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	09/19/2025

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 0600 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility failed to protect the resident's right (R3) to be free of physical abuse from (R2) for two of six residents reviewed for abuse in the sample list of 19.Findings include:R2's Abuse/Neglect Screening form dated 5/1/25, documents R2 has a history of mistreating others by physical and verbal abuse, psychiatric mental health issues which include psychotic symptoms, and documents R2 cries a lot and them becomes angry with other residents.R2's undated diagnoses list documents the following diagnoses: other specified Anxiety Disorder, and Alzheimer's Disease, unspecified. R2's Progress Note/Psychotropic dated 8/21/25, documents R2's diagnoses as: Major Depressive Disorder, Dementia in other diseases classified elsewhere, severe, with Agitation, and Anxiety with somatic features.R2's Minimum Data Set (MDS) dated [DATE], documents R2 is not cognitively intact.R2's Care Plan dated 8/27/25, documents R2 has a problematic manner characterized by ineffective coping, verbal/physical aggression related to cognitive impairment.The facility's abuse report dated 8/21/25, documents R3 was in R2's room where R3 was lying in R2's bed. R2 made physical contact with R3's upper thigh.On 9/10/25 at 2:03 PM, V3 Certified Nursing Assistant (CNA) stated R2 is very verbal, tries to reach for other residents, takes their arms and grabs them often. V3 stated staff has to call R2's daughter V13, to have V13 sit with R2 to calm R2 down. On 9/16/25 at 12:22 PM, V1 Administrator stated R2 is a resident who has been physical with residents.On 9/17/25 at 10:35 AM, V2 Director of Nursing (DON) stated R2 did hit R3 on 9/11/25.The facility's Abuse Prevention and Reporting Policy dated Revisions 10/24/22, documents the facility affirms the right of the residents to be free from abuse and therefore prohibits abuse.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide multiple scheduled showers for dependent residents. This failure affected three of three residents (R6, R8, R9) reviewed for showers on the sample list of 19. Findings Include: Facilities Bathing - Shower and Tub Bath Policy dated January 2018 documents: Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: A shower, tub bath or bed/sponge bath will be offered according to resident's preference, two times per week or according to the resident's preferred frequency and as needed or requested. Staff are to document bathing task and assistance provided in the electronic record, including pertinent observations. 1. R6's Medical Diagnoses list dated September 2025 documents R6 is diagnosed with Unspecified Dementia, Generalized Anxiety, Parkinson's Disease, Insomnia, Pressure Ulcer of the Sacral Region, Overactive Bladder, Congestive Heart Failure, and Abnormalities of the Gait and Mobility. R6's Minimum Data Set (MDS) dated [DATE] documents R6 is Dependent on staff assistance for Shower/Bathing. R6's Shower/Bathe Task for the last 30 days documents R6 is scheduled to receive showers on Tuesday and Fridays from 6:00 PM - 6:00 AM. This same record documents R6 received a shower on 8/20/25, 8/23/25, 9/3/25, 9/6/25 and 9/17/25, there are no other documented showers, baths or refusals in R6's electronic medical record. 2. R8's Medical Diagnoses list dated September 2025 documents R8 is diagnosed with Chronic Kidney Disease Stage 3, Muscle Wasting and Atrophy, Sepsis, Gangrene and Diabetes Type II. R8's Minimum Data Set (MDS) dated [DATE] documents R8 requires partial/moderate assistance for Shower/Bathing. The facility's Shower List dated 8/1/25 documents R8 is supposed to have showers on Tuesday and Friday from 6:00 PM - 6:00 AM. R8's Shower/Bathe Task for the last 30 days documents R8 received a shower on 8/26/25, 9/2/25 and 9/12/25 and refused showers on 9/3/25 and 9/5/25. There are no other documented showers, baths or refusals in R8's electronic medical record. 3. R9's Medical Diagnoses list dated September 2025 documents R9 is diagnosed with Dementia, Delusional Disorder, Depression, Need for Assistance with Personal Care. R9's Minimum Data Set (MDS) dated [DATE] documents R9 requires partial/moderate assistance for Shower/Bathing. The facility's Shower List dated 8/1/25 documents R9 is supposed to have showers on Tuesday and Friday from 6:00 AM - 6:00 PM. R9's Shower/Bathe Task for the last 30 days documents R9 received a shower on 8/26/25 and 9/9/25 and refused showers on 8/22/25 and 9/12/25. There are no other documented showers, baths or refusals in R9's electronic medical record. On 9/18/25 at 2:30 PM V1 Administrator confirmed the facility provides two showers per week to residents and staff should document when showers are given or refused. On 9/18/25 at 2:45 PM V2 Director of Nurses confirmed the facility provides two showers per week for residents and staff should document the showers in the resident's electronic medical record under Task section under the bathing task. V2 confirmed staff should be documenting if a shower is given or refused and if refused staff should be notifying the nurse who should reapproach the resident and address any barriers.

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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 complete multiple wound dressing treatments and failed to address a residents repeated refusals for wound treatment. This failure affected one of three residents (R9) reviewed for wounds on the sample list of 19. Findings Include: The facility's Pressure Injury and Skin Condition assessment dated [DATE] documents the purpose of the policy is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and assuring interventions are implemented. Dressing should be changed in accordance with physician orders and documented in the Treatment Administration Record (TAR). Physician ordered treatments shall be initialed by the staff on the electronic TAR after each administration. R9's Medical Diagnoses list dated September 2025 documents R9 is diagnosed with Dementia, Delusional Disorder, Depression, Need for Assistance with Personal Care, and Malignant Neoplasm of unspecified Site of Right Female Breast. R9's Physician Order Sheet dated September 2025 documents an order for a wound treatment to her Right Breast to be completed daily.R9's Care Plan dated 4/14/25 documents R9 has a cancer ulcer under her right breast and staff are to perform treatments per physician order. R9's September 2025 Treatment Administration Record (TAR) documents three wound treatments not completed and eight refused wound treatments between 9/1/25 and 9/17/25. R9's August 2025 Treatment Administration Record (TAR) documents five wound treatments not completed and three refused wound treatments.R9's July 2025 Treatment Administration Record (TAR) documents one wound treatment not completed and four refused wound treatments. On 9/18/25 at 2:45 PM, V2 Director of Nurses confirmed staff should be completing wound orders according to physician order. If they are not completed or if the resident has repeated refusals, the staff should notify the physician and document in the resident's electronic medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a fall investigation, develop a root cause, and implement relevant fall interventions for one resident (R4) of three residents reviewed for falls in the sample list 19. This past non-compliance occurred from 8/9/25 to 8/19/25.Findings include:R4's undated diagnoses list documents R4's diagnoses as: Cellulitis of Right Lower Limb, other Chronic Pain, other Lack of Coordination, and need for assistance with Personal Care.R4's Minimum Data Set (MDS) dated [DATE], documents R4 requires supervision or touching assistance with walking. R4's Psychiatric Notes dated 8/5/25, documents R4 has thought blocking process and poor insight.R4's Minimum Data Set (MDS) dated [DATE], documents R4 in not cognitively intact.R4's Care Plan dated 7/14/25, documents R4 has Impaired Cognitive Function or Impaired thought Processes related to Dementia with interventions to cue, reorient, and supervise as needed. This same Care Plan documents R4 is at high risk for falls.On 9/16/25 at 12:22 PM, V1 Administrator stated R4's fall was not reported in a timely manner and stated it is when we got a coroner's request from the hospital that we then realized it and then completed and submitted the documents. V1 stated V5 Assistant Director of Nursing (ADON) had the on-call phone the day R4 fell but falls with injuries should be reported to V2 Director of Nursing (DON) but at the time we did not know there was an injury. V1 stated V2 DON should have reported the fall to the Regional Clinical Coordinator and then the paperwork should have been completed and sent in. V1 stated they had communication with the hospital. The hospital said R4 was having surgery and then R4 wasn't going to have surgery and then it was reported that R4 was put on hospice and then we got word R4 passed, so once we got the coroner's inquest, we realized we did not do this correctly. On 9/16/25 at 2:06 PM, V2 DON stated V2 is pretty sure V2 got a call from V5 ADON and V2 told V5 about R4's fall. V2 stated V2 did not inform anyone because V2 was not the on-call person V5 was. V2 stated V2 thought V2 was just being kept in the loop. V2 stated V2 can't remember if V2 talked to V1 Administrator about it (R4 fall) or not. V2 stated this incident was reported late when we realized after the fact so V1 was notified, and an investigation was started. V2 stated V2 had another abuse allegation that took V2s focus. V2 stated V2 completely forgot about R4's fall. The facility's Incident and Accidents Policy dated 4/7/2019, documents an incident/accident report is completed for all accidents or incidents where there is injury or the potential to result in injury. This policy also documents an incident/accident report is to be completed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and is to include the date and time of accident/incident, full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, and treatment rendered. This policy also documents all incidents/accidents reports or reviewed, signed, and investigated by the Administrator and the Director of Nursing.Prior to survey date of 9/19/25, the facility had taken the following actions to correct the non-compliance which include these education components : Quarterly Quality Assurance meeting on 8/22/25 with managers/department heads in attendance regarding follow-up from incident occurring on 8/9/25, failing to report fall with injury for R4; Resident Rounds in-service on 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26/25 with all staff; Behavioral Health Services in-service for all staff regarding behavioral health services; Incidents and Accidents in-service on 8/22/25, 8/23/25, 8/24/25, 8/26/25, with all staff; Pain Assessment in-service on 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26//25, for all staff; Baseline Care Plan in-service on 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26/25 for all staff; Abuse Prevention and Reporting in-service on 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26//25 for all staff; Fall Prevention Program in-service on 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26//25, for all staff; Comprehensive Care Plans in-service on 8/22/25 for all nurses; and Incident Correction and IDT Completion Plan in-service on 8/22/25, for all nurses.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a per day. This failure has the potential to affect all 104 residents in the facility. Findings Include: Facility Nursing Hall Assignment Sheets reviewed from 8/27/25 through 9/15/25 documented nine days (8/27, 8/28, 9/2, 9/3, 9/4, 9/9, 9/11, 9/13, 9/14) that the facility failed to use the services of a Registered Nurse for at least eight consecutive hours. On 9/18/25 at 2:30 PM V1 Administrator confirmed there were days with no RN staffing available. V1 also confirmed the facility's average daily census was around its current census of 104 residents. The Bed Management sheet dated 9/10/25 documents a current census of 104 residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 records were accurately documented and maintained for five residents (R12, R13, R14, R15, R16) of five residents reviewed for documentation in the sample list of 19.Findings include:The facility's Employee Disciplinary Form dated 7/22/25, documents V12 Certified Nursing Assistant (CNA), received a final warning regarding incomplete documentation. This report documents five residents (R12, R13, R14, R15, R16) were audited with 10 Activities of Daily Living (ADL) examples, totaling 40 occurrences of mis-documentation occurring in the past 30 days. This form documents R12 having 6 occurrences, R13 having 16 occurrences, R14 having 6 occurrences, R15 having 10 occurrences, and R16 having two occurrences of mis-documentation. On 9/17/25 at 10:13 AM, V1 Administrator, stated V12 CNA had been terminated on 9/15/25, due to false charting previously for documenting giving baths but did not do the baths.