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	05/28/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify resident family/representatives of missed administration of significant morning medications. This failure affects eight of twelve residents (R1, R2, R3, R4, R5, R6, R7, and R8) reviewed for notification/medications on the sample list of 16.Findings include:R1, R2, R3, R4, R5, R6, R7, and R8's, Medication Administration Records dated May 1-31, 2026, do not document nurses' initials in the blank boxes, to indicate the R1, R2, R3, R4, R5, R6, R7, and R8's medications were administered on May 10, 2026, during morning medication administration.R1, R2, R3, R4, R5, R6, R7, and R8's Progress Notes do not document that family representatives were notified of the medication omission errors.On 5/21/26 at 11:10 am V23, R8's Power of Attorney said the facility did not notify V23 that R8 missed her medications on Mother's Day 5/10/26.On 5/21/26 at 1:55 pm V12, R1's Family Member stated she was not contacted by the facility to inform them that R1 missed her medications on 5/10/26.On 5/21/26 at 5:30 pm V20, R2's Family Member stated There has not been anyone call or tell me there were problems on Mother's Day (5/10/26) with my dad getting any of his medications.On 5/21/26 at 10:10 am V2, Interim Director of Nursing/Regional Nurse Consultant (DON) said that it is standard of practice that the family representatives be notified of medication errors. V2, DON said facility nurses, working the floor are expected to contact the families to inform them of the medication errors, and document the notification in the resident's medical record.The facility policy Physician-Family Notification- Change in Condition dated as revised 11/13/18 documents the following: Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. Responsibility: Licensed Nursing Personnel / Social Services Guidelines: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member.

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interview, the facility failed to ensure an adequate number of licensed nursing staff were in the facility to provide resident care and services. This failure has the potential to affect all 103 residents who reside in the facility.Findings include:The Facility Assessment Tool updated 4/1/26 documents the following: PurposeThe purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.Staffing plan Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time.The same Facility Assessment Tool documents the facility requires a total number of Licensed Nurses staffed per shift to meet the care needs of the residents:Day shift: 6:00 am -6:00 pm, four Licensed Nurses.Evening Shift: 6:00 pm -10:00pm, four Licensed Nurses.Night Shift: 6:00 pm- 6:00 am, three Licensed Nurses.The facility nurses staff timecards for May 10, 2026, the nursing schedule and the daily work assignment sheet for May 10, 2026 are incongruent and/or illegible, and had to be clarified by interviews by V1, Administrator. In addition to discrepancy noted, according to the multiple interviews below, V4, MDS/LPN worked an undetermined amount of time, and does not enter her time electronically.On 5/20/26 at 11:20 am V1, Administrator reviewed the nurses schedule and daily nurse sheets. V1 stated on Mother's Day the facility had big problems. V1 stated he was on vacation. V1 also stated We knew there were staffing problems. We had two nurses from Agency call off. We also had one of our nurses call off. We were three short. CNA's staffing was ok. (V10, Scheduler) was working diligently to find staff. The DON (V2, Director of Nursing) was already on vacation and did not return until the day after Mother's Day. I know there were two nurses from our sister facility (V7 and V8 Registered Nurses) that came in and worked partial shifts. They came in at 8:00 pm or 8:30 pm. We had issues with staffing from 6:00 pm to 6:00 am and 6:00 am - 6:00 pm. (V4, Licensed Practical Nurse/Minimum Data Set Coordinator Nurse) worked a partial shift. (V4) came in about 9:00 am and worked until about 4:00 pm or 4:30 pm, to help out. It looks like these sheets are a mess with all the call offs. (reviewing illegible day assignment sheet) (V6, Licensed Practical Nurse) worked Memory care a full shift that night. (V9, Licensed Practical Nurse) came in at 7:00 pm. On both shifts we usually have four nurses to meet the needs of the residents. Even with the extra nurses coming in to work we were still short. According to V1's interview, the interviews below and documents reviewed the facility Licensed Nurse Staff hours were short on 6:00 am to 6:00 pm shift, 12 hours on 100 hall, and approximately three hours on 200 /top of 300 hall for a total of approximately 15 hours. The facility Licensed Nurse Staff hours were short and were short approximately five hours, 6:00 pm until 8:30 pm.On 5/20/26 at 1:55 pm R2 stated Is always a bad deal. Getting my meds. Mother's Day was the worst. There was no nurse, and I did not get my insulin in the morning. I was not as concerned about my other medications. I was really concerned about my insulin that morning. They didn't even do an ACCU check.On 5/20/26 at 2:10 pm R1 stated there was not a nurse on duty all day on mother day 5/10/26 which resulted in R1 not receiving her medications.On 5/20/26 at 2:15 pm V16, CNA stated Mother's Day and I worked on 100 Hall with another aide. Several of the residents were upset because none of them got their medications. There was only a nurse on the other hall, that came over in the afternoon. She was there for about 20 minutes. That was really, bad. It shouldn't go that way.On 5/21/26 at 10:10 am V2, Interim Director of Nursing/Regional Nurse Consultant said she was on vacation and was aware there were several nursing shifts open on Mother's Day when she left the Tuesday before Mother's Day. V2 also said she was not aware until (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Monday that some 100 hall residents did not get their meds. V2 confirmed insulins and other significant medication errors were due nurse staffing issues, when the nurses on duty failed administration of all the residents' medications.On 5/21/26 at 11:50 am V27, Certified Nursing Assistant stated she worked Mother's day with no nurse all day shift on 100 hall. V27 said V4, LPN worked 200 hall and the top of 300 hall, at 9:00 am and left sometime around 4:00 pm, and there was no nurse that worked the rest of that shift.On 5/21/26 at 1:55 pm V12, R1's Family Member said there was not a nurse on 100 hall on Mother's Day, therefore, R1 did not have her blood glucose level checked until later in the day.R1's Blood Sugar tracking sheet records R1's first blood glucose measurement on 5/10/26 was completed at 2:08 pm and measured 441, which required 12 units of insulin.On 5/22/26 at 11:45 am V13, Licensed Practical Nurse (LPN) stated she worked 400 hall on Mother's Day and stayed over until 9:00 pm. There was no nurse on 100 hall. I had 30 residents of my own. On 5/22/26 at 12:15 pm V29, Agency Licensed Practical Nurse (LPN) said she worked the Memory Care unit on the opposite side of the building from the 100-hall unit. V29, LPN said there was no nurse on 100 hall day shift. A CNA called V29, LPN over to the 100 hall, when a resident (R2) to resident (R12) altercation took place in the 100-hall dining room. V29, LPN said she responded to the altercation and did an assessment. While in the process of providing R2 and R12's care, V29 was called back to the Memory Care unit to assess R13 who had a fall. V29 also said that there was a nurse that came in and worked 9:00 am until about 4:00 pm on 200 hall and the top of 300 hall. She left without saying a word, did not count narcotics at the end of her shift and left the medication cart keys on top of the medication carts. V29 also confirmed the medication keys were accessible to residents, staff and visitors at the center nurse's station.On 5/28/26 at 10:00 am V4, Licensed Practical Nurse/Minimum Data Set Coordinator stated she worked a partial shift on Mother's Day. When she came in to work at 9:00 am V4 found the medication cart/narcotic box keys on the top of the 200 hall and 300 hall medication carts, and both med carts were parked at the center (corridor) nurses' station. V4 said there was not a nurse available to count narcotic medications when she came in to work nor when she left the facility. V4 stated she left the medication keys where she found them when she came in to work. V4 also stated she does not punch in electronically for her shift as an MDS Coordinator she just reports her time to V42, Human Resource Director.On 5/21/26 at 10:10 am V2, Interim Director of Nursing/Regional Nurse Consultant (DON) acknowledged the medication omission errors on 100 hall, Mother's Day 5/10/26, resulted from being short of licensed nurse staff. The facilities CMS-802 Matrix dated 5/20/26 documents 103 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 interview and record review the facility failed to administer physician ordered medications during the morning medication administration pass on 5/10/26, which resulted in significant medication errors for eight of twelve residents (R1, R2, R3, R4, R5, R6, R7, and R8) reviewed for medications on the sample list of 16. This failure resulted in R5, R6 and R7 to endure and sustain pain and discomfort for an extended amount of time due to not receiving physician ordered narcotic pain medications.Findings include: Findings include:1. R5's Minimum Data Set (MDS) dated [DATE] documents the following: R5's Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment. R5's same MDS documents R5 has routine pain medications, frequent Pain, at a moderate level that occasionally interferes with her activities of daily. R5's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Oxycod/APAP (Oxycodone/ Acetaminophen treatment for moderate to severe pain), TAB 5-325MG Give 1 tablet orally every 4 hours (routine) for pain related to Rheumatoid Arthritis Unspecified, Unilateral, Primary Osteoarthritis Left Hip, and Other Forms of Scoliosis, Site Unspecified. The associated Pain assessment scheduled at 8:00 am was not documented as completed.Benazepril HCl Oral Tablet 10 MG (Benazepril HCl), Give 10 mg by mouth one time a day related to Essential Hypertension.R5's Corresponding May 1-31, 2026, Medication Administration Record does not document nurses' initials in the blank boxes, to indicate the above medications were administered on May 10, 2026, during morning medication administration.On 5/22/26 at 10:20 am R5 stated I have a lot of pain every day. On Mother's day (5/10/26) it was extreme. I was hurting on that pain scale thing, 10 out of 10 because I did not get pain medication when it was scheduled. I did not get any of my morning medications. I needed Oxycodone, it is scheduled for breakfast. The other medications I take, I need them, but I was not overly concerned about that. Meds (medications) are late, frequently. I know I will get them when the nurse gets caught up. I needed my oxy (Oxycodone) and had asked the CNA (unidentified). There was no nurse down this hall. The other nurse was busy and never made it over here to give me my meds.R5's Controlled Substance Proof Of Use sheet dated 5/10/26 entry, documents R5 did not have R5's Oxycodone/APAP Tab 5-325 mg removed from the Narcotic supply until the 12:00 pm dose. This confirms there was no 8:00 am dose administered to R5.R5's Care Plan dated 4/19/26 documents the following: Potential for pain related to: osteoarthritis Will have any complaints of pain controlled to acceptable level. I am on pain medication, Date Initiated: 06/24/2025. Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness. 2. R1's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML (units per milliliter) (Insulin Aspart), Inject 5 (five) units subcutaneously before meals related to Type II Diabetes Mellitus Without Complications.Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 200 - 250 = 3; 251 - 300 = 5; 301 - 350 = 8; 351 - 400 = 10; 401+ = 12u Notify MD (Physician) or NP (Nurse Practitioner) if Blood Sugar is <60 or >400, (less than 60, or greater than 400) subcutaneously before meals related to Type II Diabetes Mellitus Without Complications. No measurement of R1s's blood glucose was recorded on the corresponding Medication Administration Record to determine if the sliding scale insulin was needed 8:00 am on 5/10/26.R1's Blood Sugar Summary sheet documents R1's first blood sugar measurement on 5/10/26 was not completed until after lunch at 2:08 pm (instead of before meals as ordered) and measured 441 mg/dL (milligrams per deciliter). The corresponding Medication Administration record documents R1 received 12 units of insulin based on this measurement. R1's corresponding Progress Notes do not document R1's Physician or Nurse Practitioner were notified that R1's blood glucose measurement was greater than 400. Aspirin Oral Tablet Delayed Release 325 MG (Aspirin), Give 1 tablet by mouth one time a day related to Hemiplegia and Hemiparesis Following Cerebral Infarction, Affecting Left Non-Dominant (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Side. SIDE (I69.354); Essential Hypertension, Cerebral Infarction, Occlusion and Stenosis of Unspecified Cerebral Artery.Propranolol HCl ER Oral Capsule Extended Release 24 Hour 80 MG (Propranolol HCl), Give 80 mg by mouth one time a day related to Essential (primary) Hypertension.Glipizide Oral Tablet 10 MG (Glipizide), Give 1 tablet by mouth two times a day related to Type II Diabetes Mellitus Without Complications.R1's Corresponding May 1-31, 2026, Medication Administration Record does not document nurses' initials in the blank boxes, to indicate the above medications were administered on May 10, 2026, during morning medication administration.On 5/21/26 at 1:55 pm V12, R1's Family Member stated V12 had great concerns regarding R1's insulin medications not being administered on 5/10/26. V12 stated R1 not getting R1's medications was worrisome.On 5/22/26 at 11:45 am V13, Licensed Practical Nurse (LPN) stated I worked 400 hall on Mother's Day, and stayed over until 9:00 pm. There was no nurse on (working) 100 hall. I had 30 residents of my own (to care for on 400 hall). (V42, Humane Resource Director) told me I needed to go pass the meds that I could on 100 hall. That was after 1:30 pm. One of the CNA's (Certified Nursing Assistants, unidentified) said (R1) was not feeling well. I did accu-checks (finger stick blood glucose measurement) and insulin for the residents on 100 hall since those are the most important. I took (R1's) accu-check and it was over 400. I gave sliding scale insulin to cover. I did not call the doctor like (as) the order says (directs) to do. We were so busy, I guess it slipped my mind.3. R2's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders.Abilify (Antipsychotic) Oral Tablet 2 MG (Aripiprazole), Give 2 tablet by mouth one time a day related to Delirium Due To Known Physiological Condition.Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 150 - 199 = 2U; 200 - 249 = 4U; 250 - 299 = 6U; 300 - 349 = 8U; 350 - 399 = 10U Notify MD of BS 400<, subcutaneously with meals related to Type II Diabetes Mellitus Without Complications. No measurement of R2s's blood glucose was recorded on the corresponding Medication Administration Record to determine if the sliding scale insulin was needed the morning of 5/10/26.Prednisone Oral Tablet 5 MG (Prednisone), Give 5 mg by mouth two times a day related to Secondary Malignant Neoplasm of Bone.Bicalutamide Oral Tablet 50 MG (Bicalutamide), Give 50 mg by mouth one time a day for Antineoplastics and Adjunctive Therapies.Furosemide Oral Tablet 40 MG (Furosemide), Give 1 tablet by mouth two times a day for diuretic.Spironolactone Oral Tablet 25 MG (Spironolactone) Give 0.5 tablet by mouth one time a day for diuretics.Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate), Give 50 mg by mouth one time a day for Hypertension.R2's Corresponding May 1-31, 2026, Medication Administration Record does not document a nurses' initials in the blank boxes, to indicate the above medications were administered on May 10, 2026, during morning medication administration.On 5/20/26 at 1:55 pm R2 stated He has bone cancer and is very weak. R2 stated It is always a bad deal getting my meds. Mother's Day was the worst. There was no nurse, and I did not get my insulin, in the morning. I was not as concerned about my other medications. I was really concerned about my insulin that morning. They didn't even do an Accu-Chek (finger stick glucose measurement check).4. R3's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Imatinib Mesylate Oral Tablet 400 MG (Imatinib Mesylate), Give 1 tablet by mouth one time a day related to Chronic Myeloid Leukemia, BCR/ABL Positive, Not Having Achieved Remission.Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector, Inject 5 unit subcutaneously before meals related to TYPE II Diabetes Mellitus With Diabetic Neuropathy, Unspecified.Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro), Inject as per sliding scale: if 150 - 199 = 2U; 200 - 249 = 4U; 250 - 299 = 6U; 300 - 349 = 8U; 350 - 399 = 10U Call MD IF BS (blood sugar/glucose) >400, subcutaneously before meals. Related to TYPE II Diabetes Mellitus with Diabetic Neuropathy, Unspecified. No measurement of R3's blood glucose was documented to determine the dosage of insulin that needed administered the morning of 5/10/26.Bumetanide (strong diuretic) 2 MG Tablet, Give 2 tablet by mouth one time a day related to Chronic Combined Systolic (Congestion) and Diastolic (Congestion) Heart Failure.R3's Corresponding May 1-31, 2026, Medication Administration Record fails to document (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	nurses initials in the blank boxes, to indicate the above medications were administered on May 10, 2026 during morning medication administration.5. R4's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Oxcarbazepine (seizure medication) Tablet 600 MG, Give 1 tablet orally one time a day related to Multiple Sclerosis, Unspecified, Polyneuropathy, Unspecified, Unspecified Convulsions.Pregabalin Cap 150 MG, Give 1 capsule orally one time a day for pain related to Multiple Sclerosis, Unspecified, Polyneuropathy. Lamotrigine Tab 25 MG, Give 2 tablets two times a day for seizures related to Unspecified Convulsions.Furosemide Oral Tablet 20 MG, Give 20 mg by mouth one time a day related to Acute Combined Systolic (Congestion) and Diastolic (Congestion) Heart Failure.R4's corresponding May 1-31, 2026, Medication Administration Record does not document a nurse's initials in the blank boxes, to indicate the above medications were administered on May 10, 2026, during morning medication administration.On 5/20/26 at 3:40 pm R4, Resident Council President stated I was very upset on Mother's Day. I am supposed to take pain, seizure and blood pressure medication. Those are important, so that I don't have a heart attack.6. R6's Minimum Data Set assessment dated [DATE] documents a BIMS (brief interview mental status) score of 13 indicating cognitively intact. R6's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Norco (narcotic pain medication) Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for Pain - Moderate; Pain - Severe for 14 Days Pain rated 4-10 (on a scale of one to ten, ten being the worst pain).Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Give 1 tablet by mouth one time a day related to Unspecified Atrial Fibrillation.Torsemide Oral Tablet 20 MG, Give 2 tablet by mouth one time a day related to Essential (Primary) Hypertension, Pulmonary Hypertension, Unspecified, Systolic (Congestive) Heart Failure, Unspecified. R6's corresponding physician order documents Daily weight Notify MD/NP (Medical Doctor /Nurse Practitioner) if resident has a weight gain of 3lbs in a day or 5lbs in a week, every day shift for CHF (Congestive Heart Failure) Program inform NP of weight gain of 3lbs/day. R6's weight was not documented as measured on 5/10/26.Eslicarbazepine Acetate Oral Tablet 400 MG, Give 1 tablet by mouth one time a day related to Other Seizures.R6's Corresponding May 1-31, 2026, Medication Administration Record does not document nurses' initials in the blank boxes, to indicate the above medications were administered on May 10, 2026, during morning medication administration.On 5/22/26 at 10:30 am R6 stated she did not get her medications on Mother's Day and was concerned about seizure, blood pressure and pain medication. R6 then stated If staff did not want to come in and work, they should have requested off ahead of time, not called in sick on Mother's Day. We are Mothers we should not have to beg for a nurse to give us our meds. Especially if we need pain meds. At that time R6 grabbed her right thigh and stated I fractured this bone around St Patrick's day. I have so much pain in my leg, I can cry sometimes. On Mother's Day, I could not get my meds for anything. It was a horrible experience.R6's Care Plan dated 3/26/26 documents the following: I have a fracture. Date Initiated: 03/26/2026. Administer pain medications as ordered Provide medications for osteoporosis as ordered. Date Initiated: 03/26/20267. R7 Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score as 14 out of a possible 15 indicating no cognitive impairment.R7's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Tramadol HCL (narcotic medication used to treat moderate to severe pain) Tab 50MG, Give 1 tablet orally two times a day for pain related to Primary Osteoarthritis, Left Hand.Eliquis Oral Tablet (anticoagulant) 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day related to Chronic Atrial Fibrillation, Unspecified.Metoprolol Tartrate Tablet 50 MG, Give 50 mg by mouth two times a day related to Essential (Primary) Hypertension, hold for SBP (systolic blood pressure) less than 100 mmHg (millimeters of mercury), PR (pulse rate) of below 60bpm (heart rate /beats per minute). No correlating blood pressure or pulse measurements are recorded the morning of 5/10/26.Losartan Potassium Oral Tablet 50 MG (Losartan Potassium), Give 50 mg, by mouth one time a day related to Essential (Primary) Hypertension.R7's Corresponding May 1-31, 2026, Medication Administration Record does not document nurses initials in the blank boxes, to (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	indicate the above medications were administered on May 10, 2026 during morning medication administration.On 5/20/26 at 3:30 pm R7, stated she missed the administration of medications and she hurt all over.R7 Care Plan dated 3/17/26 documents the following: I have osteoarthritis of the left hand. Date Initiated: 06/23/2025. Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness, Date Initiated: 06/23/2025. Administer medications as ordered, Date Initiated: 06/23/20258. R8's Physician Order Sheet dated May 1-31, 2026, documents the following medications orders:Aspirin 81 Oral Tablet Delayed Release, Give 1 tablet by mouth one time a day for antiplatelet related to Heart Failure Unspecified (and) Essential (Primary) Hypertension.Amlodipine Besylate Oral Tablet 5 MG, Give 1 tablet by mouth one time a day for HTN (Hypertension) related to Essential (Primary) Hypertension.Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate), Give 1 tablet by mouth one time a day for HTN (Hypertension).Torsemide Oral Tablet 20 MG, Give 1 tablet by mouth one time a day for Edema related to Heart Failure Unspecified, and Essential (Primary) Hypertension. The correlating MAR for May 2026 documents: Daily weight every day shift related to HEART FAILURE, UNSPECIFIED. The 5/10/26 weight was not documented as completed.R8's Corresponding May 1-31, 2026, Medication Administration Record does not document nurses' initials in the blank boxes, to indicate the above medications were administered on May 10, 2026 during morning medication administration.On 5/27/26 at 10:05 am V30, Nurse Practitioner (NP) for V3, Medical Director (MD) stated Mother's Day I was off, (V3, MD) covers the weekend. On Monday, after Mother's Day, the Director of Nursing (V2) informed me that the residents didn't get the morning medication. She specifically said that there were some residents on the one hall hundred hall (R1-R8 reside on the 100 hall). Insulins, blood pressure medications, anticoagulants, and seizure medication in general, are all considered to be significant medication errors when not administered. These residents (that reside on 100 hall) were monitored closely, once the errors were identified. To my knowledge, there was no negative outcome.On 5/21/26 at 10:10 am V2, Interim Director of Nursing/Regional Nurse Consultant (DON) acknowledged the above significant medication errors were made on Mother's Day 5/10/26, when residents did not receive their insulins and the other significant medication.V2, DON also stated V30 Nurse Practitioner (V3, Medical Director's Co- Provider) was notified Monday 5/11/26 and two additional primary care providers (V36 and V41 Physicians) were also notified of the 100 hall medication errors. V2, Director of Nursing (DON) provided an Electronic (Email-mail), undated, and signed by V2, DON which documents the following: Good evening! In transparency, I wanted to let (V41, Physician) and (V36, Physician) know that we experienced an issue with nurse coverage on Sunday, May 10th for the 6a to 6p shift. At this time when nursing coverage was being obtained, specific residents missed their 8am medications. We did obtain coverage, however, the 8am medications were not able to be administered within the appropriate time frame. I am working on which specific residents and their medications that were not administered for the 8am medication pass. I will send over once completed tomorrow morning. I did not see physician notification in residents' charts as I am auditing. I apologize for the lack of communication. I just returned from vacation. It is a priority to complete the audit and provide the physicians with a full report on their patients. We are working diligently to improve the clinical department. Please let me know if you have any questions or issues. I take your feedback seriously and am committed to building a great relationship with the clinical team and physicians.The facility policy Preparation and General Guidelines dated November 2021 documents the following: MEDICATION ADMINISTRATION-GENERAL GUIDELINES - PolicyMedications are administered as prescribed in accordance with good nursing principles and practices and only by people legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.

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	05/28/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to complete shift count of residents' narcotic medications and failed to maintain medication room/medication carts keys, in a safe manner to prevent residents, staff and visitors full access to medications, which included narcotic medications. These failures have the potential to affect all 103 residents in the facility.Findings include:On 5/22/26 at 12:15 pm V29, Agency Licensed Practical Nurse (LPN) stated V29 LPN worked on Mother's Day from 6:00 AM to 6:00 PM. V29, LPN said there was only one nurse, V13, Licensed Practical Nurse working when she came to work. V29, Agency LPN also stated there was a nurse (later identified as V4, LPN/MDS Coordinator) that came in and worked 9:00 am until about 4:00 pm, on 200 hall and the top (front area) of 300 hall. V29 LPN stated That nurse left without saying a word. She did not count medications with me and just left the 200 and 300 hall med cart keys in the narc books on the med cart.On 5/28/26 at 10:00 am V4, Licensed Practical Nurse/Minimum Data Set Coordinator (LPN/MDS) confirmed she came in to work about 9:00 am on Mother's Day and there was not a nurse available to count narcotics with her. Narcotic shift count sheets confirmed narcotic medications were not verified to ensure the accuracy on May 10, 2026, night or day shifts. V4 stated she found medication room/ medication cart keys on top of the two med carts, inside narcotic count sheet book, for both the 200 hall and 300 halls. V4 stated Both med (medication) carts were parked at the center (corridor) nurses' station. V4 confirmed the nurse's station is at the center, corridor junction where all resident halls and the main facility entrance to the facility meet. Therefore, all residents, visitors and staff had access to the keys that unlock the medication rooms, medication carts and the narcotic box storage inside the carts. V4 then stated There was still no nurse to count narcotics and give the keys to when I left the facility around 6:00 pm. I left the med (medication) cart keys where I found them when I came in, on top of both 200 and 300 hall carts.During general tours and medication administration pass, 5/20/26-5/28/26, medication carts for 100 hall, 200 hall and 300 hall were intermittently parked at the center nurses station. The center nurses station intersects the main corridor where all resident halls meet, the facility main entrance merges, and the resident common lounge are located. On 5/27/26 at 3:50 pm V2, Interim Director of Nursing, reviewed the Narcotic shift count sheets for 5/10/16 (Mother's Day). V2 confirmed the narcotic shift count sheets were not signed off as completed by two nurses as the facility required. V2 also said V2 was not aware that the narcotic keys were left on top of the medication carts, and she will be adding these failures to the nurse education she provides.The facility CMS 802 Matrix dated 5/20/26 documents 103 residents reside in the facility.The facility policy Medication Storage In The Facility dated November 2021 documents the following: STORAGE OF MEDICATIONS - PolicyMedications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.ProceduresB. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.The facility policy Narcotic/ Controlled Substances- Counting dated as revised November 26, 2017, documents the following:Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log sheets.2. Knowledge of correct response should an error be discovered in the controlledsubstance count.General Guidelines:Always participate in the counting of the controlled substances at the beginning and ending of your shift. Never say, go ahead without me and I'll sign later. Never leave it to someone else's discretion when you are the one on duty. If you do not observe the medications that you sign as being present, you may be implicated if the medications are later missing.General (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure for Counting Controlled Substances1. Follow your facility's specific guidelines and use their specific log sheet.2. Obtain sign-out records/logs and keys to the controlled storage compartment.3. Have partner to assist in the count.