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	06/23/2026

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview, and record review the facility failed to ensure that residents and/or their designated financial powers of attorney received individual quarterly resident fund statements, as well as fund statements or receipts upon request for four of four residents (R4, R16, R18, R20) reviewed for personal funds in the sample list of 11. Findings include:R20 reported R20 has twenty dollars in R20's account as R20 keeps R20's own written record of spending. R20 stated R20 does not receive monthly statements. R20 does have a financial Power of Attorney (POA). R16 reported R16 does not receive statements for R16's account. R18 reported R18 has sixty dollars in R18's account and does not get a statement from the facility. R4 stated R4 does not receive monthly or quarterly fund statements. R4, R16, and R18 do not have financial POA's documented.V16 Business Office Manager (BOM) reported that V16 sends resident fund statements to the resident's POA but does not distinguish between a Health Care POA and a Financial POA. V16 acknowledged that V16 does not provide statements directly to alert and oriented residents and had not previously considered doing so. V16 also stated that although V16 prints the quarterly statements, V16 does not keep any documentation or tracking to verify when statements were sent or to whom they were provided.The facility's Resident Funds Policy states that residents and/or their representatives must be provided with quarterly accounting of their personal funds held by the facility, as well as statements upon request. Policy also requires that resident statements reflect debits, credits, and current balances.Review of R4's fund account statement showed deposits from Social Security transferred to the facility for management. The record documented a $200 resident advance on 2/2/2026 and a remaining balance of $280 as of 6/3/2026. There was no documentation showing the statement had been provided to R4 or to an appropriate financial POA.There was no evidence in facility records demonstrating that quarterly fund statements or requested statements were provided to residents or properly designated financial POAs.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 implement fall interventions to prevent a fall for one resident (R12) and failed to adequately assess, monitor and evaluate residents post falls for three of three residents (R2, R12, R14) reviewed for falls in the sample list of 11. This failure resulted in R12 being sent to the hospital and receiving two sutures.Findings include: 1.On 6/23/26 at 11:40PM, R12 was near the dining area in R12's wheelchair. R12 reported R12 fell out of bed the other day and busted R12's head. R12 had to go to the hospital to get stitches. The nurse put a band-aid over the stitches. R12 stated R12's head hurts where the stiches are.R12's Fall note, dated 6/20/26 at 12:32PM, documents R12 fell on 6/20/26 at 9:20AM. R12 was bleeding on the left side of R12's head and was transferred to the local hospital.R12's Fall-Initial Occurrence Note, dated 6/20/26 at 1:01PM, documents R12 fell and had a laceration to R12's forehead requiring R12 to go to the local hospital and receive two sutures. An immediate intervention is not documented to help prevent further falls.R12's Emergency Department Note, with a date of service of 6/20/26, documents R12 had a laceration to R12's forehead after sustaining a fall from R12's bed. It also documents R12 had a Computed Tomography (CT) scan of the head with results indicating R12 had a soft tissue injury to the left forehead.R12's care plan, with an initiation date of 7/23/25, documents R12 is at risk for falls with interventions including but not limited to a scoop mattress and keeping pathway clutter free.R12's Minimum Data Set (MDS), date 4/1/26, documents she is moderately cognitively impaired.R12's Administration Record Report, dated June of 2026, does not document any orders to monitor R12's sutures.R12's Electronic Health Record did not document any post-fall monitoring after R12's fall on 6/20/26.R12's Neurochecks 72-Hr (hour) assessment, dated 6/20/26 at 9:35AM, does not document neurological assessments completed for five of the 4-hour checks and five of the 8-hour checks.On 6/23/26 at 11:43AM, R12's room had two fall mats on either side of the bed. There were towels on floor by foot of bed. R12 mattress was a regular mattress not a scoop mattress. There was a chair in the corner of room and was covered with various unfolded blankets.On 6/23/26 at 11:46AM, V27 (Assistant Director of Nursing) went to R12's room and confirmed R12 did not have a scoop mattress and confirmed there should be a scoop mattress on R12's bed.On 6/23/26 at 12:05PM, V4 (Wound Nurse) stated she had not yet looked at or reviewed R12's sutures or orders for her sutures. Sutures should be monitored daily by staff. V4 confirmed there was no order in R12 Electronic Health Record for the sutures to be monitored daily.On 6/23/26 at 1:20PM, V30 Certified Nursing Assistant (CNA), recalled R12's fall on 6/20/26. V30 stated that morning R12 wanted to have breakfast in bed. When breakfast was brought to R12, R12 decided R12 only wanted coffee. R12 was lying in bed and went to try to get R12's coffee and slipped and fell out of bed.On 6/23/26 at 1:28PM, V2 Regional Nurse/ Interim Director of Nursing stated staff should document a fall in Risk Management. They should get statements from staff present at the time of the fall, complete a fall risk assessment, complete neurological checks if a fall is unwitnessed or the resident hits their head, complete a skin assessment, and 72-hour follow-up charting should be completed every shift. Nurses should be documenting an immediate intervention to help prevent another fall. The interdisciplinary team will review the fall the next business day. Maintenance is part of the interdisciplinary team when it comes to falls. Fall interventions should be maintained at all times. If a resident has sutures, they should have an order to be monitored daily for any signs or symptoms for infection and to make sure they are clean, dry and intact. The staff nurses should put this order in for any resident who has sutures. Any nurse who is notified of a new skin condition of a resident should assess it, document it, and open a Risk Management for it. V2 reviewed R12's Electronic Health Record and confirmed that there is no order for monitoring R12's sutures, an immediate intervention was not documented after R12's fall on 6/20/26, R12's neurological checks were not completed, and R12's 72-hour post-fall monitoring was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	not completed. 2. On 5/24/26 at 8:30AM, R2's Nurses Note documents R2 was sent to the local hospital for assessment due to an unwitnessed fall. R2's Nurses Note dated 5/24/26 at 11:35AM, documents R2 returned from the local hospital and was negative for any fractures.R2's Risk Management for Unwitnessed Fall, dated 5/24/26 at 8:15AM, documents V22 Licensed Practical Nurse (LPN) was informed by the Certified Nursing Assistant (CNA) that they saw R2 on the floor face down on the mat and R2 was sent to the hospital. R2 had a bruise to R2's upper, center chest measuring 13 centimeters (cm) by 6 cm and was deep purple in color. It does not document any further assessment, predisposing factors, or intervention put into place to prevent another fall.R2's Neuro Checks- 72 HR (Hour) Assessment, with an effective date of 5/24/26 at 1:31PM, does not document R2's neurological assessments being started until 5/24/26 at 7:15PM (7 hours and 50 minutes after returning from the hospital). The initial and first three 15-minute assessments, four 30-minute assessments, first four-hour assessment, and last 8-hour assessment were not completed.R2's Administration Record Report, dated May of 2026, does not document any treatment or monitoring orders for bruises.R2's Administration Record Report, dated June of 2026, documents an order to monitor bruising to R2's upper chest and bilateral lower legs.R2's Progress Notes did not document post fall documentation on 5/25/26. It also did not document any skin assessments or injuries identified after the fall.On 6/23/26 at 8:26AM V22 LPN recalled R2's fall on 5/24/26. V22 reported that the CNA went to the room next to R2's and a few minutes later when the CNA came back to R2's room, R2 was face down on the floor mat next to R2's bed. V22 stated R2 hit R2's head and had some bleeding and bruising to R2's head. V22 assessed R2 and sent R2 to the hospital. V22 cannot recall V22's assessment of R2 after the fall. V22 said the documentation of V22's assessment can be found in the risk management.On 6/22/26 at 12:12PM, V5 CNA stated V5 was working at the time of R2's fall. V5 saw R2 lying on R2's right side on R2's floor mat by the bedside table. V5 went to get the nurse. The nurse checked R2 out. R2 had a little blood by R2's mouth and one of R2's arms that V5 wiped off with a washcloth. When R2 returned from the hospital, V5 did not see any bruising on R2. V5 went to work on a Friday after the fall (5/29/26) and that's when V5 saw the bruising on R2's chest.On 6/23/26 at 9:05AM V23 LPN stated when V23 worked on 5/25/26, V23 had no knowledge of R2's fall on 5/24/26.On 6/22/26 on 11:57AM V1 Administrator provided the Risk Management on R2's fall on 5/24/26. V1 confirmed there was no documentation that the interdisciplinary team reviewed the fall.On 6/23/26 at 1:28PM, V2 Regional Nurse/ Interim Director of Nursing stated staff should document a fall in Risk Management. V2 reviewed R2's electronic medical record and confirmed the risk management was not filled out correctly, the neurological checks were not fully completed, the appropriate assessments were not completed, a skin assessment wasn't completed and all of the 72-hour follow-up was not completed in entirety.3. R14's Fall-Initial Occurrence Note, dated 6/7/26, documents R14 had an unwitnessed fall in R14's bathroom. R14 reported R14 was going to the bathroom, but the floor was slick. No injuries were observed.R14's Care Plan, dated 6/1/26, documents R14 is at risk for falls. An intervention added on 6/7/26 to prevent falls for R14 was skid strips to be placed in front of the toilet.R14's Minimum Data Set, dated [DATE], documents R14 is moderately cognitively impaired.On 6/23/26 at 1:19 p.m., R14 was lying in R14's bed. R14 told writer to ask the staff about R14, because they know more about R14 than R14 does about R14's self. In R14's bathroom there were no skid strips on the floor in front of the toilet.On 6/23/2026 at 2:02PM, V21 LPN stated V21 was working on the day of R14's most recent fall. V21 stated that R14 transferred R14's self and independently went to the bathroom. V21 reported that R14's functional abilities vary from day to day; however, R14 typically calls for assistance when needed and did not do so on the day of the fall. V21 stated V21 was not aware whether skid strips had been installed on the bathroom floor following the incident.On 6/23/26 at 1:28PM, V2 Regional Nurse/ Interim Director of Nursing stated staff should document a fall in Risk Management. V2 stated V2 was unaware of the new intervention of skid strips needing to be put into place for R14 as V2 has been off of work, but maintenance is present at interdisciplinary meetings that occur after falls. V2 stated V2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	will reach out to maintenance to ensure that the skid strips are put into place.The facility's Fall Prevention Program Policy, revised 11/21/17, documents a fall risk assessment will be completed after any fall incident, all nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained, and accident/incident reports will be reviewed by the interdisciplinary team.The facility's Neurological Assessment policy, revised 2/16/26, documents neurological assessments will be completed upon a physician's order, when indicated for a change of resident's condition, after all head injuries, and when nursing judgement deems necessary.The facility's Comprehensive care Plan policy, revised 11/17/17, documents the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.