

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058685		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/30/2025	
NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE TOLUCA				STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST VIA GHIGLIERI , TOLUCA, Illinois, 61369			
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S0000	Initial Comments		S0000				
	Complaint Investigation						
	25210538 / 2653739						
S9999	FINAL OBSERVATIONS		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.3240a)						
	Section 300.610 Resident Care Policies						
	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.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	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.						
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.						
	Section 300.3240 Abuse and Neglect						
	a) An owner, licensee, administrator, employee or agent						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S0000	Continued from page 1 of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interview and record review, the Facility failed to protect Residents' Rights to be free of Mental Abuse and Verbal Abuse from a Facility staff perpetrator that caused mistreatment, emotional distress, and mental anguish for one of three Residents (R1) reviewed for Abuse in a sample of three. Findings include: The Facility Abuse Prevention and Reporting Policy, dated 10/24/22, documents: the Facility affirms the right of our Residents to be free from abuse; the Facility prohibits abuse and mistreatment of Residents; the Facility has established a Resident sensitive and secure environment; the policy assures the Facility is doing all that is within its control to prevent occurrences of abuse; the Facility will establish an environment that promotes Resident sensitivity, security and prevent mistreatment; identify occurrences and patterns of potential mistreatment; implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment; filing accurate and timely investigative reports; abuse means any mental injury other than by accidental means; abuse is the willful infliction of intimidation, punishment or mental anguish to a Resident; and willful in the definition of abuse means the individual must have acted deliberately; mental abuse is verbal/non-verbal conduct which causes or has the potential to cause the Resident to experience humiliation, intimidation, fear, shame, agitation or degradation; verbal abuse is a type of mental abuse and includes oral or gestured communication to Residents within hearing distance such as harassing a Resident, insulting, yelling or hovering over a Resident with the intent to intimidate and threatening a Resident; and orientation/training of employees includes sensitivity to Resident rights/needs, what constitutes abuse, how to assess/prevent/manage aggressive/violent/catastrophic reactions in a way to protect both Residents and staff and an employees obligation under the law for reporting a suspected crime to the facility, state survey agency and local law enforcement. The Facility Resident Rights Policy, dated 1/4/19, documents: to promote the exercise of rights for each			S0000			

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S0000	Continued from page 2 Resident, including any who face barriers (communication problems, hearing problems and cognition limits) in the exercise of these rights; a Resident even though determined to be incompetent, should be able to assert these rights based on his/her degree of capability; to have autonomy to the maximum extent about how they wish to live their everyday lives and receive care, subject to the Facility's rules and regulatory requirements; and the Facility will not hamper, compel, treat differentially or retaliate against a Resident for exercising his/her rights. The Facility Final Abuse Investigation, dated 9/17/25, documents an incident on 9/15/25, between V4 (former Social Service Director) and R1. On 9/15/25, V2 (Director of Nursing/DON) reported to V18 (former Administrator/Abuse Coordinator) an inappropriate conversation/language between V4 and R1. The Final Abuse Investigation documents V4 used profane language during a conversation with R1 and that the profane language was not directed towards R1. The Facility unsubstantiated the allegation. The Facility's Social Service Director Job Description, dated 5/2/17, documents: purpose to assist in planning, organizing, implementing, evaluating and directing the overall operation of our Facility's Social Service Department in accordance with federal, state and local standards, guidelines and regulations, our established policies and procedures, as may be Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis; review Facility policies and procedures as part of the Facility's Interdisciplinary team to assure compliance with state and federal regulations; ensure and provide therapeutic interventions to assist Residents in coping with their transition and adjustment to a long-term care Facility, including social, emotional and psychological needs; and provide clinical interventions to address catastrophic events that occur during the Resident's stay in the Facility/V4's Termination Notice, dated 9/18/25, documents V4's last day worked as 9/15/25. V4's reason for termination is documented that on 9/15/25, a complaint was received from a Resident regarding conduct during an interaction. Specifically, that profane language was used during a conversation and that the behavior was found to be inconsistent with Facility policy which requires staff to treat Residents with courtesy, professionalism and respect at all times. The Employee Conduct Standards which list the use of profane, discourteous or unprofessional language toward Residents is grounds for immediate dismissal.		S0000				

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S0000	Continued from page 3 R1's Admission Record, dated 12/27/25, documents R1's current age of 57 years old and an admission date to the Facility as 9/23/25. R1's current Care Plan documents R1's diagnoses including Anxiety Disorder, Diabetes Type Two, Vertebral Disc Degeneration, Discogenic Back Pain, Heart Failure, Psychoactive Substance Abuse, Liver Disease, Depression, Age Related Nuclear Cataract, Hepatic Encephalopathy, Fall History, Abnormal Gait, Lack of Coordination and Abnormal Posture. R1's Care Plan also documents: Activities of Daily Living performance deficit; risk for falls; at risk for abuse/neglect and will be cared for in a safe manner and verbalize to staff any incidences of abuse or neglect and impaired visual function. The Final Abuse Investigation, dated 9/17/25, documents a written statement from V17 (Certified Nursing Assistant/CNA) wherein V17 was delivering R1 a lunch tray and R1 requested a salad. V17 went to request a salad for R1 from the kitchen and the kitchen was closed. R1 told V17 to "Get out of my room. Go." V17 removed R1's lunch tray and exited R1's room. V17 notified V4 (former Social Service Director) that V17 did not want to go back into R1's room by V17's self. V4 went to R1's room to talk to R1 and, V4 told V17 that V4 told R1, "He can get up to the dining room and ask for extra things when he wants extra things." V17 stated that prior to that incident, R1 stated R1 was not getting discharge planning help from V4. The Final Abuse Investigation, dated 9/17/25, documents a written statement from V2 (Director of Nursing/DON) that V13 (Certified Occupational Therapy Assistant/COTA) overheard in R1's room. V13 told V2 that V4 (former Social Service Director) told R1 "do not be a f***** a***** to my staff." V2 immediately notified V18 (former Administrator). The Final Abuse Investigation, dated 9/17/25, documents a written statement from V13 (Certified Occupational Therapy Assistant/COTA). V13 was in R1's room providing therapy services with shaving at sink level, to R1's roommate. V13 overheard V4 approach R1's bedside and said, "You have to quit being an a***** to my staff." V4 "proceeded to argue and have a bad attitude with (R1)." V4 stated to R1, "You can go get your own salad next time" and "I know you are leaving in a few days, but you cannot yell at the staff, she is the only CNA down here today." V13 stated R1 remained calm during the conversation. The Final Abuse Investigation, dated 9/17/25, documents			S0000			

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S0000	Continued from page 4 a typewritten statement, signed by V18 (former Administrator) from V4 (former Social Service Director). V4 was overheard telling R1 "do not be an a***** to my staff." The statement documents verbal abuse did not occur, however, V4 displayed unprofessional conduct by cursing during the conversation with R1. The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from V4 (former Social Service Director). V17 (CNA) reported to V4, that R1 called V17 a "piece of s*** and some other names." R1 called V17 a liar and threw a tray at V17 after V17 returned from the kitchen and said the kitchen did not have a side salad. V4 stated, "(V13, COTA) was in R1's bathroom and we could ask (V13) as well." The Final Abuse Investigation, dated 9/17/25, documents an unsigned typewritten statement from R1. R1 stated R1 was frustrated with V17 (CNA) over lunch, when V4 entered R1's room. R1 stated R1 did not like the way V4 approached R1 about R1's discharge from the Facility. R1 stated V4 called R1 a "f***** a*****" during the conversation. R1 continues to state frustration with V4. On 12/27/25 at 11:02 am, V11 (Therapy Director) stated, "(V13/COTA) came to me and told me (V13) overheard (V4) cussing in (R1's) face and (V13) was concerned because (V13's) behavior was inappropriate. Honestly, (V4) was not all the way there and was very weird. (V4) was degrading to even me and I even heard other Residents complain about (V4)." On 12/27/25 at 11:30 am, R4 (Resident Council President) stated, "I heard people talking about (V4) getting fired for cursing at (R1). I did not surprise me because (V4) had issues." On 12/27/25 at 12:17 pm, V13 (Certified Occupational Therapy Assistant/COTA) stated, "I was doing occupational therapy with (R1's) roommate. We were in (R1's) bathroom, because we were practicing shaving. I saw (V4) enter (R1's) room, and (V4) even saw me. (V4) walked in and immediately had an attitude and pretty much got right into (R1's) face and was very aggressive and rude to (R1). (V4) was berating (R1) and called (R1) an a*****, and a lot of other bad words. (R1) was so upset. The sad thing is (V4) knew I was in that room and could hear (V4), and (V4) still treated (R1) like that. I immediately reported it, because I thought it was really bad."			S0000			

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S0000	Continued from page 5 On 12/27/25 at 9:47 am, R1 stated, "(V4) ignored me all the time. I just wanted (V4's) help with my discharge, but (V4) was always too busy for me. I have an explosive attitude, and I cannot help it. I am not going to lie; I was not very nice to (V17). When (V17) came into my room and I asked (V17) for a salad, then (V17) told me that (V17) could not get me one, I got very mad and angry because all I wanted was a salad. Other people heard her talking to me and they all admitted that she did. (V4) ended up getting fired over it. (V4) came into my room right after I got into it with V17 (CNA), (V4) got right in my face, inches from my face, and was cussing and screaming at me. (V4) was telling me to "f*** off" and called me an "a*****." (V13/COTA) was in here and heard everything. (V4) belittled me and made me feel terrible. I thought it was totally inappropriate, and it made me even more upset, and (V4) was supposed to be someone that was helping me, but instead (V4) degraded me. I cannot do some things for myself, and I felt so humiliated, helpless, and like an idiot. How do you think I feel if I cannot even go the one person who is supposed to me helping me. It still makes me mad, I cannot even think about it." On 12/27/25 at 9:35 am, V2 (Director of Nursing/DON) stated, "(V18/former Administrator) is no longer employed here. I was involved in the incident between (V4) and (R1) and helped with the investigation. (V13/COTA) came to me because (V13) overheard (V4) cursing and yelling at (R1) in R1's room. (V13) reported that (V4) told R1 "do not be a f***** a***** to my staff." V2 immediately notified V18 (former Administrator). (B)		S0000				