STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Gibson City	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)
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** 37813 Based on observation, interview, and record review the facility failed to provide supervision to prevent a fall for one resident (R1) of three residents reviewed for falls in a sample list of three residents. This failure resulted in R1 falling and sustaining a laceration to R1's head requiring sutures. Finding Include: R1's Care Plan reviewed 9/25/24 includes the following diagnoses: Urinary Incontinence, Anxiety, Right Sided Hemiplegia, Osteoarthritis, Parkinson's Disease, and Dysphagia. This Care Plan also documents R1 is at risk for falls related to Gait and Balance Deficit, Incontinence, Poor Communication and Comprehension, Diagnosis of Parkinson's and History of Cerebral Vascular Accident with Right Sided Hemiparesis. This care plan also documents R1 has a physician's order for a Regular, Pureed Diet with Nectar Thick liquids. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired, has decreased range of motion for lower and upper extremities of one side, and requires supervision or touching assistance for eating. R1's After Visit Summary from the emergency room dated 9/24/24 documents (R1) came to the emergency room after (R1) had a fall and hit (R1's) forehead and had a laceration that was bleeding. (hospital staff) repaired the the laceration with sutures. These sutures need to come out in one week. This can be done through your primary care provider, at a convenient care location or at the emergency room . On 10/25/24 at 12:14 PM, R1 was observed sitting in the dining room at the table for lunch. R1 had a divided plate with pureed foods and nectar thickened liquids. R1 was receiving hands on assistance with feeding. R1 was not talking and was weak to the right side. R1 did not respond meaningfully to verbal stimuli. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	On 10/22/24 at 2:00 PM, V3 (Certified Nurse's Aide) CNA stated I was passing trays on the hall (on 9/24/24), and I heard another resident scream out (R1) was 'on the floor.' (R1) had her tray. I think probably someone from dietary gave it to her. (R1) was on the floor and her head was bleeding. It looked like R1 was reaching either for the call light or to turn on the light. The light wasn't on. I immediately called the nurse and (R1) was sent to the hospital (R1) should not have been left in her room alone with her tray. On 10/23/24 at 9:30 AM, V5 (Certified Nurse's Aide) CNA stated I would not have left (R1) alone for a meal in her room. (R1) is on thickened liquids and is very confused and often tries to get up unassisted. (R1) is pretty much total care. I regularly care for (R1) and she needs supervision and some help during meals. On 10/24/24 at 11:00 AM, V1 Administrator and V2 Director of Nursing verified that (R1) should not have been left in her room alone with her food tray and that the fall and sutures might have been prevented if (R1) had been taken to the dining room for her meal.