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	01/13/2026

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 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** Based on interview and record review the facility failed to ensure resident rights to dignified care for four of five residents (R5, R8, R9 and R10) reviewed for dignified care on the sample list of 30.Findings include:1. R8's Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status score as 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents R8 is frequently incontinent of bowel and bladder.On 12/24/25 at 1:35 p.m., R8 stated to this surveyor that on the overnight of 12/22/25, she put on her call light to be toileted. Two unidentified agency Certified Nursing Assistants (CNAs) passed by her room while the call light was on. They said nothing to me as they passed by. R8 stated she waited and waited and figured the staff were just busy. R8 stated she had taken Tylenol and Gabapentin earlier that night-medications that can cause drowsiness-and fell back to sleep with the call light on.R8 stated, I woke up again and was very wet. I was soaked in urine. My incontinence brief and my bedsheets were wet. R8 stated, I then turned my call light on and waited and waited. No staff came in-not a nurse or either of the agency CNAs I had seen earlier. After what seemed like a very long time, maybe close to a half hour, R8 stated she fell back to sleep.R8 stated that a third time she woke up and was urinating again in her incontinence brief. She turned on the call light and waited a long time again. R8 stated, I really felt I was being neglected because that is the nursing staff's job. They were not even trying to provide the care I needed.R8 then stated, I laid in my wet diaper the rest of the night. The day shift-two of the regular CNAs (unidentified)-came in and had to change my full bed linens. I told them I laid in my own urine all night. They washed me up like I was having a total bed bath. I was embarrassed and told them what happened. I told my nurse (V29, Licensed Practical Nurse) too. I was so ashamed. It was the agency CNAs that neglected me.On 12/24/25 at 2:00 p.m., V28, Certified Nursing Assistant (CNA), stated, I don't know about the other night (12/22/25), but I do know that I have come in to get R8 up first thing in the morning, and she obviously was not checked or changed all night. I can't count how many times I have had to change her bed sheets in the morning when I got her up, completed morning care, and dressed her. She is not a heavy wetter. When there are several wet rings of urine on her sheets and her incontinence brief is wringing wet, she has not been checked or changed all night.On 12/26/25 at 11:15 a.m., V17, CNA, stated, It was sad, and it's at least a dignity issue. When we follow agency CNAs who work night shift, they don't do rounds-sometimes all night long-or they do a round just before day shift comes in. Either the residents' briefs and sheets are saturated, or the brief was just changed. I can guarantee from the look of the linens and bed pads that residents have not been changed. The bed pads and sheets will be saturated with multiple rings of wet and dry circles. Following agency CNAs has been a problem for a long time. They do not take good care of the residents, and I'm not sure why the nurses on night shift aren't tracking that. Agency CNAs on night shift do absolutely nothing. It is sad to see rings all over the bed showing bowel movement and (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple urine circles. When the whole bed is totally saturated, it's obvious residents have not been changed.On 12/26/25 at 12:00 p.m., V15, CNA, stated, Most of the time when we (day shift) follow agency staff on night shift, the residents and their beds are totally saturated. I have followed night agency staff and found R8 soaked. She is always embarrassed. It is not her fault. Nights should be checking her every two hours. When her sheets are saturated, it is plain to see she was not checked on two-hour rounds. I can't believe it's still happening. The facility has been aware of this for a long time.On 1/13/25 at 2:25 p.m., V29, Licensed Practical Nurse (LPN), stated that V1, Administrator/Abuse Prevention Coordinator, had called her and asked about R8 being left overnight incontinent. V29 stated, R8 said to me one morning, 'I woke up in a puddle under me. I have never laid in a puddle in my bed before.' I told her the CNAs would be right in to clean her up. I believe she probably was not changed as she should have been on night shift. V29 further stated, I don't even know what day that was. I work a lot of hours and just had several days off. It happened, and it shouldn't have.The facility provided a final Illinois Department of Public Health abuse/neglect allegation report dated 12/29/25, which documents the facility did not identify the agency CNAs involved in R8's delay in incontinent care because the resident was unclear about the date of occurrence. The report documents the facility made the decision to place a do not return status on all agency CNAs who worked during the timeframe of 12/21/25 through 12/22/25. 2. R10's Minimum Data Set (MDS) dated [DATE] documents R10's Brief Interview of Mental Status score as 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents R10 is always incontinent of bowel and bladder.On 12/30/25 at 12:20 p.m., V37, Certified Nursing Assistant (CNA), stated, My first day working in the facility was Christmas Eve (12/24/25). I was working on the 100 halls. Two unidentified CNAs went into R10's room. I was right behind them and heard R10 ask if they would get her cleaned up and out of bed. She was incontinent of bowel and had diarrhea. She requires a full-body mechanical lift transfer, which takes two people. The CNAs told her she could not get out of bed and that they were not going to change her. She asked them again to at least change her. One of them said, 'Not until we get you up-you're not finished going yet.' I think R10 knew if she was done or not.V37 stated she immediately reported this to V35, Registered Nurse (RN), and returned to R10's room to change her by herself. V37 stated R10 repeatedly said, Thank you, thank you so much, and told her she felt bad for making a mess. V37 reassured her that it was her job and she was happy to care for her. R10 stated she could not stand laying in her own feces any longer.V37 stated R10 wanted to get up, but she could not transfer her alone. Clean pads were placed under R10 to keep her clean. V37 stated, I didn't want her laying there in her own diarrhea. I think it was wrong that the CNAs did not change her immediately. They denied her request to get up. The delay in incontinent care was very bad. She obviously needed to be changed. Her sheets were soiled, and her brief was full.V37 stated that about 20 minutes later someone transferred R10 out of bed, which she believed was the unidentified CNAs.On 12/31/25 at 8:45 a.m., V35, RN, stated she was informed that R10 wanted to be changed and gotten up. V35 stated that V37 reported two CNAs told R10 she could not get up and needed to stay in bed. V35 stated she did not address the CNAs but acknowledged that if such statements were made, it was not appropriate and constituted a dignity issue.On 12/31/25 at 9:15 a.m., V44, CNA, stated she recalled R10 asking to get up and that she told her she would return after giving her time to finish her bowel movement. V44 stated R10 had already been changed when she returned to transfer her.On 1/6/26 at 1:10 p.m., R10 stated she could not remember being told she could not get up but remembered being told to lay in her dirty, wet bed. R10 stated, I didn't like it one bit. R10 stated a staff member eventually cleaned her and that she knew when she needed to be cleaned. 3. R9's Minimum Data Set (MDS) dated [DATE] documents (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's Brief Interview of Mental Status score as 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R9 is incontinent of bowel and bladder.On 12/26/25 at 3:35 p.m., R9 stated, I don't think they check overnight consistently to see if I need changed. That has been a problem. I think it's agency staff. I have laid in my own incontinence for hours. It's not okay. It's frustrating. Other than that, I am treated with dignity and respect.On 1/9/26, V2, Director of Nursing, stated, Any time a resident is left wet or soiled, it is a dignity issue. Residents are to be checked every two hours on all shifts and as needed. We are fighting a losing battle with agency staff. 4. R5's Minimum Data Set (MDS) dated [DATE] documents R5's Brief Interview of Mental Status score as 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R5 is occasionally incontinent of bowel and bladder.On 12/26/25 at 12:05 p.m., R5 stated, Nobody checks on us overnight when it's agency staff. If it's facility staff, the CNAs do rounds every couple of hours and make sure we're clean and dry. It makes me feel horrible when agency staff ignore us. I feel like a burden. It is a dignity issue when I have to lay in urine all night.On 1/9/26, V2, Director of Nursing, reiterated that any time a resident is left wet or soiled, it is a dignity issue and residents must be checked every two hours on all shifts.The facility policy Dignity, dated 4/23/18, documents: The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.Staff shall carry out activities in a manner that assists the resident to maintain and enhance self-esteem and self-worth.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's physician of a significant change of condition (severe increase is pain). This failure affected one of five residents (R7) reviewed for pain on the sample list of 30.Findings Include: R7's Hospital Discharge After Visit Summary documents that R7 was discharged to the facility on [DATE], status post left total knee replacement surgery. Discharge orders included instructions to call the physician's office for any severe, uncontrolled pain. R7's pain medication orders included Hydrocodone 5/325 mg, take 1-2 tablets by mouth every four hours as needed for moderate or severe pain. Additional pain medication orders included Hydromorphone 4 mg by mouth every four hours as needed for moderate to severe pain; Morphine 15 mg by mouth every 12 hours; and Tizanidine 4 mg, two tablets by mouth every six hours as needed for muscle spasms. R7's medical diagnoses included chronic pain status post motor vehicle injury, morbid obesity, and left knee osteoarthritis status post total knee arthroplasty. R7 was to continue Dilaudid, as she had been taking this medication chronically prior to surgery.R7's undated Hospital Report Note Sheet documents that a report was received from hospital staff indicating R7 is a [AGE] year-old female who underwent a left total knee arthroplasty on 11/13/25. R7 was admitted to the facility for post-surgical pain control. She required a gait belt and one-person assist with a walker for transfers and was completely cognitively intact. R7 was taking Dilaudid, Morphine, and Hydrocodone for pain control. Morphine was next due at 9:00 p.m. Controlled substance prescriptions were sent with the hospital discharge packet. R7 was last administered 4 mg of Dilaudid at 4:00 p.m. and was to receive a Hydrocodone tablet prior to transport to the facility. R7 was referred to a pain specialist for pain management and was expected to arrive at the facility after 6:00 p.m.R7's Nursing Progress Note dated 11/20/25 at 1:10 a.m. documents that R7's prescribed pain medications were not delivered by the pharmacy and were not available through the facility's emergency medication supply. At 1:00 a.m., R7 was tearful, shaking, and stated she could not wait any longer for pain medication to be administered, requesting transfer to the emergency room. The progress note does not document physician notification.On 1/7/26 at 3:37 p.m., V12, Licensed Practical Nurse (LPN), stated she was the nurse who cared for R7 overnight on 11/19/25-11/20/25 and sent her to the emergency room. V12 stated R7 complained of severe left knee pain on multiple occasions between 11:00 p.m. and 1:00 a.m. V12 confirmed R7 was admitted earlier in the evening on 11/19/25 and had not received any pain medication since admission. V12 stated she did not notify the physician regarding R7's severe pain, the unavailability of ordered pain medications, or R7's request to go to the emergency room because she was unsure who R7's physician was at the time.On 1/6/26 at 1:54 p.m., V48, Regional Nurse, confirmed that nursing staff should have actively managed R7's pain and notified the physician when R7's pain became severe, when ordered pain medications were unavailable, and when R7 was transferred to the hospital.The facility's Physician-Family Notification: Change of Condition policy dated 11/13/18 documents that the facility will notify a resident's physician when there is a significant change in the resident's clinical condition or when a decision is made to transfer a resident from the facility.

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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** Based on interview and record review the facility failed to recognize an allegation of abuse and report the allegation to the State Agency. This failure affected one of eight residents (R8) review for abuse/misappropriation on the sample list of 30.Findings include:The facility's Grievance Tracking Log dated November 2025 documents that R8 filed a grievance on 11/06/25. The tracking log does not document any additional information regarding the grievance.The facility's Grievance Concern/Compliment Form dated 11/6/25 documents that V23, Housekeeper/Laundry Supervisor, was the staff member who received the report. Under Nature of Concern/Compliment (Complaint), the form documents: Resident (R8) stated a CNA, described as a 'heavier-set (race) girl,' needed an upgrade, as she threw clothes at the resident and stated the resident needed to get herself dressed and put herself in her wheelchair.R8's Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status score as 13 out of a possible 15, indicating no cognitive impairment.On 12/24/25 at 8:35 a.m., V1, Administrator/Abuse Prevention Coordinator, provided the above grievance Concern/Compliment Form dated 11/6/25. V1 stated he did not report the grievance to the Illinois Department of Public Health (IDPH) because, at the time, he considered it a customer service issue rather than abuse. V1 acknowledged that R8's grievance should have been reported to IDPH as an abuse allegation.On 12/24/25 at 1:35 p.m., R8 stated, On my original complaint, a CNA threw my clothes and told me to dress myself and get in the chair myself. That was V28, CNA, a while back-around 11/6/25. I can't remember the exact date. I was pretty upset and told the nurse (unidentified) once I dressed myself. I then went into the hall and told V23, Housekeeper Supervisor, too. I thought V28 was rude and in a hurry. I don't remember for sure if she told me to get into my wheelchair by myself, but I had to get into the wheelchair once I was dressed. I remember her tossing my clothes to me and telling me to get dressed on my own. I want to do more for myself so I can go back home, but she could have been a lot nicer. No one deserves to be rushed or treated rudely.On 12/24/25 at 1:45 p.m., V23 stated, R8 was pretty upset. She was anxious and a little agitated as she propelled her wheelchair into the hallway. She stopped me and said that V28, CNA, threw her clothes at her and told her to dress herself and get into her wheelchair by herself. She did not cry, but her facial expression looked like she was holding back tears. Another CNA (unidentified) was in the hallway, and R8 told her about V28 as well. We reported this immediately to V1, Administrator/Abuse Prevention Coordinator. V1 is the Abuse Coordinator, and R8 stated she felt abused. We are in-serviced on abuse frequently and are required to report everything immediately.The facility policy Abuse Prevention and Reporting - Illinois, revised 10/24/22, documents the following:Guidelines:This facility affirms the right of residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment. The facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents and seeks to establish a resident-sensitive and resident-secure environment. The purpose of this policy is to ensure the facility does all that is within its control to prevent abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services, and mistreatment of residents.This will be done by, including but not limited to, filing accurate and timely investigative reports.The same policy further documents: Any allegation of abuse or any incident that results in serious bodily injury shall be reported to the Illinois Department of Public Health immediately, but no later than two hours after the allegation. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.

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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 observations, interviews and record review the facility repeatedly failed to honor residents' preference to choose the shift their showers would be scheduled, and repeatedly failed to provide dependent residents with showers. These failures affected five of five resident (R2, R3, R9, R24, and R26) resident reviewed for showers on the sample list of 30. Findings include:1.R2's current Diagnoses sheet documents the following: Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites and Other Lack Of Coordination.R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental Status score as 14 out of a possible 15, indicates no cognitive impairment. The same MDS documents R2 has had no behavior and has not declined care.R2's Care Plan dated 11/24/25 documents R2 has a potential for skin impairment and directs staff to keep resident clean and dry. The same care plan documents R2 requires partial to moderate assistance with shower/bathing.R2's shower sheet document R2 is scheduled to receive showers on 6:00 pm-6:00 am shift.R2's shower sheet dated 11/22/25 documents R2 was offered a shower on night shift 6:00 pm -6:00 am and requested that her shower be given on a day shift 6:00 am - 6:00 pm.There were no shower sheets for one week to indicate R2 was offered or received a shower.R2's shower sheet dated 11/29/25 documents R2 was given a shower on 11/29/25 on night shift 6:00 pm -6:00 am. R2 had previously requested to have showers on day shift (as noted above 11/22/25)R2's shower sheet dated 12/03/25 documents R2 was given a shower on 12/03/25 on night shift 6:00 pm -6:00 am. R2 had previously requested to have showers on day shift (as noted above).R2's shower sheet dated 12/06/25 documents R2 was scheduled for a shower that was not given, again on night shift 6:00 pm -6:00 am, though she had requested to have showers on day shift.There were no shower sheets for one week to indicate R2 was offered or received a shower.R2's shower sheet dated 12/13/25 documents R2 was scheduled for a shower that R2 declined, again on night shift 6:00 pm -6:00 am. R2 had had again requested to have showers on day shift (as noted above).There were no shower sheets for one week to indicate R2 was offered or received a shower.R2's shower sheet dated 12/20/25 documents R2 was scheduled, again on night shift 6:00 pm - 6:00 am, for a shower that was not documented as offered or declined. R2 had previously requested to have showers on day shift (as noted above).There were no shower sheets for one week to indicate R2 was offered or received a shower.R2's shower sheet dated 12/27/25 documents R2 was given a shower on 12/27/25 on night shift 6:00 pm -6:00 am. R2 had previously requested to have showers on day shift (as noted above) On 12/23/25 at 10:50 am V4, R2 Family Member stated the facility does not provide R2 showers.On 12/26/25 at 11:15 am V17, Certified Nursing Assistant (CNA) stated There are three residents. That rarely get their showers, because it takes a long time to give these residents one (shower). One is (R3), one is (R9) and another is (R2). It breaks my heart, and I will try to make up that shower when I work.On 12/26/25 at 11:45 AM. R2 stated R2 is supposed to get two showers a week. R2 stated she would like to have her showers in the morning. R2 stated she does not get her showers like she's supposed to. R2 also stated she has never refused to shower, unless they want to get her up at night, which has happened a couple of times. R2 stated she has had to asked for showers, because she's not getting them routinely every week like she should. R2 stated R2's family (unidentified) has also mentioned to the staff that R2 is not getting her showers.2. R3's current Diagnoses sheet documents the following: Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities Of Gait and Mobility, Malaise, and Generalized Edema.R3's Minimum Data Set (MDS) dated [DATE] document Brief Interview of Mental Status score of 15 out of a possible 15, which indicates no cognitive impairment. The same MDS (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents R3 has had no behaviors or rejection of care.R3's shower sheets document R3 is scheduled to receive showers on day shift 6:00 am -6:00 pm.R3's shower sheets dated 12/20/25 and 12/24/25 documents R3 was scheduled to receive a shower. The same shower sheets do not document R3's shower was offered, done or refused.On 12/26/25 at 11:15 am V17, Certified Nursing Assistant (CNA) stated There are three residents. That rarely get their showers, because it takes a long time to give these residents one (shower). One is (R3), one is (R9) and another is (R2). It breaks my heart, and I will try to make up that shower when I work.On 12/26/25 at 2:50 pm R3 stated I am provided showers. I haven't refused, but I can tell you I'm not always getting them twice a week. They say they don't have time. It is always agency staff that say this, not the facility CNA's. Most weeks, I request a shower, and I will get one. Last week I got one on 12/16/25, before I went to my mother's funeral. I have not asked for or been offered one since.3. R9's current Diagnoses sheet documents the following: Primary Progressive Multiple Sclerosis, Unspecified, Limitation O Activities Due to Disability, Unspecified Fracture of Lower End of Left Femur, Osteoarthritis Of Knee, Unspecified, Foot Drop, Left Foot, Muscle Wasting and Atrophy, Not Elsewhere Classified, Unspecified Site, and Other Abnormalities Of Gait and Mobility.R9's Minimum Data Set (MDS) dated [DATE] document R9's Brief Interview of Mental Status score of 15 out of a possible 15, which indicates no cognitive impairment. The same MDS documents R9 has had no behaviors or rejection of care.R9's shower sheets document R9 is scheduled to receive showers on day shift 6:00 pm -6:00 am.R9's shower sheet dated 12/02/25 documents R9 was scheduled for a shower that R9 declined. There is no other documentation as to why R9 declined, or if another shower time was offered.There were no shower sheets between for one-week between12/09/25 - 12/16/25 to indicate R9 was offered or received a shower. R9 was given a shower 12/16/25.There were no shower sheets between for one-week between12/16/25 - 12/23/25 to indicate R9 was offered or received a shower.On 12/26/25 at 11:15 am V17, Certified Nursing Assistant (CNA) stated There are three residents. That rarely get their showers, because it takes a long time to give these residents one (shower). One is (R3), one is (R9) and another is (R2). It breaks my heart, and I will try to make up that shower when I work.On 12/26/25 at 3:35 PM. R9 stated I do not get showers routinely, not twice a week for sure. They (staff) came in at 3:00 in this morning and wanted to give me a shower. That is unacceptable and I will not get up at 3:00 in the morning. I did refuse this morning. I like my showers and don't usually refuse. I enjoy sleeping in till (until) about 10:00 am, at least 9:30 am. The facility staff know this. It seems to be night shift, and it seems to be agency (contracted staff) that want to shower me overnight.On 12/30/25 at 12:40 pm V39, Agency CNA stated I pick up shifts here (in the facility) mostly at night. I pick up shifts three or four times a week. I have never had an issue with residents on any unit refuse care from me. The other night staff say the residents refuse care and showers. I try to help the residents that supposedly refuse the other night staff. I answer the resident call lights if it is my assigned resident, or not. I provide the cares and have no problem with residents refusing me.4. R24's current Diagnoses sheet documents the following: Wedge Compression Fracture OF T9-T10 Vertebra, Subsequent Encounter For Fracture With Routine Healing, Restless Leg Syndrome, Chronic Pain Syndrome, Muscle Wasting and Atrophy, Not Elsewhere Classified, and Other Abnormalities Of Gait and Mobility.R24's Minimum Data Set (MDS) dated [DATE] document R24's Brief Interview of Mental Status score of 15 out of a possible 15, which indicates no cognitive impairment. The same MDS documents R24 has had no behaviors or rejection of care.R24's shower sheet below document R24 is scheduled to receive showers on day shift 6:00 pm - 6:00 am.R24's shower sheets dated 11/02/25 documents R24 was scheduled to receive a shower. The same shower sheet does not document R24 shower was offered, done or refused.There were no shower sheets to indicate R24 was scheduled for a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower between 11/02/25 - 12/02/25.R24's shower sheets document R24 is now scheduled to receive showers on day shift 6:00 am - 6:00 pm according to R24's shower sheets below:R24's shower sheet dated 12/02/25 documents R24 was scheduled to receive a shower. The same shower sheet does not document R24 shower was offered, done or refused.R24's shower sheet dated 12/9/25 documents R24 was scheduled to receive a shower. The same shower sheet does not document R24 declined a shower due to pain. No further offers were documented.R24's shower sheet dated 12/23/25 documents R24 was scheduled to receive a shower. The same shower sheet does not document R24 shower was offered, done or refused.R24's shower sheet dated 12/30/25 documents R24 was scheduled to receive a shower. The same shower sheet documents R24 shower was offered and refused twice, but does not indicate why resident declined, to remedy the situation.On 1/06/26 at 12:05 pm, R24 was lying in bed. R24's hair was shoulder length, greasy and uncombed. R24 stated I know the staff are busy, I try to be considerate of that. I need a shower. I did not even get one last week. A shower was not offered. Staff were too (d**n) busy.On 01/06/26 at 12:30 pm V2, Director of Nursing (DON) stated All residents are too have two showers every week. The assigned CNA (Certified Nursing Assistant) have their list of residents, scheduled each day for shower. The CNAs know this at the beginning of the shift. We have had issues with showers not getting done. They know they are to sign off as done on the sheet, once the shower is given. If the resident refuses, they are expected to find out why, document the resident refused, and report to the nurse. There must be three attempts, and a reason documented. If it was not documented. The shower was not given or refused. 5. R26 current Diagnoses sheet documents the following: Unspecified Visual Disturbance, Cognitive Communication Deficit, Morbid Obesity Due To Excess Calories, Pain In Left Shoulder, Pain In Left Hip, Pain In Left Knee, Trochanteric Bursitis Left Hip, Unilateral Primary Osteoarthritis, Sacroiliitis Not Elsewhere Classified, Muscle Wasting and Atrophy, Not Elsewhere Classified, Difficulty Walking, Not Elsewhere Classified.R26's Minimum Data Set (MDS) dated [DATE] document R26's Brief Interview of Mental Status score of 15 out of a possible 15, which indicates no cognitive impairment. The same MDS documents R26 has had no behaviors or rejection of care.R26's shower sheets document R26 is scheduled to receive showers on night shift 6:00 pm - 6:00 am.R26's shower sheet dated 12/01/25 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.R26's shower sheet dated 12/04/25 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.R26's shower sheet dated 12/15/25 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.R26's shower sheet dated 12/25/25 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.R26's shower sheet dated 12/29/25 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.R26's shower sheet dated 01/01/26 documents R26 was scheduled to receive a shower. The same shower sheet does not document R26's shower was offered, done or refused.On 1/6/26 at 1:00 pm R26 was seated in a wheelchair, clean with uncombed hair. R26 stated I got my first shower in two weeks last night (confirmed on shower sheet 01/05/26). I have never refused. When I get them, it is basically once a week. I would like to have them twice a week, as staff say two are scheduled. (R26's shower sheets document R26 received his last shower prior to 01/05/26, on 12/22/25).On 1/6/26 at 12:30 pm V2, Director of Nursing (DON) stated All residents are too have two showers every week. The assigned CNA (Certified Nursing Assistant) have their list of residents, scheduled each day for shower. The CNAs know this at the beginning of the shift. We have had issues with showers not getting done. They know they are to sign off as done on the sheet, once the shower is given. If the resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refuses, they are expected to find out why, document the resident refused, and report to the nurse. There must be three attempts, and a reason documented. If it was not documented. The shower was not given or refused.The facility policy Bathing - Shower and Tub Bath dated 01/31/18 documents the following: 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.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than on deficient practice statement:A .Based on interview and record review the facility failed to complete a thorough admission process including greeting the resident within 15 minutes of arrival, providing access to the call light, notifying the pharmacy of resident's arrival, faxing prescriptions to the pharmacy within two hours, admission assessment including care plan focus, pain observation assessment, and fall assessment with transfer status. This failure affected one of five residents (R7) reviewed for quality of care on the sample list of 30. This failure resulted in R7 experiencing significant physical pain, severe anxiety and feelings of being disregarded by staff.B. Based on interviews and record review the facility repeatedly failed report the results of a Chest X-ray to the physician, which resulted in a four delay in treatment for a resident (R4) with pneumonia. R4 is one of six residents reviewed for infection/treatment on the sample list of 30.Findings include: A. R7's Hospital Discharge After Visit Summary documents that R7 was discharged to the facility on [DATE], status post left total knee replacement surgery. Discharge orders included instructions to call the physician's office for any severe, uncontrolled pain. R7's pain medication orders included Hydrocodone 5/325 mg, take 1–2 tablets by mouth every four hours as needed for moderate or severe pain. Additional pain medication orders included Hydromorphone 4 mg by mouth every four hours as needed for moderate to severe pain; Morphine 15 mg by mouth every 12 hours; and Tizanidine 4 mg, two tablets by mouth every six hours as needed for muscle spasms. R7's medical diagnoses included chronic pain status post motor vehicle injury, morbid obesity, and left knee osteoarthritis status post total knee arthroplasty. R7 was to continue Dilaudid, as she had been taking this medication chronically prior to surgery. R7's undated Hospital Report Note Sheet documents that a report was received from hospital staff indicating R7 is a [AGE] year-old female who underwent a left total knee arthroplasty on 11/13/25. R7 was admitted to the facility for post-surgical pain control. R7 required a gait belt and one-person assist with a walker for transfers and was completely cognitively intact. R7 was taking Dilaudid, Morphine, and Hydrocodone for pain control. Morphine was next due at 9:00 p.m. Controlled substance prescriptions were sent with the hospital discharge packet. R7 was last administered four milligrams of Dilaudid at 4:00 p.m. and was to receive a Hydrocodone tablet prior to transport to the facility. R7 was referred to a pain specialist for pain management and was expected to arrive at the facility after 6:00 p.m. On 12/23/25 at 12:00 p.m., R7 stated she was admitted to the facility on [DATE] at approximately 6:15 p.m. R7 stated she was transported from the hospital to the facility and arrived in her room with a roommate but did not see a facility staff member until after 8:00 p.m. At approximately 8:00 p.m., R7's roommate activated the call light, and V55, Certified Nursing Assistant (CNA), responded. R7 stated she asked V55 to assist her to the bathroom, and V55 instructed her to use her walker and take herself to the bathroom. R7 stated she had not walked independently since surgery and was supposed to have staff walking beside her using a gait belt. R7 stated she was very scared she might fall and injure her new knee and felt very unsteady and unsure of her ability to safely transfer. R7 stated she was already in significant pain because the last time she received pain medication was prior to leaving the hospital. R7 stated that when she walked back from the bathroom, V55 watched her walk but did not assist her or help her get her legs back into bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R7 stated her bed was broken, the remote did not work, and she was not provided a call light. R7 stated she told V55 she felt that since arriving she had not seen any staff and felt like no one even knew she was there. R7 stated that at approximately 9:00 p.m., V11, Licensed Practical Nurse (LPN), entered the room and told R7 she knew she was there but had not yet made it back to see her. R7 stated V11 did not complete an assessment, ask questions, or assess her surgical knee. R7 stated she told V11 she was in pain and requested pain medication. V11 told her she was unsure whether she had any pain medication available to administer. R7 stated she repeatedly told V11 she was in severe pain and that something did not feel right, but V11 offered no solution. R7 stated V11 left the room and did not return with any pain medication. R7 stated she later took herself to the bathroom again and still did not have access to a call light. After returning to bed, R7 stated she found the call light on the floor next to the bed. R7 stated that approximately two hours later, around 12:00 a.m., she used the call light to request help because she could no longer tolerate the pain and discomfort. R7 stated she felt disregarded and not cared for. R7 stated she was in severe pain and felt she had suffered long enough. She stated no nurse had assessed her, no one was addressing her pain, and she felt forgotten, anxious, and scared something was wrong with her knee because the pain was unbearable. R7 stated that at approximately 12:00 a.m., V12, Licensed Practical Nurse (LPN), entered her room, asked about her pain, and left to determine why she had not received pain medication. V12 returned shortly thereafter, apologized, and informed R7 that her pain medication prescriptions had not been faxed to the pharmacy upon admission and that she would fax them herself. R7 stated V12 informed her that once the pharmacy received the prescriptions, V12 could request a code and access the medications from the emergency medication supply; however, V12 was unsure how long the process would take. R7 stated she was fed up and requested to leave the facility and return to the hospital. V12 contacted emergency medical services, and R7 stated she was transferred to the hospital at approximately 1:30 a.m. on 11/20/25, where she was treated for uncontrolled pain. R7's Nursing Progress Note dated 11/20/25 at 1:10 a.m. documents that R7's prescribed pain medications were not delivered by the pharmacy and were not available through the facility's emergency medication supply. The prescriptions required refaxing, and a new access code was required for medication retrieval. At 1:00 a.m., R7 was tearful, shaking, and stated she could not wait any longer for pain medication, requesting transfer to the emergency room. On 1/7/26 at 3:37 p.m., V12, Licensed Practical Nurse (LPN), stated she was the nurse who cared for R7 overnight on 11/19/25–11/20/25 and sent her to the emergency room. V12 stated she assumed care of R7 at 10:00 p.m. V12 stated she was alerted by an unknown staff member of R7's severe left knee pain multiple times between 11:00 p.m. and 1:00 a.m. and did go to see R7 to address her pain. V12 confirmed R7 was admitted earlier in the evening at approximately 6:30 p.m. and had not received any prescribed pain medications since arrival. V12 stated that a full admission assessment and admission process were not completed for R7. V12 stated R7's controlled substance prescriptions were not faxed to the pharmacy until approximately 1:00 a.m. V12 stated she received only a minimal report on R7, was unfamiliar with her history, and was unable to identify R7's assigned physician. V12 stated that when she first assessed R7 around midnight on 11/20/25, R7 was in extreme pain, visibly upset, shaking, and requesting transfer to the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	emergency room. On 1/6/26 at 1:54 p.m., V48, Regional Nurse, confirmed nursing staff should have completed the admission process, greeted the resident upon arrival, ensured access to a call light, notified the pharmacy of the resident's arrival, faxed prescriptions within two hours, and completed admission assessments including pain assessment, fall risk assessment, transfer status, and care plan focus. V48 stated staff should have addressed R7's pain before it escalated and acknowledged that failure to do so caused undue stress and pain for R7. B. R4 was discharged from the facility on 12/08/25. R4's most recent diagnoses sheet documents chronic obstructive pulmonary disease with acute exacerbation and pneumonia, unspecified organism. R4's chest X-ray, performed by a private company on 11/13/25, documents the X-ray was completed and reported to the facility on [DATE] at 9:36 p.m. Procedure: Chest, two viewsClinical Information: Cough, congestion, other pulmonary embolism without acute cor pulmonale, and acute systolic congestive heart failure. Significant Findings: No abnormal radiopaque foreign body Cardiac silhouette normal No visible pneumothorax No radiographic evidence of pulmonary edema Opacities in the right lung base Impression:Opacities in the right lung base, which may be due to atelectasis or pneumonia. The facility's Infection Control Log dated November 2025 documents that on 11/17/25, R4 was diagnosed with pneumonia of an unknown organism and was started on antibiotic therapy. R4's Nursing Progress Note dated 11/17/25 at 8:00 a.m. documents: Writer called V45, physician, due to resident R4's chest X-ray results and condition. Resident extremely congested and coughing; vital signs within normal limits. R4's Nursing Progress Note dated 11/17/25 at 10:00 a.m. documents: Office staff from V45 returned call with new diagnosis of pneumonia and new orders for antibiotic therapy for 10 days and DuoNeb treatments as needed. Appropriate parties notified. R4's Medication Administration Record (MAR) dated 11/01/25–11/30/25 documents the following medication:Amoxicillin 675 mg by mouth twice daily for pneumonia, unspecified organism, for 10 days. The MAR further documents R4 did not receive the antibiotic until 11/17/25 at 8:00 p.m., four days after the chest X-ray results were reported to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The MAR also documents: Ipratropium-Albuterol 0.5–2.5 mg/3 mL solution, inhale one vial by mouth every four hours as needed for cough, congestion, and shortness of breath, start date 11/17/25. On 12/30/25 at 1:50 p.m., V2, Director of Nursing/Infection Preventionist, acknowledged that the delay in antibiotic and respiratory treatment for R4's confirmed pneumonia resulted in prolonged infection and symptoms.

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F 0689 Level of Harm - 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** Failures at this level required more than one deficient practice statement.A. Based on observation, interview, and record review, the facility failed to effectively supervise a cognitively impaired resident to prevent repeat traumatic falls requiring emergency transfers to the hospital for evaluation and treatment. These falls resulted in R1 sustaining a large head hematoma, skin tear to the knee, and pain in R1's head, neck, back, and pelvis. These failures affect one resident (R1) of three reviewed for falls in the sample of three. B. Based on record review and interview the facility failed to complete a thorough fall investigation to determine root cause of a fall in order to implement a targeted intervention. The facility also failed to assess a resident for the use of side rails, failed to complete neurological assessment post unwitnessed fall, failed to document frequent safety checks post fall, and failed to care plan measurable time intervals for the frequency of safety checks to prevent falls. These failures affect one of three residents (R6) reviewed for falls on the sample of three.Findings include: A. 1. R1's diagnosis list (printed 12/30/2025) documents that R1's diagnoses include dementia, syncope (fainting) and collapse, difficulty in walking, muscle wasting and atrophy, pain, cognitive communication deficit, depression, and anxiety. R1's Resident assessment dated [DATE] documents R1 has severely impaired cognition and requires substantial/maximal staff assistance for transfers, including going from a seated position to a standing position. The same record documents R1 does not have behaviors, delusions, or hallucinations. R1's Fall Risk assessment dated [DATE] documents R1 is at risk for falls. The facility fall log (September–December 2025) documents R1 had an unwitnessed fall in the facility on 9/26/2025. The facility Fall Investigation dated 9/26/2025 documents staff overheard R1 gasp and then found R1 on the floor in the living room of the facility's memory care unit. The same record documents R1 reported hitting R1's head on the floor and complained of head pain. R1 was noted to have redness and swelling to the left side of R1's head. The record further documents R1 experienced a skin tear to R1's knee, complained of knee pain, and was transferred to the hospital emergency department via ambulance for evaluation and treatment. R1's hospital emergency department report dated 9/26/2025 documents R1 complained of neck and pelvis pain while at the hospital and required multiple computed tomography (CT) radiographic scans to evaluate possible injuries. R1's Pain Level Summary dated 9/26/2025 documents R1 did not assess positive for pain in the weeks prior to the 9/26/2025 fall and then scored 7 out of 10 for pain immediately following the fall. R1's Pain Observation dated 9/26/2025 documents R1 experienced new-onset back and neck pain following the 9/26/2025 fall. R1's diagnosis list (printed 12/30/2025) documents that R1's diagnoses include dementia, syncope (fainting) and collapse, difficulty in walking, muscle wasting and atrophy, pain, cognitive communication deficit, depression, and anxiety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Resident assessment dated [DATE] documents R1 has severely impaired cognition and requires partial/moderate staff assistance for transfers, including going from a seated position to a standing position. The same record documents R1 does not have behaviors, delusions, or hallucinations. R1's Fall Risk assessment dated [DATE] documents R1 is at risk for falls. The facility fall log (September–December 2025) documents R1 had an unwitnessed fall in the facility on 12/11/2025. R1's Progress Notes dated 12/11/2025 document R1 had an unwitnessed fall in the facility and was found by staff on the dining room floor of the memory care unit, screaming, Get me up. The same record documents R1 reported hitting R1's head, complained of dizziness and pain, and staff noted a knot and bruising to the left temple area. R1's Progress Notes dated 12/13/2025 document R1 must be supervised closely due to continuing attempts to get up from the wheelchair to walk independently. The facility Fall Investigation dated 12/11/2025 documents V33 (Licensed Practical Nurse) overheard V39 (Certified Nurse Aide) exclaim, (R1) just fell. The investigation documents R1 was not under direct staff supervision at the time of the fall, had impaired safety awareness, and attempted to get up from the wheelchair to walk. The report documents R1 fell onto the dining room floor when the wheelchair rolled backward due to the brakes not being applied. R1 was transferred to the hospital emergency department via ambulance for evaluation and treatment. On 12/30/2025 at 2:20 PM, V39 (Certified Nurse Aide) reported working the night shift on 12/11/2025 when R1 experienced the fall in the memory care dining room. V39 reported R1 repeatedly attempted to get up from the wheelchair and staff redirected R1 to sit down. V39 reported no staff were present with R1 at the time of the fall, as staff were taking residents to their rooms following supper. V39 reported believing R1 fell face down and noted a knot on R1's forehead following the fall. On 12/30/2025 at 2:55 PM, V2 (Director of Nursing) reported R1 does not have intact safety awareness and frequently attempts to self-transfer from the wheelchair. V2 reported not being aware of the presence of auto-locking brakes on R1's wheelchair prior to the 12/11/2025 fall and stated these behaviors had been occurring for a long time. R1's hospital emergency department report dated 12/11/2025 documents R1 had an unwitnessed fall resulting in a medium egg-size forehead hematoma, complained of pain to the forehead and back of the head, and required multiple CT scans to evaluate possible injuries. The same record documents R1 was given one gram of acetaminophen and discharged back to the nursing home with new orders for pain medication (325–650 mg acetaminophen orally every 6–8 hours as needed) and application of ice to the hematoma for 5–15 minutes every few hours. R1's Pain Level Summary dated 12/11/2025 documents R1 did not assess positive for pain in the weeks prior to the fall and scored 8 out of 10 for pain immediately following the fall. R1's Pain Observation dated 12/11/2025 documents R1 experienced facial pain with vocal complaints and facial expressions of pain following the fall. R1's Physician Orders dated 12/31/2025 document an order to monitor bruising of the left eye area (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	until healed. R1's Treatment Administration Record (December 2025–January 2026) documents the forehead hematoma sustained on 12/11/2025 was not resolved as of 1/2/2026. R1's Care Plan (printed 12/30/2025) documents a resolved intervention related to fall risk and impaired judgment. The same record documents the intervention of adding auto-locking brakes to R1's wheelchair. On 12/24/2025 at 1:34 PM, R1 was observed seated in a wheelchair in the memory care living room with an approximately 1.5-inch egg-shaped purple hematoma on the left temple area from the 12/11/2025 fall. The facility Fall Prevention Program policy dated 11/21/2017 documents residents will be assessed for fall risk and appropriate interventions implemented, including supervision and assistive devices. B. R6's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 2 out of 15, indicating severe cognitive impairment. The same MDS documents R6 was totally dependent on staff for bed mobility. There was no Fall Risk Assessment in R6's medical record before or after the fall on 9/5/2025. R6's Fall–Initial Occurrence Note dated 9/5/2025 at 11:03 PM documents R6 had an unwitnessed fall at 8:30 PM in the resident's room. R6 was found lying on the floor mat next to the bed after rolling out of bed. R6 was confused and unable to provide a coherent statement. Vital signs and pain assessment were documented, including a pain level of 5 out of 10. Neurological checks were initiated. No injuries were observed. R6's Unwitnessed Fall report dated 9/5/2025, documented by V60 (previous Director of Nursing), does not document a thorough investigation or identify predisposing environmental, physiological, or situational factors. A CNA witness statement dated 9/6/2025 documents R6 rolled out of bed and the bed was in the lowest position. No Fall Risk Assessment was completed after the 9/5/2025 fall. R6's second fall was inaccurately documented as witnessed. The Witnessed Fall report dated 9/30/2025 documents R6 was already partially out of bed and hanging from the side rail when observed. No CNA was identified, and no witness statements were included. Neurological assessments required for 72 hours were not completed as ordered. Only two assessments were documented. There was no bedside side-rail assessment in R6's medical record. R6 experienced a third unwitnessed fall on 11/19/2025. Although safety checks were ordered, no documentation exists showing they were completed. On 11/20/2025, R6 was transferred to the hospital due to neurological decline and passed away later (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that morning. On 1/9/2026, V2 (Director of Nursing) reviewed R6's fall investigations and confirmed deficiencies in investigation, assessment, neurological monitoring, care planning, and documentation. The facility Fall Prevention Policy revised 11/21/2017 outlines required assessments, interventions, documentation, and monitoring, including documentation of safety checks when implemented.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to address a resident's post-surgical pain. This failure affected one of five residents (R7) reviewed for pain on the sample list of 30. This failure resulted in R7 experiencing a significant increase of uncontrolled pain which required hospitalization. This past non compliance occurred from 11/19/25 to 12/19/25. Findings Include: R7's Hospital Discharge After Visit Summary documents R7 was discharged to the facility on [DATE], status post left total knee replacement surgery. Discharge orders included instructions to call the physician's office for any severe uncontrolled pain. R7's pain medication orders included hydrocodone 5/325 mg, take one to two tablets by mouth every four hours as needed for moderate to severe pain; hydromorphone 4 mg by mouth every four hours as needed for moderate to severe pain; morphine 15 mg by mouth every 12 hours; and tizanidine 4 mg, two tablets by mouth every six hours as needed for muscle spasms. R7's medical diagnoses include chronic pain status post motor vehicle injury, morbid obesity, and left knee osteoarthritis status post total knee arthroplasty. R7 was to continue Dilaudid, which she had been taking chronically prior to surgery.R7's undated Hospital Report Note Sheet documents a verbal report was received from the hospital stating R7 is a [AGE] year-old female who underwent a left total knee arthroplasty on 11/13/2025. R7 was admitted to the facility for post-surgical pain control. R7 required a gait belt and one-person assistance with a walker for transfers and was cognitively intact. R7 was taking Dilaudid, morphine, and hydrocodone for pain control. Morphine was next due at 9:00 PM. Controlled substance prescriptions were sent with the hospital discharge packet. R7 last received 4 mg of Dilaudid at 4:00 PM and was to receive hydrocodone prior to transport to the facility. R7 was referred to a pain specialist for pain management and was expected to arrive at the facility after 6:00 PM.On 12/23/2025 at 12:00 PM, R7 reported she was admitted to the facility on [DATE] at approximately 6:15 PM and was already experiencing significant pain at that time. R7 stated no nurse entered her room until approximately 9:00 PM. R7 reported that at 9:00 PM, V11 (Licensed Practical Nurse) entered her room, and R7 informed V11 she was in pain and requested pain medication. According to R7, V11 stated she was unsure whether any pain medication was available. R7 reported she repeatedly stated she was in severe pain and that something did not feel right, but V11 provided no intervention. R7 stated V11 left the room and did not return with pain medication.R7 stated she used her call light at approximately 11:00 PM and informed an unidentified staff member she was in pain; however, no intervention occurred. R7 reported that at approximately 12:00 AM, she again used her call light because she could no longer tolerate the pain and discomfort. R7 stated she felt disregarded and not cared for, was in severe pain, and believed she had suffered long enough without relief. R7 reported no nurse had assessed her or addressed her pain, causing her to feel anxious and fearful that something was wrong with her knee due to the severity of the pain.R7 stated that at approximately 12:00 AM, V12 (Licensed Practical Nurse) entered her room, assessed her pain, and left to determine why pain medication had not been administered. V12 returned shortly thereafter, apologized, and informed R7 her medication orders had not been faxed to the pharmacy upon admission and that she would fax them. V12 explained that once the pharmacy received the prescriptions, a code would be needed to access the medications from the emergency medication supply, but the timeframe was uncertain. R7 stated she requested to be sent back to the hospital due to uncontrolled pain. Emergency medical services were contacted, and R7 was transferred to the hospital at approximately 1:30 AM on 11/20/2025, where she was treated for uncontrolled pain.R7's Nursing Progress Note dated 11/20/2025 at 1:10 AM documents R7's prescribed pain medications were not delivered by the pharmacy and were not available in the emergency medication supply. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The prescriptions had to be faxed again, and a new access code was required. At 1:00 AM, R7 was tearful, shaking, and stated she could not wait any longer for pain medication, requesting transfer to the emergency department.On 1/7/2026 at 3:37 PM, V12 (Licensed Practical Nurse) stated she was the nurse responsible for R7's care overnight on 11/19-11/20/2025 and facilitated R7's transfer to the emergency department. V12 stated she assumed care of R7 at 10:00 PM. V12 reported she was notified by unidentified staff members multiple times between 11:00 PM and 1:00 AM regarding R7's severe left knee pain and did assess R7 during that time. V12 confirmed R7 was admitted earlier in the evening at approximately 6:30 PM and had not received any prescribed pain medications since admission. V12 stated the controlled substance prescriptions were not faxed to the pharmacy upon admission and were faxed at approximately 1:00 AM. V12 reported that when she assessed R7 shortly after midnight, R7 was in extreme pain, visibly distressed, shaking, and requesting transfer to the emergency department.On 1/6/2026 at 1:54 PM, V48 (Regional Nurse) confirmed nursing staff should have ensured R7's pain medication prescriptions were available upon admission and, if issues arose, should have contacted the physician for further direction. V48 stated staff should have addressed R7's pain proactively by completing pain assessments, administering ordered pain medications, and implementing non-pharmacological pain management interventions. V48 stated the failure to do so likely caused undue stress and severe pain for R7, who had a history of chronic pain and was a newly post-surgical resident.Prior to the survey date of 1/13/2026, the facility implemented the following corrective actions:On 12/17/2025, the Compliance Assurance Committee developed a plan of correction related to the failures involving R7 on 11/19/2025.On 12/17/2025, all nursing staff received formal training on pain assessments, pain management, admission processes, pharmacy practices, and documentation.On 12/17/2025, all related policies were reviewed and updated as needed.On 12/17/2025, the Quality Assurance Committee held an impromptu meeting to discuss improvement strategies.On 12/19/2025, the Quality Assurance Committee began conducting ongoing audits of all facility admissions to ensure proper admission processes were completed and no related issues occurred.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 107 residents in the facility. Findings Include: Facility Nursing Staff Schedules reviewed from 12/17/25 through 1/7/26 documented five days (12/20, 12/21, 12/26, 12/29, 12/30/25) that the facility failed to use the services of a Registered Nurse for at least eight consecutive hours. On 1/7/26 at 11:50 AM V2 Director of Nurses (DON) confirmed the facility did not have eight hours of Registered Nurse coverage every day and needed to hire more RNs in order to meet the requirement. V2 also confirmed the facility's current census was 107 residents. The facility's Facility assessment dated [DATE] documents a Registered Nurse is needed every day in order to provide competent support and care for the facility's resident population. The Central Management Services 802 Matrix dated 12/23/25 documents the facility has a census of 107 residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review the facility failed to order, failed repeatedly to obtain medications from the pharmacy in a timely manner, and failed to administer a resident's pain medications. These failure affected three of five residents (R7, R9 and R24) reviewed for medications on the sample list of 30. Findings Include: 1.R7's Hospital Discharge After Visit Summary documents R7 was discharged to the facility on [DATE], status post left total knee replacement surgery. Discharge orders included instructions to follow physician orders for medications to control pain. R7's pain medication orders included hydrocodone 5/325 mg, take one to two tablets by mouth every four hours as needed for moderate to severe pain; hydromorphone 4 mg by mouth every four hours as needed for moderate to severe pain; morphine 15 mg by mouth every 12 hours; and tizanidine 4 mg, two tablets by mouth every six hours as needed for muscle spasms. R7's medical diagnoses include chronic pain status post motor vehicle injury, morbid obesity, and left knee osteoarthritis status post total knee arthroplasty. R7's undated Hospital Report Note Sheet documents a report received from hospital staff stating R7 is a [AGE] year-old female who underwent a left total knee arthroplasty on 11/13/2025. R7 was admitted to the facility for post-surgical pain control. R7 required a gait belt and one-person assistance with a walker for transfers and was cognitively intact. R7 was taking Dilaudid, morphine, and hydrocodone for pain control. Morphine was next due at 9:00 PM on 11/19/2025. R7 last received 4 mg of Dilaudid at 4:00 PM on 11/19/2025 and was to receive a hydrocodone tablet prior to transport to the facility. Controlled substance prescriptions were sent with the hospital discharge packet. R7 was expected to arrive at the facility after 6:00 PM. R7's Nursing Progress Note dated 11/20/2025 at 1:10 AM documents R7's prescribed pain medications were not delivered by the pharmacy and were not available through the facility's emergency medication supply. On 1/7/2026 at 3:37 PM, V12 (Licensed Practical Nurse) stated she was the nurse who provided care to R7 overnight on 11/19/2025–11/20/2025. V12 reported R7 complained of severe left knee pain multiple times between 11:00 PM and 1:00 AM. V12 confirmed R7 was admitted earlier in the evening on 11/19/2025 and had not received any pain medications since admission. V12 stated she contacted the pharmacy when R7's pain medications were not included in the midnight delivery and was informed the pharmacy had not received faxed controlled substance prescriptions. V12 reported she faxed the prescriptions at approximately 1:00 AM on 11/20/2025, which had originally been sent with R7's admission packet. On 1/6/2026 at 1:54 PM, V48 (Regional Nurse) confirmed nursing staff should have faxed R7's controlled substance prescriptions to the pharmacy upon admission and ensured pain medications were available. On 1/6/2026 at 1:05 PM, V47 (Pharmacist) confirmed the pharmacy did not receive R7's controlled substance prescriptions until 1:14 AM on 11/20/2025. All medications were delivered during the 8:00 AM pharmacy delivery on 11/20/2025. The facility's Medication Ordering and Receiving from Pharmacy policy dated November 2021 documents (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that controlled substances prescribed for a specific resident are delivered only after the pharmacy receives a valid prescription. The facility's undated admission Checklist documents that orders for new admissions must be faxed to the pharmacy within two hours of arrival and the pharmacy must be notified of the resident's admission. 2. R9's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 15 out of 15, indicating no cognitive impairment. R9's Medication Administration Record (MAR) dated 12/01/2025–12/31/2025 documents R9 was not administered several medications due to unavailability from the pharmacy. Missed doses included Wellbutrin XL 150 mg on 12/28/2025, oxcarbazepine 150 mg (three tablets) on 12/27/2025, and estradiol cream 0.01% on 12/25/2025. Each missed dose directed the reader to corresponding progress notes. R9's Orders – Administration Note dated 12/28/2025 at 8:57 AM documents:Wellbutrin XL Oral Tablet Extended Release 24 Hour, give 150 mg by mouth in the morning related to morbid (severe) obesity due to excess calories and depression, unspecified. Unavailable. R9's Orders – Administration Note dated 12/27/2025 at 8:26 PM documents:Oxcarbazepine 150 mg tablets, give three tablets by mouth at bedtime related to multiple sclerosis. Medication unavailable. R9's Orders – Administration Note dated 12/25/2025 at 8:20 PM documents:Estradiol cream 0.01%, insert one application vaginally at bedtime every Tuesday, Thursday, and Saturday related to postmenopausal atrophic vaginitis. Medication not available. On 12/26/2025 at 3:35 PM, R9 stated, My medications—I have a big problem with them. They're always out of something. 3. R24's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 15 out of 15, indicating no cognitive impairment. The same MDS documents R24 experiences occasional moderate pain that frequently interferes with activities and sleep. R24's MAR dated 12/01/2025–12/31/2025 documents missed doses of medications due to pharmacy unavailability, including labetalol 200 mg at bedtime and duloxetine 60 mg at bedtime on 12/21/2025. Each missed dose directed the reader to progress notes. R24's Administration Note dated 12/22/2025 at 9:26 PM documents:Labetalol HCl 200 mg, give one tablet by mouth every morning and at bedtime related to atherosclerotic heart disease without angina pectoris. No medication. The same dated note documents:Duloxetine HCl 60 mg, give 60 mg by mouth twice daily related to depression, unspecified. No medication. R24's Administration Note dated 12/21/2025 at 9:03 PM documents:Labetalol HCl 200 mg, give one tablet by mouth every morning and at bedtime related to atherosclerotic heart disease without angina pectoris. Out of stock. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/2025 at 8:55 AM, V9 (Assistant Director of Nursing) stated medications are not always ordered in advance as required and acknowledged delays from both nursing and pharmacy that have resulted in missed doses. On 12/31/2025 at 1:50 PM, V47 (Registered Pharmacist) stated the pharmacy expects notification three to five days before medications run out and typically fills prescriptions within two days. V47 stated same-day delivery is available when the facility notifies the pharmacy of urgent needs. On 1/6/2026 at 12:05 PM, R24 stated, The facility is always running out of my medications. On 1/6/2026 at 2:40 PM, V2 (Director of Nursing) confirmed R9's and R24's medications were out of stock and acknowledged ongoing issues with timely medication delivery and ordering practices. The facility's Preparation and General Guidelines policy dated November 2021 documents that the facility must maintain sufficient staff and an effective medication distribution system to ensure medications are administered safely and without unnecessary interruption.

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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** Based on record review and interview the facility failed repeatedly to administer muscle relaxer/pain/medication, resulting in a significant medication error for one of nine residents (R24) reviewed for medications administration on the sample list of 30.Findings include:R24's current Diagnoses sheet documents the following: Wedge compression fracture of T9-T10 vertebra, subsequent encounter for fracture with routine healing; restless leg syndrome; chronic pain syndrome; muscle wasting and atrophy, not elsewhere classified; and other abnormalities of gait and mobility.R24's Minimum Data Set (MDS) dated [DATE] documents R24's Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R24 experiences occasional, moderate pain that frequently interferes with activities and sleep.R24's current physician Order Summary sheet documents the following medication order: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain.R24's 12/01/25-12/31/25 Medication Administration Record (MAR) documents the following: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain, scheduled at 6:00 a.m., 1:00 p.m., and 8:00 p.m. The same MAR documents the chart code 9, which indicates Other/See Progress Notes (administration notes below). A 9 is documented on 12/24/25 at 6:00 a.m.; 12/25/25 at 6:00 a.m., 1:00 p.m., and 8:00 p.m.; 12/26/25 at 6:00 a.m., 1:00 p.m., and 8:00 p.m.; and 12/27/25 at 6:00 a.m., 1:00 p.m., and 8:00 p.m.R24's Administration Note dated 12/27/25 at 7:30 p.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Is on order (from the pharmacy).R24's Administration Note dated 12/27/25 at 5:12 a.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Not available.R24's Administration Note dated 12/27/25 at 1:48 a.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Not available.R24's Administration Note dated 12/26/25 at 12:09 p.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Awaiting pharmacy.R24's Administration Note dated 12/26/25 at 5:27 a.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Medication unavailable.R24's Administration Note dated 12/25/25 at 9:45 p.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Medication unavailable.R24's Administration Note dated 12/25/25 at 12:55 p.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Out of medication; on order.R24's Administration Note dated 12/25/25 at 5:34 a.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. Medication unavailable.R24's Administration Note dated 12/24/25 at 5:22 a.m. documents: Note text: Methocarbamol oral tablet 750 mg, give one tablet by mouth three times a day for pain. On order.On 1/06/26 at 12:05 p.m., R24 stated, I am hurting almost constantly, deep down in the muscle. They don't have my muscle relaxer medication (Methocarbamol) all the time, or they don't give it when I am supposed to be taking it. Even with the hydrocodone (narcotic pain medication), I still hurt. The combination of these medications significantly changes how comfortable I can get.On 1/06/26 at 12:30 p.m., V2, Director of Nursing (DON), stated, I know nothing about issues with R24's medications. There have been issues with our pharmacy sending medications. The nurses order the medications a few days ahead of running out. The nurse must often call the pharmacy to get them. I will look into his medications. I will get you his narcotic count sheet and his MAR and review these. It is very significant if he is not getting his medications, especially pain medication.On 1/06/26 at 2:40 p.m., V2, DON, stated, I see, while reviewing the MAR with this surveyor, that R24 missed his Methocarbamol medications several times in December. This is (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	significant. We are not talking about one dose delayed. Yes, this is significant and should have never happened. Had I been aware of this, I would have contacted the pharmacy immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident with an active, symptomatic pneumonia infection was placed on isolation precautions to prevent transmission of a bacterial infection, and repeatedly failed to ensure a second resident was not subjected to the exposure of the respiratory infection while treatment was delayed for four days, then while treatment was in progress for a total of 10 days. This failure affected two of six residents (R3 and R4) reviewed for transmittable infections on the sample list 30.Findings include:R3's Minimum Data Set (MDS) dated [DATE] documents the following: R3's Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment.On 12/26/25 at 2:50 p.m., R3 stated, My complaint about (R4) was that she (R4) was brought into my (R3) room as my new roommate. She was actively coughing all the time. She had pneumonia, and staff knew it. No one wore gowns or masks. It was terrible. She coughed constantly. I am in my bed a lot. I had to pull my curtain when I came to my room. I did not want to get sick. That was my only complaint about (R4). She was very sweet.R4's Physician Order Sheet (POS) dated 11/01/25-11/30/25 does not document an order to implement infection control precautions. The same POS documents the following medication with an order date of 11/17/25: Amoxicillin (antibiotic) oral tablet 675 mg, give one tablet by mouth two times a day related to pneumonia, unspecified organism, for 10 days.The same POS documents: On-hand Ipratropium-Albuterol 0.5-2.5 (3) mg/3 mL solution, inhale one vial by mouth every four hours as needed for cough, congestion, and shortness of breath.R4's care plan dated 11/08/25 (admission) through 12/08/25 (discharge) does not document that R4 was being treated for pneumonia or that isolation precautions were initiated or implemented.R4 was discharged from the facility on 12/08/25. R4's most recent diagnoses sheet documents the following: Chronic Obstructive Pulmonary Disease with acute exacerbation and pneumonia, unspecified organism.R4's chest X-ray from a private company dated 11/13/25 documents the X-ray was completed on 11/13/25, and the results were reported to the facility on [DATE] at 9:36 p.m.Procedure: Chest, two viewsInterpretationClinical Information:Cough, congestion, other pulmonary embolism without acute cor pulmonale, and acute systolic congestive heart failure.Significant Findings:There is no abnormal radiopaque foreign body.The cardiac silhouette is normal.There is no visible pneumothorax.There is no radiographic evidence of pulmonary edema.There are opacities in the right lung base.Impression:There are opacities in the right lung base. This may be due to atelectasis or pneumonia.The facility's Infection Control Log dated November 2025 documents that on 11/17/25, R4 had a diagnosis of pneumonia of unknown organism and was started on antibiotic therapy, as noted above.R4's Medication Administration Record (MAR) dated 11/01/25-11/30/25 documents the following medication: Amoxicillin (antibiotic) oral tablet 675 mg, give one tablet by mouth two times a day related to pneumonia, unspecified organism, for 10 days.The same MAR documents R4 was not administered the antibiotic until 11/17/25 at 8:00 p.m. (four days after the X-ray results were reported to the facility) and continued receiving the antibiotic until 11/27/25 at 8:00 a.m. Therefore, droplet isolation precautions were never implemented from 11/13/25, when the X-ray confirmed the diagnosis, through the treatment end date of 11/27/25, resulting in approximately 14 days of potential exposure.The same MAR documents: On-hand Ipratropium-Albuterol 0.5-2.5 (3) mg/3 mL solution, inhale one vial by mouth every four hours as needed for cough, congestion, and shortness of breath, with a start date of 11/17/25.On 12/30/25 at 1:50 p.m., V2, Director of Nursing (DON) and Infection Control Preventionist, stated, (R4) was treated in the hospital with pneumonia prior to her admission on [DATE]. (R4) had been in the facility for a while when she required a chest X-ray due to congestion. (R4) had an active cough, and it was confirmed she had pneumonia again. She should have been placed on droplet (continued on next page)

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	01/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	isolation precautions immediately. (R4) should never have been placed in the same room with (R3). (R3) did not have pneumonia. Although we never obtained a sputum culture on (R4), (V45, physician) ordered antibiotics to treat (R4's) pneumonia. We dropped the ball. We missed it. We should have implemented isolation precautions immediately and informed staff. We can do that with or without a physician's order and then notify the physician, who provides the order for the duration of isolation. (R4) should never have been placed in (R3's) room. Fortunately, (R3) did not get sick. I was not aware until now, after reviewing the nurses' notes, that (V45, physician) did not respond to our fax for treatment of (R4's) pneumonia for several days, which delayed the antibiotic order. Her recovery was prolonged due to the delay in treatment. Once she started the antibiotic, she responded well and has since returned home.The facility policy titled Infection Precaution Guidelines, dated 5/15/23, documents the following: Guidelines:It is the policy of this facility to prevent the transmission of infections within the facility through the use of isolation precautions when necessary. The 2007 Centers for Disease Control and Prevention (CDC) Guidelines for Isolation Precautions will be utilized in this facility with some modifications.The same policy documents: Transmission-Based Precautions will be employed for known or suspected infections for which the route of transmission is known. The transmission-based categories are as follows: Airborne, Droplet, and Contact.Isolation precautions may be instituted by a physician, infection preventionist, director of nursing, assistant director of nursing, or nursing supervisor and may be discontinued only by one of the above. A private room is preferred. When a private room is not available, place the resident in a room with another resident with the same infection and no other infections (cohorting). Isolation precautions are considered a nursing assessment and judgment. A resident may be placed in isolation precautions without a physician's order. Notify the infection preventionist.The same policy further documents: Droplet Precautions: In addition to Standard Precautions, use Droplet Precautions for residents known or suspected to be infected with microorganisms transmitted by droplets generated by coughing, sneezing, or talking. This includes bacterial infections such as Mycoplasma pneumonia and Streptococcus infections, and viral infections including influenza. Spatial separation greater than three feet or drawing the curtain between resident beds is especially important in multi-bed rooms.