| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000517 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/13/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDWATER CARE CLINTON | 1 PARK LANE WEST , CLINTON, Illinois, 61727 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| S0000 | Initial Comments<br><br>Complaint #25612256/2693600, #25611447/2678181, #25612434/2695697, #25612756/2702428 & Facility Reported Incident of 11/20/25/2675972 | S0000 | | 01/14/2026 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations: ONE OF TWO300.610a)300.690b)300.690c)300.1210a)300.1210b)300.1210c)300.1210d)6) Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.690 Incidents and Accidents<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each | S9999 | | 01/14/2026 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>reportable accident or incident to the Department within seven days after the occurrence.Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Failures at this level required more than one deficient practice statement.<br><br>A. Based on observation, interview, and record review, the facility failed to effectively supervise a cognitively impaired resident to prevent repeat traumatic falls requiring emergency transfers to the hospital for evaluation and treatment and failed to notify the Illinois Department of Public Health Regional Office of R1's fall occurring on 12/11/2025 | S9999 | | |

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| S9999 | Continued from page 2<br>requiring emergency transfer to the hospital for evaluation and treatment. These falls resulted in R1 sustaining a large head hematoma, skin tear to the knee, and pain in R1's head, neck, back, and pelvis. These failures affect one resident (R1) of three reviewed for falls in the sample of three.<br><br>B. Based on record review and interview the facility failed to complete a thorough fall investigation to determine root cause of a fall in order to implement a targeted intervention. The facility also failed to assess a resident for the use of side rails, failed to complete neurological assessment post unwitnessed fall, failed to document frequent safety checks post fall, and failed to care plan measurable time intervals for the frequency of safety checks to prevent falls. These failures affect one of three residents (R6) reviewed for falls on the sample of three.<br><br>Findings include:<br><br>A. 1. R1's diagnosis list (printed 12/30/2025) documents that R1's diagnoses include dementia, syncope (fainting) and collapse, difficulty in walking, muscle wasting and atrophy, pain, cognitive communication deficit, depression, and anxiety.<br><br>R1's Resident Assessment dated 8/8/2025 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.<br><br>R1's Fall Risk Assessment dated 6/8/2025 documents R1 is at risk for falls.<br><br>The facility fall log (September–December 2025) documents R1 had an unwitnessed fall in the facility on 9/26/2025.<br><br>The facility Fall Investigation dated 9/26/2025 documents staff overheard R1 gasp and then found R1 on the floor in the living room of the facility's memory care unit. The same record documents R1 reported hitting R1's head on the floor and complained of head pain. R1 was noted to have redness and swelling to the left side of R1's head. The record further documents R1 experienced a skin tear to R1's knee, complained of knee pain, and was transferred to the hospital emergency department via ambulance for evaluation and treatment. | S9999 | | |

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| S9999 | Continued from page 3<br>R1's hospital emergency department report dated 9/26/2025 documents R1 complained of neck and pelvis pain while at the hospital and required multiple computed tomography (CT) radiographic scans to evaluate possible injuries.<br><br>R1's Pain Level Summary dated 9/26/2025 documents R1 did not assess positive for pain in the weeks prior to the 9/26/2025 fall and then scored 7 out of 10 for pain immediately following the fall.<br><br>R1's Pain Observation dated 9/26/2025 documents R1 experienced new-onset back and neck pain following the 9/26/2025 fall.<br><br>R1's diagnosis list (printed 12/30/2025) documents that R1's diagnoses include dementia, syncope (fainting) and collapse, difficulty in walking, muscle wasting and atrophy, pain, cognitive communication deficit, depression, and anxiety.<br><br>R1's Resident Assessment dated 11/8/2025 documents R1 has severely impaired cognition and requires partial/moderate staff assistance for transfers, including going from a seated position to a standing position. The same record documents R1 does not have behaviors, delusions, or hallucinations.<br><br>R1's Fall Risk Assessment dated 9/26/2025 documents R1 is at risk for falls.<br><br>The facility fall log (September–December 2025) documents R1 had an unwitnessed fall in the facility on 12/11/2025.<br><br>R1's Progress Notes dated 12/11/2025 document R1 had an unwitnessed fall in the facility and was found by staff on the dining room floor of the memory care unit, screaming, "Get me up." The same record documents R1 reported hitting R1's head, complained of dizziness and pain, and staff noted a knot and bruising to the left temple area.<br><br>R1's Progress Notes dated 12/13/2025 document R1 must be supervised closely due to continuing attempts to get up from the wheelchair to walk independently.<br><br>The facility Fall Investigation dated 12/11/2025 documents V33 (Licensed Practical Nurse) overheard V39 (Certified Nurse Aide) exclaim, "(R1) just fell." The investigation documents R1 was not under direct staff supervision at the time of the fall, had impaired safety awareness, and attempted to get up from the wheelchair to walk. The report documents R1 fell onto | S9999 | | |

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| S9999 | Continued from page 4<br>the dining room floor when the wheelchair rolled backward due to the brakes not being applied. R1 was transferred to the hospital emergency department via ambulance for evaluation and treatment.<br><br>On 12/30/2025 at 2:20 PM, V39 (Certified Nurse Aide) reported working the night shift on 12/11/2025 when R1 experienced the fall in the memory care dining room. V39 reported R1 repeatedly attempted to get up from the wheelchair and staff redirected R1 to sit down. V39 reported no staff were present with R1 at the time of the fall, as staff were taking residents to their rooms following supper. V39 reported believing R1 fell face down and noted a knot on R1's forehead following the fall.<br><br>On 12/30/2025 at 2:55 PM, V2 (Director of Nursing) reported R1 does not have intact safety awareness and frequently attempts to self-transfer from the wheelchair. V2 reported not being aware of the presence of auto-locking brakes on R1's wheelchair prior to the 12/11/2025 fall and stated these behaviors had been occurring for a long time.<br><br>R1's hospital emergency department report dated 12/11/2025 documents R1 had an unwitnessed fall resulting in a "medium egg-size" forehead hematoma, complained of pain to the forehead and back of the head, and required multiple CT scans to evaluate possible injuries. The same record documents R1 was given one gram of acetaminophen and discharged back to the nursing home with new orders for pain medication (325–650 mg acetaminophen orally every 6–8 hours as needed) and application of ice to the hematoma for 5–15 minutes every few hours.<br><br>R1's Pain Level Summary dated 12/11/2025 documents R1 did not assess positive for pain in the weeks prior to the fall and scored 8 out of 10 for pain immediately following the fall.<br><br>R1's Pain Observation dated 12/11/2025 documents R1 experienced facial pain with vocal complaints and facial expressions of pain following the fall.<br><br>R1's Physician Orders dated 12/31/2025 document an order to monitor bruising of the left eye area until healed.<br><br>R1's Treatment Administration Record (December 2025–January 2026) documents the forehead hematoma sustained on 12/11/2025 was not resolved as of 1/2/2026. | S9999 | | |

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| S9999 | Continued from page 5<br>R1's Care Plan (printed 12/30/2025) documents a resolved intervention related to fall risk and impaired judgment. The same record documents the intervention of adding auto-locking brakes to R1's wheelchair.<br><br>On 12/24/2025 at 1:34 PM, R1 was observed seated in a wheelchair in the memory care living room with an approximately 1.5-inch egg-shaped purple hematoma on the left temple area from the 12/11/2025 fall.<br><br>The facility Fall Prevention Program policy dated 11/21/2017 documents residents will be assessed for fall risk and appropriate interventions implemented, including supervision and assistive devices.<br><br>On 12/30/2025 at 10:55AM, V1 (Administrator) reported R1's 12/11/2025 fall was not reported to Illinois Department of Public Health Regional Office.<br><br>B. R6's Minimum Data Set (MDS) dated 9/08/2025 documents a Brief Interview of Mental Status score of 2 out of 15, indicating severe cognitive impairment. The same MDS documents R6 was totally dependent on staff for bed mobility.<br><br>There was no Fall Risk Assessment in R6's medical record before or after the fall on 9/5/2025.<br><br>R6's Fall–Initial Occurrence Note dated 9/5/2025 at 11:03 PM documents R6 had an unwitnessed fall at 8:30 PM in the resident's room. R6 was found lying on the floor mat next to the bed after rolling out of bed. R6 was confused and unable to provide a coherent statement.<br><br>Vital signs and pain assessment were documented, including a pain level of 5 out of 10. Neurological checks were initiated. No injuries were observed.<br><br>R6's Unwitnessed Fall report dated 9/5/2025, documented by V60 (previous Director of Nursing), does not document a thorough investigation or identify predisposing environmental, physiological, or situational factors. A CNA witness statement dated 9/6/2025 documents R6 rolled out of bed and the bed was in the lowest position.<br><br>No Fall Risk Assessment was completed after the 9/5/2025 fall.<br><br>R6's second fall was inaccurately documented as witnessed. The "Witnessed Fall" report dated 9/30/2025 documents R6 was already partially out of bed and hanging from the side rail when observed. No CNA was | S9999 | | |

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| S9999 | Continued from page 6<br>identified, and no witness statements were included.<br><br>Neurological assessments required for 72 hours were not completed as ordered. Only two assessments were documented.<br><br>There was no bedside side-rail assessment in R6's medical record.<br><br>R6 experienced a third unwitnessed fall on 11/19/2025. Although safety checks were ordered, no documentation exists showing they were completed.<br><br>On 11/20/2025, R6 was transferred to the hospital due to neurological decline and passed away later that morning.<br><br>On 1/9/2026, V2 (Director of Nursing) reviewed R6's fall investigations and confirmed deficiencies in investigation, assessment, neurological monitoring, care planning, and documentation.<br><br>The facility Fall Prevention Policy revised 11/21/2017 outlines required assessments, interventions, documentation, and monitoring, including documentation of safety checks when implemented.<br><br>(B)<br><br>TWO OF TWO<br><br>300.696b)<br><br>300.1210b)<br><br>300.1210d)1)3)<br><br>300.1220b)2)<br><br>Section 300.696 Infection Prevention and Control<br><br>b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable | S9999 | | |

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| S9999 | Continued from page 7<br>Diseases Code, and the Control of Sexually Transmissible Infections Code.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br><br>These requirements were not met as evidenced by:<br><br>Failures at this level required more than on deficient practice statement:<br><br>A .Based on interview and record review the facility failed to complete a thorough admission process including greeting the resident within 15 minutes of arrival, providing access to the call light, notifying the pharmacy of resident’s arrival, faxing prescriptions to the pharmacy within two hours, | S9999 | | |

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| S9999 | Continued from page 8<br>admission assessment including care plan focus, pain observation assessment, and fall assessment with transfer status. This failure affected one of five residents (R7) reviewed for quality of care on the sample list of 30. This failure resulted in R7 experiencing significant increase of uncontrolled physical pain which required hospitalization, severe anxiety and feelings of being disregarded by staff.<br><br>B. Based on interviews and record review the facility repeatedly failed report the results of a Chest X-ray to the physician, which resulted in a four delay in treatment for a resident (R4) with pneumonia. R4 is one of six residents reviewed for infection/treatment on the sample list of 30.<br><br>Findings include:<br><br>A. R7's Hospital Discharge After Visit Summary documents that R7 was discharged to the facility on 11/19/25, status post left total knee replacement surgery. Discharge orders included instructions to call the physician's office for any severe, uncontrolled pain. R7's pain medication orders included Hydrocodone 5/325 mg, take 1–2 tablets by mouth every four hours as needed for moderate or severe pain. Additional pain medication orders included Hydromorphone 4 mg by mouth every four hours as needed for moderate to severe pain; Morphine 15 mg by mouth every 12 hours; and Tizanidine 4 mg, two tablets by mouth every six hours as needed for muscle spasms. R7's medical diagnoses included chronic pain status post motor vehicle injury, morbid obesity, and left knee osteoarthritis status post total knee arthroplasty. R7 was to continue Dilaudid, as she had been taking this medication chronically prior to surgery.<br><br>R7's undated Hospital Report Note Sheet documents that a report was received from hospital staff indicating R7 is a 53-year-old female who underwent a left total knee arthroplasty on 11/13/25. R7 was admitted to the facility for post-surgical pain control. R7 required a gait belt and one-person assist with a walker for transfers and was completely cognitively intact. R7 was taking Dilaudid, Morphine, and Hydrocodone for pain control. Morphine was next due at 9:00 p.m. Controlled substance prescriptions were sent with the hospital discharge packet. R7 was last administered four milligrams of Dilaudid at 4:00 p.m. and was to receive a Hydrocodone tablet prior to transport to the facility. R7 was referred to a pain specialist for pain management and was expected to arrive at the facility after 6:00 p.m. | S9999 | | |

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| S9999 | Continued from page 9<br>On 12/23/25 at 12:00 p.m., R7 stated she was admitted to the facility on 11/19/25 at approximately 6:15 p.m. R7 stated she was transported from the hospital to the facility and arrived in her room with a roommate but did not see a facility staff member until after 8:00 p.m. At approximately 8:00 p.m., R7's roommate activated the call light, and V55, Certified Nursing Assistant (CNA), responded. R7 stated she asked V55 to assist her to the bathroom, and V55 instructed her to use her walker and take herself to the bathroom.<br><br>R7 stated she had not walked independently since surgery and was supposed to have staff walking beside her using a gait belt. R7 stated she was very scared she might fall and injure her new knee and felt very unsteady and unsure of her ability to safely transfer. R7 stated she was already in significant pain because the last time she received pain medication was prior to leaving the hospital. R7 stated that when she walked back from the bathroom, V55 watched her walk but did not assist her or help her get her legs back into bed.<br><br>R7 stated her bed was broken, the remote did not work, and she was not provided a call light. R7 stated she told V55 she felt that since arriving she had not seen any staff and felt like no one even knew she was there. R7 stated that at approximately 9:00 p.m., V11, Licensed Practical Nurse (LPN), entered the room and told R7 she knew she was there but had not yet made it back to see her. R7 stated V11 did not complete an assessment, ask questions, or assess her surgical knee.<br><br>R7 stated she told V11 she was in pain and requested pain medication. V11 told her she was unsure whether she had any pain medication available to administer. R7 stated she repeatedly told V11 she was in severe pain and that something did not feel right, but V11 offered no solution. R7 stated V11 left the room and did not return with any pain medication.<br><br>R7 stated she later took herself to the bathroom again and still did not have access to a call light. After returning to bed, R7 stated she found the call light on the floor next to the bed. R7 stated that approximately two hours later, around 12:00 a.m., she used the call light to request help because she could no longer tolerate the pain and discomfort. R7 stated she felt disregarded and not cared for.<br><br>R7 stated she was in severe pain and felt she had suffered long enough. She stated no nurse had assessed her, no one was addressing her pain, and she felt forgotten, anxious, and scared something was wrong with her knee because the pain was unbearable. R7 stated | S9999 | | |

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| S9999 | Continued from page 10<br>that at approximately 12:00 a.m., V12, Licensed Practical Nurse (LPN), entered her room, asked about her pain, and left to determine why she had not received pain medication. V12 returned shortly thereafter, apologized, and informed R7 that her pain medication prescriptions had not been faxed to the pharmacy upon admission and that she would fax them herself.<br><br>R7 stated V12 informed her that once the pharmacy received the prescriptions, V12 could request a code and access the medications from the emergency medication supply; however, V12 was unsure how long the process would take. R7 stated she was fed up and requested to leave the facility and return to the hospital. V12 contacted emergency medical services, and R7 stated she was transferred to the hospital at approximately 1:30 a.m. on 11/20/25, where she was treated for uncontrolled pain.<br><br>R7's Nursing Progress Note dated 11/20/25 at 1:10 a.m. documents that R7's prescribed pain medications were not delivered by the pharmacy and were not available through the facility's emergency medication supply. The prescriptions required refaxing, and a new access code was required for medication retrieval. At 1:00 a.m., R7 was tearful, shaking, and stated she could not wait any longer for pain medication, requesting transfer to the emergency room.<br><br>On 1/7/26 at 3:37 p.m., V12, Licensed Practical Nurse (LPN), stated she was the nurse who cared for R7 overnight on 11/19/25–11/20/25 and sent her to the emergency room. V12 stated she assumed care of R7 at 10:00 p.m. V12 stated she was alerted by an unknown staff member of R7's severe left knee pain multiple times between 11:00 p.m. and 1:00 a.m. and did go to see R7 to address her pain. V12 confirmed R7 was admitted earlier in the evening at approximately 6:30 p.m. and had not received any prescribed pain medications since arrival.<br><br>V12 stated that a full admission assessment and admission process were not completed for R7. V12 stated R7's controlled substance prescriptions were not faxed to the pharmacy until approximately 1:00 a.m. V12 stated she received only a minimal report on R7, was unfamiliar with her history, and was unable to identify R7's assigned physician. V12 stated that when she first assessed R7 around midnight on 11/20/25, R7 was in extreme pain, visibly upset, shaking, and requesting transfer to the emergency room.<br><br>On 1/6/26 at 1:54 p.m., V48, Regional Nurse, confirmed | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000517 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/13/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDWATER CARE CLINTON | 1 PARK LANE WEST , CLINTON, Illinois, 61727 |

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| S9999 | Continued from page 11<br>nursing staff should have completed the admission process, greeted the resident upon arrival, ensured access to a call light, notified the pharmacy of the resident's arrival, faxed prescriptions within two hours, and completed admission assessments including pain assessment, fall risk assessment, transfer status, and care plan focus. V48 stated staff should have addressed R7's pain before it escalated and acknowledged that failure to do so caused undue stress and pain for R7.<br><br>B. R4 was discharged from the facility on 12/08/25. R4's most recent diagnoses sheet documents chronic obstructive pulmonary disease with acute exacerbation and pneumonia, unspecified organism.<br><br>R4's chest X-ray, performed by a private company on 11/13/25, documents the X-ray was completed and reported to the facility on 11/13/25 at 9:36 p.m.<br><br>Procedure: Chest, two views<br><br>Clinical Information: Cough, congestion, other pulmonary embolism without acute cor pulmonale, and acute systolic congestive heart failure.<br><br>Significant Findings:No abnormal radiopaque foreign bodyCardiac silhouette normalNo visible pneumothoraxNo radiographic evidence of pulmonary edemaOpacities in the right lung baseImpression:<br><br>Opacities in the right lung base, which may be due to atelectasis or pneumonia.<br><br>The facility's Infection Control Log dated November 2025 documents that on 11/17/25, R4 was diagnosed with pneumonia of an unknown organism and was started on antibiotic therapy.<br><br>R4's Nursing Progress Note dated 11/17/25 at 8:00 a.m. documents: "Writer called V45, physician, due to resident R4's chest X-ray results and condition. Resident extremely congested and coughing; vital signs within normal limits."<br><br>R4's Nursing Progress Note dated 11/17/25 at 10:00 a.m. documents: "Office staff from V45 returned call with new diagnosis of pneumonia and new orders for antibiotic therapy for 10 days and DuoNeb treatments as needed. Appropriate parties notified."<br><br>R4's Medication Administration Record (MAR) dated 11/01/25–11/30/25 documents the following medication: | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000517 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/13/2026 |
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|---|---|
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| S9999 | Continued from page 12<br>Amoxicillin 675 mg by mouth twice daily for pneumonia, unspecified organism, for 10 days.<br><br>The MAR further documents R4 did not receive the antibiotic until 11/17/25 at 8:00 p.m., four days after the chest X-ray results were reported to the facility.<br><br>The MAR also documents: Ipratropium-Albuterol 0.5–2.5 mg/3 mL solution, inhale one vial by mouth every four hours as needed for cough, congestion, and shortness of breath, start date 11/17/25.<br><br>On 12/30/25 at 1:50 p.m., V2, Director of Nursing/Infection Preventionist, acknowledged that the delay in antibiotic and respiratory treatment for R4's confirmed pneumonia resulted in prolonged infection and symptoms.<br><br>(B) | S9999 | | |