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	04/15/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident rights were protected when they failed to ensure Advanced Directives were obtained and/or documented for one (R2) of one resident reviewed for advance directives in the sample of nine residents.Findings include:On 4/15/2026 at 11:45am, R2's record review does not contain an Advanced Directive, POLST (Physician Ordered Life Sustaining Treatment) form or a physicians order for life sustaining treatment.R2's record review documents an admission date of 2/2/26 with diagnosis of Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Reduced Mobility, and Type 2 Diabetes Mellitus Without Complications. Minimum Data Set, dated [DATE] documents R2 is cognitively impaired.On 4/15/2026 at 11:50am, V8 (R2's) Power of Attorney, stated V8 had not chosen or signed a POLST (Physician Ordered Life Sustaining Treatment) form for R2.On 4/15/2026 at 12:30pm, V2 Regional Nurse Consultant confirmed there is no physician order for life sustaining treatment or POLST (Physician Ordered Life Sustaining Treatment) form documented in R2's medical record.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from physical abuse for one (R5) of five residents. This failure affected two (R5 and R6) residents on the sample of seven residents. Findings include:R5's record reviews document an admission date of 3/30/2022 with diagnosis of Dementia with Psychosis, Depression, Gastritis, Basal Cell Carcinoma of Skin of Nose, Type 2 Diabetes Mellitus, and Sick Sinus Syndrome with Pacemaker. R5's Minimum Data Set, dated [DATE], documents R5 is cognitively impaired. On 4/13/26 at 10:20am, R5 was unable to be interviewed due to cognitive impairment.On 4/13/26 at 12:08pm, V9 (R5's) family member, stated V9 was informed on 03/24/26 that R5 was struck in the back of R5's head by another resident (R6) while R6 was attempting to hit a staff member. V9 stated the nurse informed V9 that R5 was uninjured but V9 insisted R5 be sent to the local emergency room for evaluation. V9 stated R5 did not have any injuries and returned to the facility. V9 stated that R6 has not been seen since the incident.On 4/14/26 at 10:10am, V3 License Practical Nurse (LPN) confirmed the incident occurred on 3/24/26. V3 LPN stated R6 was experiencing behaviors in the common area of the unit. While another employee was attempting to re-direct R6, R6 attempted to swing and hit that employee and missed hitting R5 on the back of the head. V3 LPN stated multiple employees then were able to remove R6 from the area. R5 was assessed and no injury was found. On 4/14/26 at 10:29am, V5 Certified Nursing Assistant (CNA) stated V5 was on break. V5 CNA returned to the unit and noticed R6 was having behaviors and wanting to go home. All the unit residents were gathered in the common area as staff was attempting to protect the other residents from R6 who was flipping over tables and being violent towards staff. V5 CNA stated V5 was told of R5 being hit but did not witness the incident. V5 CNA stated R5 was acting at R5's baseline, but R5's family wanted R5 sent to the local hospital for examination.On 4/14/26 at 10:46am, V4 Certified Nursing Assistant (CNA) confirmed V4 witnessed R6 attempting to hit another staff member and missed, instead R6 hit R5 in the back of the head. V4 stated R6 was having behaviors and exit seeking.On 04/15/26 at 11:55am, V7 Dietary Manager confirmed R6 did hit R5 in the back of the head, while attempting to hit another staff member. V7 stated R5 has been herself and acting at R5's baseline.On 4/15/26 at 12:30pm, V1 Administrator and V2 Regional Nurse Consultant (RNC), confirmed the incident from 3/24/26 involving R5 and R6. V1 stated R6 was attempting to hit an employee and missed the employee but hit R5 on the back of the head.Record review of the state agency received facility investigation dated 3/26/26 documents on 03/24/2026, R6 was experiencing behaviors. While experiencing behaviors R6 attempted to make contact with a staff member and made contact with peer, R5 instead. Nursing assessment completed. No injuries noted. Record review of local hospital notes dated 3/24/26 at 12:13pm documents patient (R5) presents to emergency room in care of EMS (emergency medical services) from a local nursing home. Patient (R5) was sitting in her wheelchair when another resident struck her in the back of the head. Patient (R5) is alert to her norm (dementia), has no complaints, nothing noted on visual inspection. Abuse Prevention and Reporting policy dated 11-28-16 documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment.

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

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F 0684 Level of Harm - Minimal harm or potential for 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 one deficient practice statementA. Based on interviews and record reviews the facility failed to ensure follow up medical appointments were scheduled for one (R3) of one resident reviewed for medical appointments in the sample of seven residents.B. Based on interview and record review the facility failed to ensure neurological assessments were completed for one (R5) of one resident reviewed for incidents involving a head injury in the sample of seven residents.Findings include:a. R3's record review documents an admission date of [DATE] and a discharge date [DATE] with diagnosis of Ascites, Cirrhosis, Liver Mass, Dementia, Ascites of Liver and Type 2 Diabetes Mellitus. Further record review documents R3 was admitted to hospice care on [DATE] with the terminal illness Dementia and a Liver Mass. On [DATE] at 10:10am, V15 Hospice Nurse confirmed the facility should have scheduled and transported R3 to a treatment center if paracentesis was needed. V15 confirmed that R3 self-removed R3's drain and that R3's family requested a paracentesis be performed on several occasions.On [DATE] at 11:15am, V14 Nurse Practitioner (NP), confirmed the progress note dated [DATE] stating the hospital would not re-insert the drain, but would perform paracentesis if needed. V14 NP confirmed R3 was diagnosed with a terminal illness and was on hospice and has since expired.On [DATE] at 12:30pm, V2 Regional Nurse Consultant (RNC), confirmed the progress note written by V14 NP in the medical record stated the local hospital would do the paracentesis. V2 RNC stated the hospice company should have scheduled the paracentesis for R3 as the hospice company was managing the care for R3.The nursing progress note dated [DATE] at 01:10am documents the nurse entered resident's (R3's) room and observed the indwelling catheter drain tubing located on the outside of resident (R3). V14 Nurse Practitioner documented on [DATE] at 11:12am a referral for reinsertion of indwelling catheter drain re-inserted. However, as per nursing staff from local hospital, Medical Doctor (MD) declined stating that it is too soon to attempt reinsertion. If R3 needs paracentesis, they will drain R3.On [DATE], R3's record review contained multiple nurses progress notes documenting R3's increase in abdominal girth/ascites. Many of these same note's document R3's family asking when the abdominal indwelling catheter drain can be re-inserted and questioning when R3 will have a paracentesis. b. R5's record review documents an admission date of [DATE] with diagnosis of Dementia with Psychosis, Depression, Gastritis, Basal Cell Carcinoma of Skin of Nose, Type 2 Diabetes Mellitus, Sick Sinus Syndrome with Pacemaker. R5's Minimum Data Set, dated [DATE] documents R5 is cognitively impaired. On [DATE] at 12:08pm, V9 (R5's) family member, stated V9 was informed on [DATE] that R5 was struck in the back of R5's head by another resident (R6) while R6 was attempting to hit a staff member. V9 stated the nurse informed V9 that R5 was uninjured but V9 insisted R5 be sent to the local emergency room for evaluation. On [DATE] at 10:10am, V3 License Practical Nurse (LPN) confirmed the incident occurred on [DATE]. V3 stated R6 was experiencing behaviors in the common area of the unit. While another employee was attempting to re-direct R6, R6 attempted to swing and hit that employee and missed hitting R5 on the back of the head. V3 LPN stated multiple employees then were able to remove R6 from the area, assess R5 and found no injury. On [DATE] at 10:46am, V4 Certified Nursing Assistant (CNA), confirmed V4 witnessed R6 attempting to hit another staff member and missed, instead R6 hit R5 in the back of the head. V4 stated R6 was having behaviors and was exit seeking.On [DATE] at 11:55am, V7 Dietary Manager (DM), confirmed R6 did hit R5 in the back of the head, while attempting to hit another staff member. V7 DM stated R5 has been herself and acting at her baseline.On [DATE] at 12:30pm, V1 Administrator and V2 Regional Nurse Consultant (RNC), confirmed the incident from [DATE] involving R5 and R6. V1 stated R6 was attempting to hit an employee and missed the employee but hit R5 on the back of the head. V2 RNC confirmed the medical record did not contain completed neurological assessments following a known head injury. V2 RNC stated the neurological assessments should have restarted and been completed upon R5's return from (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital. Record review of the state agency received facility investigation report dated [DATE] documents on [DATE], R6 was experiencing behaviors. While experiencing behaviors R5 attempted to make contact with staff member and made contact with peer, R5 instead. Nursing assessment completed. No injuries noted. Record review of local hospital notes dated [DATE] at 12:13pm documents patient (R5) presents to ER (Emergency Room) in care of EMS (Emergency Medical Services) from local nursing home. Patient (R5) was sitting in her wheelchair when another resident struck her in the back of the head. Patient (R5) is alert to her norm (dementia), has no complaints, nothing noted on visual inspection. There was no fall involved and no loc (loss of consciousness).Neurological assessment policy dated [DATE] documents residents will have neurological assessments completed when they experience a head injury. 1. Neurological assessments will be completed upon a physician's order, when indicated for achange of resident's condition, after all head injuries and when nursing judgement deems necessary.