to care for her mother (R1). V3 stated she reassured V4 that she would be calling V2 DON and letting him know about the situation. V3 stated after V4 left the building V3 found out that R1's assigned aide (unknown) had gone to lunch without telling V3. V3 stated she has had many issues with the agency staff who come to work at the facility. V3 stated the aides will tell charge nurses what they will and won't do and they often have attitudes and don't do the work they are supposed to be doing. V3 stated staff have just left for break and not come back or they don't show up for their shift at all. V3 stated she knows family members of residents see the decline in care and are upset about it and she is frustrated that she is unable to do anything about it. On 6/3/25 at 3:30 PM R1 stated she regularly has issues getting her call light answered in a timely manner. Staff will come in and turn off the call light and say they will be back but then never come back. R1 stated on 5/17/25 when she called her daughter, it was because she was unable to find anyone to help her get ready for bed. 2. R2's Medical Diagnoses List dated June 2025 documents R2 is diagnosed with Diabetes, Anxiety, Major Depression, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Irritable Bowl Syndrome, Repeated Falls, and Lack of Coordination. R2's Minimum Data Set, dated [DATE] documents R2 has a mild cognitive impairment and requires partial assist for activities of daily living and is independent for most transfers. R2 requires the use of a manual wheelchair for mobility. On 5/30/25 at 3:19 PM R2 stated she has issues getting her call light answered in a timely manner. R2 feels the facility needs more staff especially at night in order to provide better care for the residents. R2 stated she feels the quality of care she receives has gone down in the few months. 3. R5's Medical Diagnoses List dated June 2025 documents R5 is diagnosed with Diabetes, Down Syndrome, Depression, Congestive Heart Failure, Prosthetic Heart Valve, Long Term Anticoagulant Use, and Lack of Coordination. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Minimum Data Set, dated documents R5 is 5/1/25 documents R5 is cognitively intact and requires supervision or touching assist for most activities of daily living and transfers. R5 requires the use of a manual wheelchair for mobility. R5's Progress Note dated 5/21/25 documents R5's PT/INR (Prothrombin Time/International Normalized Ratio) results and a physician order to take ten milligrams of Coumadin and recheck PT/INR the following Monday (5/26/25). R5's Progress Note dated 5/29/25 documents R5's PT/INR lab work would be taken on 5/30/25 by outside laboratory. R5's Progress Note dated 5/30/25 documents R5's PT/INR lab work was completed and resulted with a PT of 27.3 and INR of 3.9. Orders were received to hold R5's Coumadin dose for two days and recheck PT/INR on 6/1/25. On 6/3/25 at 3:20 PM R5 stated the facility could use more staff especially at night and the staff often take a long time to answer call lights. Sometimes she waits longer than 30 minutes. R5 confirmed she takes a blood thinner and get blood work done regularly due to her blood thinning medication. R5 confirmed her blood work was delayed last week. 4. R6's Medical Diagnoses List dated June 2025 documents R6 is diagnosed with Congestive Heart Failure, Anxiety, Diabetes, Lack of Coordination, and Atrial Fibrillation. R6's Minimum Data Set, dated [DATE] documents R6 is cognitively intact and requires partial or moderate assist for most activities of daily living and supervision or touching assist for transfers. R6 requires the use of a manual wheelchair for mobility. R6's Progress Note dated 5/21/25 documents R6's PT/INR (Prothrombin Time/International Normalized Ratio) results and a physician order to hold R6's Coumadin dose for one night and recheck PT/INR in one week (5/28/25). R6's Progress Note dated 5/29/25 documents R6's PT/INR lab work would be taken on 5/30/25 by outside laboratory. R6's Progress Note dated 5/30/25 documents R6's PT/INR lab work was completed and resulted with a critical INR of 5.82. Orders were received to hold R6's Coumadin dose, give five milligrams of Vitamin K, and recheck PT/INR on 5/31/25. On 6/3/25 at 3:23 PM R6 stated the facility could use more staff especially at night and the staff often take a long time to answer call lights. Sometimes she waits longer than 30 minutes. R6 stated the week prior (5/28/25) she was told her blood work couldn't be done on time because the facility did not have the testing strips they needed. R6 stated she had to wait two extra days (5/30/25) for the blood test. 5. R7's Medical Diagnoses List dated June 2025 documents R7 is diagnosed with Diabetes, Vascular Dementia, Anxiety, Insomnia, Dysphagia, Difficulty Walking, and Communication Deficit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Minimum Data Set, dated [DATE] documents R7 is cognitively intact and requires moderate or maximal assist for most activities of daily living transfers. R6 requires the use of a manual wheelchair for mobility. On 5/30/25 at 2:50 PM R7 stated the facility could use more staff and she often waits a long time for her call light to be answered. R7 feels the quality of care has gone down. On 5/30/25 at 4:15 PM V2 Director of Nurses confirmed the facility has had to use more agency staff, especially CNAs. V3 confirmed they have had issues with the bad attitudes of agency staff and because they can just go work anywhere it is hard to keep those staff accountable for their actions or lack of actions. V2 acknowledged that this creates a risk for poor quality of resident care. On 6/3/25 at 10:30 AM V7 Registered Nurse stated she has seen an issue with long call light wait times and believes staffing is an issue not because they are short staffed but because the agency staff they have on the schedule usually aren't the best workers and don't do their jobs well. On 6/3/25 at 3:56 PM V2 DON confirmed the facility did not have the PT/INR testing strips they needed to complete physician ordered PT/INR tests. V2 confirmed the staff delayed the tests which were completed 2-3 days after originally ordered. V2 confirmed R6's lab result came back a critical result on 5/30/25. V2 confirmed the facility still does not have the Pt/INR test strips in house but instead are now drawing resident's blood and sending it to the lab in order to complete the PT/INR tests timely. V2 also confirmed the facility has had complaints in Resident Council, with Grievances, and from residents and families concerning ice water not being passed, call lights not answered timely, showers not being done per schedule, and two-hour checks not being completed. V2 confirmed they have had some issues with the quality of work from the agency CNAs that have picked up shifts with the facility.