STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145437	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Princeton	515 Bureau Valley Parkway Princeton, IL 61356

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to assess each resident for risk of entrapment and only use bed rails after trying other alternatives for five of five residents (R4, R5, R9, R46, R64) and explain the risks and benefits to the resident or the resident's representative for one of five residents (R4) in a sample of 35.Findings include: The Side Rails/Bed Rails policy dated 10/24/22 documents examples of bed rails include side rails, bed side rails and safety rails. The facility shall ensure that prior to installation of bed rails the facility has attempted to use alternatives. If alternatives fail, the facility shall assess the resident for risks of entrapment and possible benefits of bed rails; shall ensure bed is appropriate for the resident and that bed rails are properly installed and maintained; determine if bed rails meet the individual needs of a resident via resident assessment: medical diagnosis, behaviors, size and weight, medications, ability to toilet self, cognition, communication, mobility and risk of falling; evaluate resident's risks and potential risks can be exacerbated by improper match of the bed rail to bed frame, improper installation and maintenance; after alternatives have been attempted and prior to installation, the facility shall obtain informed consent and document in the medical record; the Care Plan may include the medical need, how often the bed rail is applied, duration of use and the circumstances for when it is to be used, how monitoring is provided, identify potential complications such as physical and/or psychosocial changes related to the use of bed rails, interventions to minimize or eliminate the use of bed rails; and who monitors for the implementation of use, assesses to determine ongoing need for bed rails, if use should gradually decrease and if interventions are effective; and check bed rails regularly and ensure dimensions are appropriate, confirm proper installation.The Bed Rail Safety-Gap Measurements audit sheet documented gap measurements were conducted on 5/2/25.1. R4 was admitted on [DATE] with diagnoses of history of falling, fracture lower end of left femur, orthopedic aftercare, long term uses of anticoagulants and morbid obesity.R4's Care Plan documents on 4/28/25 R4 was assessed to need right and left quarter bedrail.R4's Side Rail Assessment conducted 3/28/25 and 6/5/25 documented R4 did not have siderails attached to the bed and the assessment was not completed.On 8/12/25, 8/13/24 and 8/14/25 R4's bed was observed to have right and left quarter bedrails attached to the bed and in the up position.R4's record did not contain an Acknowledgement of Restraint/Device Use (consent form).2. R5 was admitted on [DATE] with diagnoses of Cerebral Palsy, Stroke, Schizoaffective Disorder, Bipolar Type, Muscle Wasting and Atrophy, Cognitive Communication Deficit, Anticoagulant use and Osteoarthritis.R5's Care Plan documents on 2/25/25 R5 was assessed to need right and left halos (adjustable bed mobility device).The Initial Side Rail Assessments dated 1/15/25 did not document R5's diagnoses, behaviors, if the bed rail was attached to the bed, risks of rails, restrictions and benefits or bed mobility. The Quarterly Side Rail assessment dated [DATE] identified no conditions that posed a risk and that halos were utilized.On 8/12/25, 8/13/24 and 8/14/25 R5's bed was observed to have right and left quarter bedrails attached to the bed and in the up position.3. R9 was admitted on [DATE] with diagnoses of Acquired Absence of Left Leg Below (continued on next page)

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Knee, Mood Disorder, Insomnia, Major Depressive Disorder, Osteoarthritis and Malaise.R9's Care Plan documents on 3/25/25 R9 was assessed to need right and left quarter bedrail.The Quarterly Side Rail assessment dated [DATE] did not document diagnoses, interventions attempted and no conditions that posed a risk of rails.4. R46 was admitted on [DATE] with diagnoses of Cognitive Impairments, Osteoarthritis, Diabetic Neuropathy, Major Depressive Disorder, Acquired Absence of Right Great Toe and Anxiety Disorder.R46's Care Plan documents on 2/25/25 R46 was assessed to need right and left quarter bedrail.The Quarterly Side Rail assessment dated [DATE] did not document diagnoses, prior interventions attempted and no conditions that posed a risk of rails.5. R64 was admitted on [DATE] with diagnoses of Osteomyelitis of Vertebra and Sacral Region, Severe Morbid Obesity and Osteoarthritis.R64's Care Plan documents on 2/24/25 R64 was assessed to need a right half bedrail.R64's Quarterly Side Rail Assessment conducted 6/5/25 documented R64 did not have siderails attached to the bed and the assessment was not completed.On 8/12/25, 8/13/24 and 8/14/25 R64's bed was observed to have right and left quarter bedrails attached to the bed and in the up position.On 8/14/25 at 1:10 PM, V1 (Administrator) and V13 (Maintenance Director) agreed R46's bed rails had spacers between the bed rail and mattress and the gap was measured at 5 inches. On 8/15/25 at 10:45 AM, R46's bed rails still had the spacers in place.On 8/14/25 at 1:00 PM, V13 (Maintenance Director) stated bed rails are checked annually. V13 stated R46's bed rails should not have a spacer and should be removed.On 8/14/25 at 1:05 PM, V1 (Administrator) stated the facility owns their beds, all beds have bed rails and verified bed rail inspections are conducted annually. V1 stated if bed rails are not approved for use, the rail is zip tied, although staff do break the zip ties off and use bed rails if needed. V1 stated specialty mattresses can replace the regular mattress on each bed and the nurses should be assessing if bed rails are appropriate and gaps are within acceptable limits, although the assessments are not documented. Bed rail assessments are conducted quarterly. V1 agreed bed assessments were not either completed and/or accurately completed, R4 did not have an Acknowledgement of Restraint/Device Use (consent form) and Nurse's nor Certified Nurse Aides document a gap assessment or bed rail condition was assessed. 1.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure oxygen was administered as ordered for one of three residents (R4) in a sample 35. Findings include:The Oxygen Concentrator policy dated 2013 documents the oxygen concentrator converts ambient air to a higher level of oxygen and is used to provide oxygen therapy. R4's Care Plan dated 7/11/25 documents R4 uses continuous oxygen related to Chronic Obstructive Pulmonary Disease (COPD) and Respiratory Failure. R4 will have no signs or symptoms of poor oxygen absorption through the review date. Interventions include If R4 is eating, oxygen still must be given to R4 but in a different manner (e.g., changing from mask to a nasal cannula). Return R4 to usual oxygen delivery method after the meal and monitor for signs and symptoms of respiratory distress and report to the physician as needed: respirations, pulse oximetry, increased heart rate (Tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage and skin color. R4's Physician Order dated 7/4/25 documents oxygen at 1-4 LPM (liters per minute) via nasal cannula continuously. On 08/12/2025 at 10:30 AM, R4's oxygen tubing was on the floor and not plugged into the concentrator. On 8/12/25 at 10:35 AM, V15 (Registered Nurse) was notified that R4's oxygen was not on and the oxygen tubing was on the floor. V15 did not assess R4 for respiratory distress. On 08/12/2025 at 1:10 PM, R4 was observed in the dining room with oxygen and an oxygen concentrator. V14 (Certified Nurse Aide) took the oxygen off R4, transported R4 to her room and returned R4 to bed without the oxygen. At 1:18 PM, V8 (Registered Nurse) entered R4's room with the concentrator and placed R4 back on the oxygen without an assessment for respiratory distress. R4 appeared to be anxious, short of breath and using accessory muscles to breathe. On 8/12/25 at 1:30 PM, V8 confirmed R4 was to be on continuous oxygen and R4 appeared to have signs of respiratory distress (during transport on 8/12/25 at 1:10 PM) and agreed oxygen levels were not assessed. On 8/12/25 at 2:00 PM, R4 stated she was short of breath without the oxygen on and felt afraid (during transport 8/12/25 at 1:10 PM). On 8/15/25 at 1:00 PM, V2 (Director of Nursing) stated the facility does not have portable oxygen tanks and staff have to push the oxygen concentrators down the hall to the dining room and then back to the resident's room.