

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 02/19/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care planned fall intervention was implemented for one (R1) of three residents reviewed for accidents on a sample list of four. R1's Care Plan dated 2/5/26 documents R1 admitted to the facility on [DATE], with diagnoses of Parkinson's Disease with Dyskinesia, with Fluctuations, Asthma, Depression, Atrial Fibrillation, Anemia, Obstructive Sleep Apnea (Adult), Essential (Primary) Hypertension, Gastroesophageal Reflux Disease without Esophagitis, Polyosteoarthritis, Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, Protein-Calorie Malnutrition, and Dysphagia. R1's Care Plan dated 2/5/26 documents R1 needs assistance of at least one staff member for all daily living activities, that R1 has physical mobility impairment and is non-weight bearing, and that R1 is high risk for falls with intervention added on 6/19/25 of low bed and observe for resident to be positioned in the middle of the bed. The Care Plan also documents R1 is at high risk for bleeding due to anticoagulant use. R1's Minimum Data Sheet (MDS) section C dated 2/4/26 documents R1 is cognitively intact. R1's MDS section GG dated 2/5/26 documents R1 as totally dependent on staff for activities of daily living. R1's Unwitnessed Fall Report dated 1/25/26 documents R1 was found lying prone on the floor next to the bed at 1:30 AM. The Report documents R1 made a statement that R1 rolled out of bed, and did not hit R1's head, but had some pain in the chest area. The Report documents R1 was assessed and placed back in bed by mechanical lift. R1's Hospital Records dated 1/25/25 document R1 was found on the floor with time on the floor unknown, that R1 has severe Parkinson's with tremors and cannot get out of bed or ambulate on own and that R1 is on blood thinner but was not transported to hospital at the time R1 was found on the floor stating R1 had no pain. The Hospital Records document R1 complained of pain to mid substernal chest and right sided rib area. The Hospital Records document R1 was diagnosed with four acute right side rib fractures and was admitted to the hospital to control pain and monitor for bleeding related to blood thinner. R1's Computed Tomography Scan Report dated 1/25/26 documents acute anterior right 3rd through 6th rib fractures with old rib fractures noted as well. On 2/19/26 at 11:38 AM, V10 Certified Nursing Assistant (CNA), stated that she was the aide assigned to R1 the night of 1/25/26. V10 stated that at approximately 1:00AM she observed R1 in bed sleeping and then went down the hall to the nurse's station and ate lunch with the other CNA and two nurses on shift that night. V10 stated when they finished lunch, she started rounding on her residents and observed R1's feet on the ground from the doorway. V10 stated she found R1 lying on his left side using his right arm to prop himself up on the ground next to his bed. V10 stated R1 was upset stating he had been hollering for help, but no one came. V10 stated that she has never heard R1 yell before and that he struggles with speaking after his stroke. V10 stated R1 stated R1's chest hurt and V10 alerted the nurse and V12 Licensed Practical Nurse (LPN), V13 LPN, and V11 CNA came to R1's room. V12 took R1's vitals and assessed R1 for injuries and used a mechanical lift with a sling to place R1 back in bed. V10 stated that</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145911	If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's bed was high at the time of the fall and R1's side rails were in the up position. V10 stated she is new to the facility and had no knowledge of R1 being a fall risk or that his bed needed to be lower. V10 stated R1's bed was in the position it was always in. V10 stated R1 had an air mattress on R1's bed at the time of the fall. On 2/19/26 at 12:13PM, V11 CNA stated that he was sitting in the Activity Room watching the hallway for call lights when V12 LPN asked for his assistance in R1's room. V11 stated R1 was on the floor next to R1's bed complaining of pain in his chest area. V11 stated R1's bed was waist high and the side rail bar on the right side of the bed was up. On 2/19/26 at 12:20 PM, V12 LPN stated that on 1/25/26 around 1:30AM she was alerted to R1 being on floor by V10. V12 stated R1 appeared to be in semi-prone position lying on his left side with his right arm up and over his head. V12 stated at the time of the fall R1 had half rails on his bed and the bed was waist high when R1 was found. On 2/19/26 at 11:56AM, R1 was sitting in a high-back, reclining wheelchair next to R1's bed. The mechanical lift sling was under R1 and R1 was leaning to the right side in the chair with R1's right arm held across R1's mid-chest. A low air loss mattress was on R1's bed and a quarter rail was noted to the left side of the bed flush with the wall. No rail was noted to right side of R1's bed. The distance from the top of the mattress to the floor measured 33 inches, and the distance from the top of the bed rail to the floor measured 39 inches. On 2/19/26 at 11:58AM, R1 stated that he rolled out of bed and was hollering for help to get up. R1 stated he was not clear on how he managed to fall up and over the side of the bed to the floor but that he was alone when he fell. R1 stated he has tremors related to his Parkinson's disease and maybe he was thrashing around in his sleep. R1 stated the aide V10 came in and got the nurse. R1 stated he told the staff his chest hurt on his right side, and it still hurts. R1 stated he has no use of his left arm after the stroke. R1 confirmed that his bed is usually higher than where it is currently. This surveyor stood next to bed and R1 indicated that the bed is normally at the same level as this surveyor's waistline which measured at 42inches. On 2/19/26 at 12:30PM V2 Director of Nursing (DON) confirmed R1's Care Plan documents interventions entered on 6/19/25 for R1's bed to be in low position and R1 to be positioned in the middle of the mattress. V2 stated that R1's bed is not a low bed and doesn't go all the way to the floor. V2 stated that R1's bed should not have been in a high position while R1 was sleeping in bed. V2 stated there is a binder at the nurses' station with all fall risk residents in it, they have alert messages on the electronic medical record, and all staff receive fall prevention training at time of hire. The Facility Policy Incidents and Accidents dated 4/7/2019 documents an accident is defined as any happening not consistent with the routine operation of the facility that results in bodily injury other than abuse. The Facility Policy Fall Prevention Program dated 11/21/2017 documents safety interventions will be implemented for each resident identified as a risk, and all assigned nursing personnel are responsible for ensuring ongoing precautions are in place and consistently maintained.</p>		