

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/09/2024
NAME OF PROVIDER OR SUPPLIER  Goldwater Care Gibson City		STREET ADDRESS, CITY, STATE, ZIP CODE  620 East First Street Gibson City, IL 60936	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40385</p> <p>Based on interview and record review the facility failed to respond to call lights timely for five (R6, R7, R10, R9, R12) of 12 residents reviewed for call lights in the sample list of 17.</p> <p>Findings include:</p> <p>The facility's Resident Council Meetings dated 4/29/24, 5/28/24, and 6/24/24 document concerns of call light wait times on all shifts, including wait times of almost an hour on second shift.</p> <p>On 7/9/24 at 10:00 AM, R6 stated sometimes R6 waits awhile for R6's call light to be answered.</p> <p>On 7/9/24 at 10:25 AM, R7 stated R7 waits awhile for call lights to be answered due to the facility being short of staff.</p> <p>On 7/9/24 between 10:35 AM and 10:50 AM, R10 stated it takes a long time for staff to answer R10's call light, because staff are too busy, and this happens on any day and shift.</p> <p>On 7/9/24 at 10:44 AM, R9 stated R9 waits awhile with R9's call light on before staff provide help.</p> <p>On 7/9/24 at 12:58 PM, R12 stated R12 is the Resident Council President and long call light wait times is frequently mentioned in the council meetings.</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40385</p> <p>Based on interview and record review the facility failed to provide showers as scheduled for one (R10) of seven residents reviewed for Activities of Daily Living in the sample list of 17.</p> <p>Findings:</p> <p>On 7/9/24 from 10:35 AM-10:50 AM, R10 stated residents are suppose to get showers/bed baths twice per week, but sometimes that doesn't happen. R10 stated the staff get too busy and forget, usually because they don't have enough staff. R10 stated R10's showers are scheduled for Mondays and Thursdays, and R10 did not get a shower yesterday (Monday).</p> <p>R10's Minimum Data Set, dated dated dated [DATE] documents R10 is cognitively intact and is dependent on staff for bathing/showers.</p> <p>The undated East Evening Showers list documents R10's showers are scheduled on Monday and Thursday evenings. R10's Shower Day Skin Inspections for June and July 2024 were requested. R10's shower documentation, provided by V2 Director of Nursing, documents showers on 6/6/24, 6/10/24, 6/13/24, 6/20/24 (refused), and 6/27/24. There are no documented showers for July 2024 and no other documented showers for June 2024.</p> <p>On 7/9/24 at 1:20 PM, V2 Director of Nursing stated V2 could not find documentation that R10 received showers in July 2024. V2 confirmed there are no documented showers for R10 from 6/14-6/19/24 and 6/21/24-6/26/24. V2 stated when a resident refuses a shower staff should offer a shower the next day, but V2 could not find documentation that R10 was offered a shower after 6/20/24 until 6/27/24.</p> <p>The facility's Bathing-Shower and Tub Bath policy dated 1/31/18 documents showers/bathing will be offered twice weekly or according to resident's preferred frequency, and will be documented in the resident's electronic record.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50430</p> <p>Based on Observation, Interview and Record Review the facility failed to serve meals at an appropriate or palatable temperature. This failure effects nine (R6, R7, R9, R10, R13, R14, R15, R16, and R17) of 17 residents reviewed for food on the sample list of 12.</p> <p>Findings include:</p> <p>The Policy titled In-Room Dining dated 2020 states Meals served in rooms may be periodically checked at the point of service for Palatable food temperatures. Food temperatures of hot foods on room trays the point of service are preferred to be at 120 degrees Fahrenheit or greater to promote palatability for the resident. If there is concern about the temperature or palatability of a meal, a new meal should be ordered from dining services.</p> <p>On 7/9/24 at 1:55 PM, there was a sign with posted meal times on dining room door that documented Breakfast at 7:00 AM, Lunch at 11:45 AM, and Dinner at 5:00 PM.</p> <p>On 7/9/24 at 12:00 PM, V17 Dietary Aide pushed a cart of uncovered meal trays to the assisted dining room and distributed the trays to half of the residents. V12 and V20 Certified Nurse's Assistants (CNAs) were in the room with 14 residents. The meal trays sat uncovered in front of residents and there was no staff assisting these residents to eat. On 7/9/24 at 12:04 PM, a second cart of uncovered meal trays was delivered to the assisted dining room. Dietary staff passed the trays and residents R13-R17 sat in the dining with uncovered meals and no staff assistance.</p> <p>On 7/9/24 at 12:06 PM, there were two Certified Nursing Assistants (V20,V12 ) in the assisted dining room. Residents R13-R17 sitting with food in front of them uncovered and no staff assisting. V17 did unwrap silverware and instructed R15 to start eating. R15 took a drink of water. R17 told V17 that her and R16 can't feed themselves. At 12:09 PM, V11(Certified Nursing Assistant) entered dining room and started feeding R16 and R17.</p> <p>On 7/9/24 at 11:47 AM, V17 (Dietary aide) stated we serve room trays then assisted dinning room then dining room. V17 stated she can take food carts to hallway and they may sit for 20 min waiting for a CNA to pass them. V17 stated on 7/8/24 we didn't start serving breakfast until late because staff didn't have residents in the dining room. V17 stated we often have to wait to serve assisted dining room because we wait on CNAs. V17 stated I don't think there is enough CNAs to cover all the people who need help.</p> <p>On 7/9/24 at 12:06 PM, V20 (Certified Nursing Assistant) stated normally we pass the room trays and hurry back to assisted dining room to feed residents. V20 stated we try and run and pass trays, then assist with feeding, however depends on staffing how long that takes. Some of the CNAs stay on the floor to answer lights. V20 stated CNAs also have to go pick trays up after residents are finished with meal.</p> <p>On 7/9/24 at 10:00 AM, R6 stated sometimes he receives cold food; it depends on how fast they move the cart down the hall. On 7/9/24 at 1:10 PM electronic record review shows R6's MDS dated [DATE] documents R6 is cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/9/24 at 10:25 AM, R7 stated sometimes she gets cold food at mealtimes. R7 states residents complain at Resident Council meetings, but she feels nothing ever gets done. On 7/9/24 at 1:20 PM, electronic record review of MDS dated [DATE] documents R7 is cognitively intact.</p> <p>On 7/9/24 at 10:44 AM, R9 stated that sometimes he waits awhile with call light on before staff come help. R9 stated that the food is often cold when served at mealtimes and sometimes residents wait over an hour once getting to dining room to be served. R9's MDS dated [DATE] was reviewed and was still in progress. R9 was alert and oriented and answered questions appropriately during interview</p> <p>On 7/9/24 between 10:35 AM and 10:50 AM, R10 stated the facility doesn't serve the meals on time, the meals are usually late. R10 stated it is all meals, they just don't have enough staff. R10's Minimum Data Set, dated dated dated [DATE] documents R10 is cognitively intact.</p> <p>On 7/9/24 at 1:30 PM, V22 (Dietary Manager) stated that kitchen staff start plating room trays for breakfast at 7:00 AM, Lunch at 11:45 AM and Supper at 5:00 PM. V22 stated we don't have set meal times to eat because each day is different. V22 stated there could be times that food sits if staff are not ready to serve yet, however I try and communicate with them if they are running behind. When asked about plates going to dining room uncovered, V22 stated I was always taught they didn't need covered. V22 stated that if the food is left uncovered and not served right away then the resident's food would be cold. V22 stated that there has been multiple cold food complaints in the past.</p>		