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	02/18/2026

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 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** Based on observation, interview and record review the facility failed to provide supervision in a resident bathroom and the dining room and failed to remove a mechanical lift sling from the wheelchair to prevent falls, and failed to implement fall interventions, complete a fall assessment for five of six residents (R1, R17, R21, R23 and R112) reviewed for accidents on the sample list of 46. These failures resulted in R21 falling in the dining room and suffering a fractured clavicle and laceration to the back of the head when staff were not present supervising, R23 falling and suffering an acute fracture to the tailbone when R23 slid out of the wheelchair after staff failed to remove the mechanical lift sling, and R112 falling in the bathroom and suffering a hematoma to R112's right cheek/neck area and a laceration to R112's cheek requiring adhesive skin closures when staff turned away from R112. Findings include: The facility's Fall Prevention Program Policy dated 11/28/12 with a revision on 11/21/17 documents that the purpose of this policy is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Guidelines for this policy include methods to identify risk factors, methods to identify residents at risk, use and implementation of professional standards of practice and adherence to manufacturer's recommendation in use of alarm and medical devices and special care equipment. 1.) R21's Minimum Data Set (MDS) dated [DATE] indicates the resident has moderate cognitive impairment and diagnoses of Parkinsonism and Dementia. The MDS further documents that the resident does not have the ability to safely ambulate ten feet due to medical condition and safety concerns. The Nursing Note dated 1/19/26 documents that at 6:35 pm a Certified Nurse Assistant (CNA) called out for help in the 100-hall dining room. Writer responded immediately and observed resident laying on the floor on her right side. Wheelchair was behind her, broom at her side. Resident from dining room witnessed fall and stated resident was standing up trying to sweep the floor, appeared to lose her balance and fall. When asked resident what happened, resident stated I don't know. Visible head wound to right side of head with moderate bleeding noted. Resident complained of right shoulder and right hip pain. Pressure applied to head wound. No further injuries were noted at this time. Resident is on anticoagulant therapy. Medical Doctor (MD) notified and gave order to send to ER for eval/treat. R21's X-ray Report dated 1/19/26 documents an acute fracture of the distal clavicle was identified. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R21's Care Plan dated 12/23/25 documents that the resident is at risk for falls related to a history of falls. Interventions include frequent checks on the resident (initiated 12/21/25) and increased supervision during mealtimes (initiated 11/26/25). On 2/10/26 at 10:09 a.m., V8, CNA, stated R21 is confused and has to be monitored very closely and checked at least every 15 minutes if not more. On February 10, 2026, at 10:58 a.m., V25, CNA, stated that she was aware of R21's fall but was unsure whether she was working at the facility when the incident occurred. During the same interview, V25 confirmed that R21 requires monitoring at least every 15 minutes, or more frequently as needed. V25 explained that staff are expected to maintain continuous observation of R21 to ensure her safety. She further stated that staff on the Hall, where R21 resides, make efforts to keep R21 in close proximity to staff at all times, either at the nurse's station with nurses and CNAs or engaged in activities. On 2/10/26 at 11:09 a.m., V26 CNA stated she was not present when R21 fell on 1/19/26, as she left at 6:00 p.m. that day and most residents were still in the dining room. V26 confirmed that R21 was at the dining room table when she left. V26 stated she was later informed that R21 and another resident were in the dining room when R21 got up and attempted to sweep the floor. V26 stated R21 is always confused and requires constant supervision, stating, If I'm going to be honest, staff always have to keep a very close eye on (R21), but sometimes that is very difficult to do when caring for all the other residents too. V26 stated that R21 is able to stand independently and is mobile but very unstable when up. On 2/10/26 at 11:45 a.m., R41 stated he was in the dining room with R21 when she fell. R41 stated that R21 was in her wheelchair, grabbed a broom, and began sweeping. R41 further stated that R21 then got out of her wheelchair and continued sweeping. R41 stated he turned his back for just a second, and when he did, R21 fell. R41 stated there were no staff in the dining room at the time of the fall, only himself and another resident who is cognitively impaired (name unknown). R41 stated staff had not been in the dining room that evening for quite some time and that R21 is often left on her own. R41 added that other residents frequently have to look after R21 and remind her to sit down. R41's MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 14, indicating R41 is cognitively intact. On 2/10/26 at 9:59 a.m., V15, Registered Nurse (RN), stated that R21 falls frequently and that her Care Plan documents the need for close attention from staff. V15 reported there is no specific time frame for frequent checks, but staff are expected to keep an eye on R21. V15 added that if she were working on the floor, R21 would remain with her at all times because she requires one-on-one supervision. V15 also stated she is unsure why R21's Care Plan includes an intervention for increased supervision in the dining room during mealtimes. On 02/10/2026 at 2:36 p.m., V14, Regional Nurse Consultant/Interim Director of Nursing, stated there should always be a staff member present in the dining room to provide supervision for R21 as well as other residents. V14 explained that the timing of checks for R21 depends entirely on her behavior at the time, confirming that there are occasions when R1 requires constant direction. V14 further stated staff should have remained in the dining room until all residents had left. 2.) R23's MDS dated [DATE] documents that the resident is cognitively intact and has diagnoses of Multiple Sclerosis, Demyelinating Disease of the Central Nervous System, Muscle Wasting and Atrophy (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(multiple sites), Polyneuropathy, and Abnormal Posture. The MDS further documents that R23 is dependent on staff for all aspects of mobility and requires substantial to maximal assistance with bathing. On 2/8/2026 at 10:31 a.m., R23 stated that (on1/31/26) V24, CNA, and V23, Licensed Practical Nurse (LPN), transferred her to the shower chair using a mechanical lift and left the mechanical lift sling beneath her. R23 confirmed that V23 left the room, and V24 did not pick up the mechanical lift straps from the floor before pushing the shower chair. R23 stated the straps became caught in the wheels, causing the chair to come to an abrupt stop and thrusting her forward. R23 reported that she began to slide out of the chair, and V24 called for help. R23 stated V23 returned to the room and was sent to retrieve the mechanical lift while V24 attempted to hold her in the shower chair with her body. R23 stated that before they could get her back into the shower chair with the mechanical lift, she was dropped to the floor. R23 reported experiencing excruciating pain from the fall, was sent to the local emergency department, and was diagnosed with a broken tailbone. The Computed Tomography (CT) Report dated 1/31/26 documents There is angulation at the sacrococcygeal junction (tailbone). This is new in comparison to the prior CT. No additional fractures are appreciated. On 2/09/26 at 11:54 a.m., R94 (R23's former roommate) stated she was present when R23 slid out of the shower chair. R94 stated she did not witness the incident but heard commotion and V24 calling for help. On 2/09/26 at 11:24 a.m., V24 CNA stated that while preparing resident R23 for a shower, R23 slid from the shower chair. V24 stated that earlier, V23 LPN had assisted in transferring R23 into the shower chair using a mechanical lift and then left the room. V24 stated that after V23 exited, R23 requested her bra. V24 stated R23 adjusted herself in the chair and began sliding. V24 confirmed that the mechanical lift sling was still beneath R23 and was slick, contributing to the slide. V24 stated she attempted to hold R23 in the chair using her body and called for help. V24 stated R94, R23's roommate, activated the call light and then entered the hallway with her walker to seek assistance. V24 stated that V23 and another CNA (unknown name) responded, but before they could reposition R23 into the lift, R23 fell to the floor. On 2/10/26 at 8:22 a.m., V23, LPN stated he was the nurse on duty the day R23 slid out of the shower chair. V23 reported that he assisted V24 with transferring R23 into the shower chair, spotting V24 during the mechanical lift transfer, and then left the room. V23 confirmed that the mechanical lift sling was left beneath R23 and stated this was common practice, noting that CNAs typically provide R23's bath with assistance from only one staff member. On 2/11/26 at 9:25 a.m., V20 CNA stated that she works at the facility through an agency but is frequently assigned to R23. V20 stated R23 is dependent on staff for activities of daily living (ADLs) and confirmed that R23 is fully aware of her surroundings, describing her as totally with it. On 2/11/26 at 9:36 a.m., V29, CNA, stated that R23 requires assistance with all activities and prefers to use the Reclining Shower Chair, and be wheeled to the shower room. V29 stated R23 is cognitively aware and is able to make her needs known. On 2/9/26 at 3:20 PM, V14 Interim DON/Regional Nurse Consultant stated she was aware of the incident in which R23 slid out of the shower chair. V14 indicated that, given R23's current condition, two (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	staff members should have been present at all times to complete shower tasks. V14 further stated that the mechanical lift sling should have been removed from beneath R23 before the CNA attempted to move the shower chair. 3.) R112 's diagnosis list (printed 2/11/26) 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. R112'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. R112's Fall Risk assessment dated [DATE] Completed 2/10/26 documents R112 is at risk for falls. The facility fall log (11/9/25 thru 2/9/26) documents R112 had an unwitnessed fall in the facility on 12/11/25. The facility provided a fall investigation dated 1/31/26 documenting a fall. The facility Fall Investigation dated 1/31/26 documents staff turned around as R112 stood up from the wheelchair in the bathroom of the resident room and was reaching for the towel bar then fell into the towel bar causing a laceration on the right cheek. The record further documents R112 was transferred to the hospital emergency department via ambulance for evaluation and treatment. R112's Emergency Department Report dated 1/31/26 documents R112 was diagnosed with a Facial Contusion (Acute), Soft tissue swelling of the right infraorbital region of the face with an abrasion noted about 1 centimeter in diameter at the soft tissue swelling site and required computed tomography (CT) radiographic scans to evaluate possible injuries as the physician documented there is the possibility of cervical injury depending on how hard R112's face hit the wall. The Emergency Department Note dated 1/31/26 documents adhesive skin closures were applied to R112's facial wound. The facility Fall Investigation dated 1/31/26 documents V36 (Licensed Practical Nurse) was informed by V35 (Certified Nursing Assistant) that V35 was assisting R112 from the toilet to the wheelchair, V35 stated she turned so that she could back R112 from the bathroom and when V35 turned back around V35 observed R112 had risen from the wheelchair, and was attempting to grab ahold of the towel bar. V35 stated R112 fell into the towel bar. V35 stated R112 did hit her right side of the face on the towel bar causing a laceration and swelling to the right cheek. The same investigation documents V36 entered R112's room and noted R112 laying in a low bed, noting R112's right cheek bleeding from a laceration and swollen. Nursing Progress Notes dated 1/31/26 at 7:30 PM by V36 document R112 complained of some pain to the right cheek area. V36 documents calling the primary care physician and R112 being sent to the emergency room for further evaluation. Further record review does not document a fall risk assessment following the fall dated 1/31/26. R112's Care Plan dated 05/25 was not revised after R112's documented fall on 1/31/26 with a targeted intervention. On 2/8/26 at 11:45am R112 was sitting at the dining room table. R112's right cheek and right neck were discolored yellowish green transitioning into purple from the right infraorbital/cheekbone down to the collar bone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/8/26 at 12:30pm R112's bathroom contained a towel rack above and to the right of the safety grab bar. The left end piece of the towel rack was loose and dislodged. On 2/8/26 at 11:45am V33, Memory Care Coordinator, stated R112 recently had a fall and R112 hit R112's cheek on the towel bar in her bathroom that causing a laceration and bruising and it is now healing. On 2/8/26 at 12:30pm V34, Certified Nursing Assistant, confirmed the towel bar remained in R112's bathroom located at R112's head height and the left end piece of the towel bar was loose and dislodged. V34 stated she was not present at the time of the fall. V34 confirmed R112 did have injuries related to hitting the towel bar upon falling. On 2/9/26 at 10:03am V38, R112 Family, confirmed she received a phone call stating R112 fell in the bathroom and hit R112's cheek on the towel bar and was being transferred to the local emergency room for further evaluation. On 2/9/26 at 12:05pm V15, Minimum Data Set/Care Plan Coordinator (MDS) stated falls are discussed in meetings, the root cause is determined and if a safety concern is identified it is addressed, and the care plan is then updated with a targeted intervention. V15 confirmed R112's care plan was not updated with an intervention following the fall documented on 1/31/26. V15 confirmed the towel bar presented a safety hazard. On 2/9/26 at 12:25pm V14, Regional Nurse Consultant (RNC), stated fall risk assessments are to be completed after a fall. V14 stated there should be 72 hour follow up charting on any resident involved in an incident/accident. V14 confirmed R112's medical record did not contain a fall risk assessment completed after the 1/31/26 documented fall. V14 confirmed R112's medical record did not contain follow up charting after the documented 1/31/26 fall. On 2/9/26 at 12:25pm V1, Admin and V14, RNC, confirmed the fall investigation for R112 dated 1/31/26 did not contain a targeted intervention, the care plan did not contain a targeted intervention, and the towel bar in R112's bathroom presented a safety hazard. On 2/10/26 at 3:50pm V18, Former Director of Nursing, stated V18 did not recall any intervention being put in place for R112's fall on 1/31/26. V18 stated the CNA should not have turned away from R112 when R112 was in the bathroom to walk around the wheelchair. V18 stated if the CNA was facing R112, the CNA would have seen R112 attempting to stand up and been able to redirect R112 to sit down and prevent the injury. On 2/11/26 The Fall Prevention Program/Policy dated 11-28-12 documents the Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Program further documents Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate- Preventative measures--Standards: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk. Fall/safety interventions may include but are not limited to: The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards. 4.) R1's fall prevention Care Plan with a revision date of 8/8/25 documents a 6/24/25 intervention to have floor mats on each side of bed. On 2/08/2026 at 9:14 AM, R1 was lying in bed. A fall mat was leaning against the wall by the door. There was not a fall mat in place on R1's right side of the bed on the floor. On 2/08/2026 at 1:36 PM, R1 was lying in bed. A fall mat was leaning against the wall by the door. There was not a fall mat in place on R1's right side of the bed on the floor. On 2/08/2026 at 1:36 PM, V6 Licensed Practical Nurse stated that R1 was supposed to have the fall mat on the floor on both sides of the bed when R1 is in bed. 5.) R17's fall prevention Care Plan with a revision date of 5/19/25 documents R17 is at high risk for falls. This care plan documents a 10/10/25 interventions for activities to provide working task for R17. This care plan also includes a 9/15/25 intervention for a concave mattress and a 10/29/25 intervention for skid strips to be placed by the bed. On 2/10/2026 at 3:12 PM R17 was lying in bed, R17 was lying on a regular mattress and not on a concave mattress. At this time, there were no non-skid strips observed by the bed. On 2/11/2026 at 9:53 AM, V7 Certified Nurse Assistant stated she has worked in the facility since August of this year and has taken care of R17 since starting in the facility. V7 stated she has never seen a concave mattress on R17's bed or non-skid strips on the floor. On 2/11/2026 at 8:49 AM, R17 was sitting in the television room holding a news flyer. R17 was not working on any type of a task at that time. On 2/11/2026 at 10:00 AM, V32 Activity Aide stated R17 occasionally participates in activities. V32 stated she is not familiar with the interventions about a working task for R17. V32 stated they do not always communicate the interventions to her. On 2/11/2026 at 10:04 AM, V1 Administrator stated R17's interventions of the concave mattress and the non-skid strips should have been put into place. V1 stated the intervention about the working task on R17's care plan was not measurable and unclear and that this intervention should be conveyed to the activity staff.

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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 provide a registered nurse for eight consecutive hours daily. This failure has the potential to affect all 104 residents of the facility. Findings include:On 2/9/26 at 10:10am V1, Administrator, stated the facility does not have a stand-alone staffing policy and follows the minimum guidelines for nurse staffing hours including registered nurse coverage. On 2/9/26 V1, Administrator, provided nursing staffing sheets that document the facility nurses work twelve (12) hour shifts. On the following dates per the provided nurse staffing sheets, no registered nurse coverage was scheduled or available in the nursing facility:1/3/26; 1/4/26; 1/17/26; 1/18/26; 1/31/26; 2/1/26.On 2/10/26 at 3:50pm V18, Former Director of Nursing, stated V18's last day of employment in the facility was 1/30/26. V18 stated the facility did not always have a registered nurse available especially on weekends. V18 stated the facility used agency nurses to fill in when house nursing staff were unavailable, and agency Registered nurses were not always available to fill the open shifts.The Long-Term Care Facility Application for Medicare and Medicaid form dated 2/08/26 documents 104 residents reside in the facility.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately transcribe an order for Seroquel (antipsychotic), failed to administer an antiparkinsonian medication as recommended prior to meals and failed to ensure medications were taken by the resident for three of 46 residents (R7, R83 and R44) reviewed for medications in the sample list of 46 residents. This failure resulted in exacerbation of R7's behavioral symptoms related to dementia when R7 missed 13 days of R7's antipsychotic due to a transcription error. Findings Include:1.R7's Care Plan updated 11/6/25 documents the following diagnoses: Type II Diabetes, Alzheimer's Dementia, Repeated Falls, and Major Depression.R7's Minimum Data Set (MDS) dated [DATE] documents R7 has no behavioral symptoms.On 2/8/26 at 9:00AM R7 was in his bed watching television (TV). The Surveyor knocked on R7's open door. R7 shouted What and who the H*** are you. The Surveyor introduced self and identified to R7 we are here from IDPH (Illinois Department of Public Health) to talk with residents about the care they receive at the facility. R7 seemed very agitated and shouted Well if you are from the F******(expletive) state get me out of here now. I am being held prisoner. That F******(expletive) B****(expletive) had them arrest me. The Florida state police went into Georgia and arrested me and brought me to Illinois. R7 beat his fists on the bed rail and shook the bed. The Surveyor replied she could see how upset R7 was and would let him get back to his TV. R7 became even louder and continued to pound on the bed with his fists. R7 shouted You F******(expletive) B****(expletive) if you are with the state why can't you get my A**(expletive) out of here and get my money back.On 2/8/26 at 3:00PM V1, Administrator stated we are aware (R7's) behavior is escalating and he has been seen by (a contracted psychiatric provider). V14, Corporate RN and acting DON stated (R7) is very suspicious of his POA (Power of Attorney), he doesn't like women and his behavior related to Dementia is really increasing.R7's Psychiatric Notes dated 12/10/25 by V17, Physician's Assistant (PA) for psychiatric contractor document an order for: Med Changes: Patients diagnosis of Major Depressive Disorder is worsening and unstable at this visit. Increase Sertraline to 100Mg in the AM. Start Trazadone 25Mg at HS (bedtime). Start Quetiapine 25Mg PO (by mouth) every 6 hours PRN (as needed). Continue Quetiapine 50Mg (Daily) for agitation related to Dementia. Continue Memantine 5Mg daily for cognitive decline related to Dementia.R7's Medication Administration Record (MAR) for February and R7's current Physician's Order Sheet document R7's Quetiapine 50Mg was discontinued in error on 1/28/26 and no PRN doses were administered.On 2/9/26 at 2:00PM V14 acting DON verified that the Quetiapine was discontinued in error and R7 had missed doses from 1/28/26 until the surveyor brought this error to the facility's attention on 2/9/26 totaling 13 doses. On 2/10/26 at 12:30PM V17 Psychiatric PA stated It was my intention to continue (R7's) dose of 50Mg Quetiapine daily. (R7) was having increasing agitation and aggressive behavior. It is never a good idea to stop an antipsychotic without tapering and I rarely give a PRN order for antipsychotic especially in a senior, but I spent nearly an hour with (R7), and I really thought it was justified. I do believe that stopping (R7's) quetiapine so abruptly caused (R7's) behavior to escalate even more.The package insert for Seroquel revised January 2022 documents Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been described after abrupt cessation of an atypical antipsychotic drugs including Seroquel.On 2/11/26 at 1:00PM V1, Administrator and V14 Acting Director of Nurses verified R7's behaviors including cursing, isolating, shouting, and refusal of care have increased since R7 has not received the correct dose of Seroquel.On 2/11/26 at 2:00PM V11, Activity Director stated Since the end of January (R7) has not come to activities at all. I have heard him in his room shouting and cursing. I was helping pass trays on Sunday (2/8/26). I took (R7's) tray to him. He pointed at the tray table, and I placed the tray (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	on it and went to get another tray. As I was walking by his room, I heard a commotion and (R7) had knocked his tray off the table and across the room. (R7) is more agitated.2. R83's Care Plan initiated 1/7/26 documents the following diagnoses: Depressive Disorder, History of Fracture of Right Femur with Hip Replacement, and Parkinson's Disease.R83's Minimum Data Set (MDS) dated [DATE] documents R83 as moderately cognitively impaired.On 2/8/26 at 1:00PM V43 (R83's family member) stated When (R83) was ordered the Carbidopa/Levodopa we were told to always give it 30-60 minutes prior to food because high protein food interferes with the absorption of the medication. It is ordered here at 5:00AM, 11:00AM, and 5:00PM. They tell me they have one hour before and one hour after to give his medication. It is sometimes before and sometimes after and sometimes with meals and I think it's causing (R83's) Parkinson's symptoms to get worse.R83's Medication Administration Record (MAR) for February 2026 documents Sinemet Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE WITH DYSKINESIA, WITH FLUCTUATIONS. The package insert for Levodopa/Carbidopa 25/100 documents The patient should be advised that a change in diet to foods that are high in protein may delay the absorption of levodopa and may reduce the amount taken up in circulation. Excessive acidity also delays stomach emptying, thus delaying the absorption of levodopa. Iron salts (such as in multivitamin tablets) may also reduce the amount of levodopa available to the body. The above factors may reduce the clinical effectiveness of levodopa or carbidopa-levodopa therapy.On 2/9/26 at 1:30PM V13, R83's primary physician stated The timing 30-60 minutes prior to meals for (R83's) Sinemet is crucial for absorption of this medication. If it isn't given prior to meals high protein food will compete with the medication for absorption. If Sinemet is being given incorrectly I believe this is causing (R83's) increase in Parkinson's symptoms.On 2/8/26 V10, Licensed Practical Nurse verified medications are given within one hour prior or one hour after the time on the MAR. V10 stated I have 35 residents to get meds out to. Have you ever had to do that?On 2/9/26 at 2:15PM V14, Acting DON (Director of Nursing) confirmed R83's medication had been given without regard to meals.3. R44's Minimum Data Set (MDS) dated [DATE] documents R44 is cognitively intact. On 2/10/26 at 10:00AM R44 stated Sunday evening (2/8/26) the agency nurse that was working left all my evening meds on the dresser for the empty bed next to me. I didn't remember I hadn't taken them until (V28), Activity Assistant found them the next day. I missed all my evening meds.R44's MAR documents the medications due at 8:00PM include the following: Amlodipine (antihypertensive) 5Mg twice daily, Atorvastatin (anticholesterol) 40mg at bedtime daily,Lisinopril (antihypertensive) 40 mg at bedtime daily, Senna (laxative) 8.6 mg two tablets at bedtime daily, Eliquis (anticoagulant) 5 mg twice daily, Famotidine (pump inhibitor) 20mg twice daily, Keppra (Antiseizure) 1000mg twice daily, Metoprolol (Beta Blocker) 37.5 mg twice daily.On 2/10/26 at 11:00AM V14, Acting DON verified V28 found R44's 8:00PM medications in a cup. V14 verified the medications were identified as all V14's 8:00PM medications.On 2/10/26 at 11:15AM V1, Administrator verified R11 did not receive any of her 8:00PM medications on 2/8/26 as they were left in a cup sitting on the dresser by an agency nurse.The facility's policy Physician's Orders Entering and Processing revised 1/31/18 states Following a physician's visit, a licensed nurse will check for any orders that require confirmation under: Clinical, Orders, Pending Orders. The orders will be confirmed by the nurse and instructions for the order will be completed.