STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145016	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Bloomington	700 East Walnut Bloomington, IL 61701

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to notify a resident's Power of Attorney (POA) of a fall with injury for one of three residents (R1) reviewed for notifications on the sample list of three. Findings include: R1's undated Face Sheet documents R1's medical diagnoses includes a history of Left Femur Fracture, Muscle Weakness, Abnormalities of Gait and Mobility, Hemiplegia and Hemiparesis following Cerebral Infarction, Dislocation of Left Shoulder Joint, Homonymous Bilateral Field Defects on Left Side, Optic Neuritis and Trochanteric Bursitis. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. R1's Electronic Medical Record (EMR) documents V4 as R1's Power of Attorney (POA). R1's Nurse Progress Note dated 6/7/24 at 9:05 PM documents (R1) assisted to bathroom before bedtime tonight by (V5) Certified Nurse Aide (CNA). (R1) stood up to sit on toilet and his legs became unstable. (V5) CNA assisted (R1) to a sitting position on the ground and called for the nurse. (R1) reports he did not hit his head as well as (V5) CNA stating (R1) was slowly slid from standing to sitting on the ground with no head injury. (R1) assisted via lift (total body mechanical lift) with (V5) and (V7 Registered Nurse/RN) off of the floor and onto his bed. (R1) Left Forearm has two skin tears which were cleansed, and steri-strips applied. R1's Skin Evaluation dated 6/8/24 documents new skin concerns for R1's Left Forearm measuring 2.0 centimeters (cm) and a second skin tear to R1's Left Forearm measuring 3.0 cm. This same report documents bruising around both skin tears. On 6/20/24 at 8:30 AM V4 stated The facility never notified me of (R1's) fall on 6/7/24. (R1) called me and told me. I did ask (V6) Care Plan Coordinator (CPC) who told me that the facility is supposed to notify the family when someone falls. (R1's) Left Arm was bruised and he got skin tears because of this situation. (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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Goldwater Care Bloomington	700 East Walnut Bloomington, IL 61701

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/24 at 8:45 AM V7 (RN) stated V4 (R1's POA) was not called about R1's fall on 6/7/24 due to V7 was told by V5 (CNA) that R1 was lowered to the floor. V7 stated We (staff) are not required to notify anyone if the resident was lowered. It should have been done in hindsight, but I didn't realize (R1) had fallen. On 6/21/24 at 10:25 AM V6 (CPC) stated V4 (R1's) Power of Attorney (POA) asked V6 on 6/10/24 if R1 had fallen on 6/7/24. V6 stated (V4) wanted to know why she hadn't been notified. I looked through the documentation and there was nothing to show that they (staff) called (V4). (V4) is (R1's) POA and should have been notified. I let (V2) Director of Nurses (DON) know that same day (6/10/24) what (V4's) concerns were. On 6/21/24 at 12:30 PM V2 (DON) stated anytime a resident falls with or without injury the Power of Attorney (POA) should be notified. V2 stated the previous fall nurse is no longer with us (facility). She should have been the one to make sure everything was being handled timely, but I guess she didn't. The facility policy titled 'Physician-Family Notification-Change in Condition' revised 11/13/2018 documents the purpose of this policy is to ensure that medical care problems are communicated to the attending Physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. The facility will inform the resident, consult with the resident's Physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring Physician intervention.

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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 - Minimal harm or potential for 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** 41970 Based on interview and record review the facility failed to implement fall prevention interventions and complete a thorough fall investigation for one (R1) resident out of three residents reviewed for falls in a sample list of three residents. Findings include: R1's undated Face Sheet documents R1's medical diagnoses as a history of Left Femur Fracture, Muscle Weakness, Abnormalities of Gait and Mobility, Hemiplegia and Hemiparesis following Cerebral Infarction, Dislocation of Left Shoulder Joint, Homonymous Bilateral Field Defects on Left Side, Optic Neuritis and Trochanteric Bursitis. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 as requiring maximum assistance for toileting, dressing and moderate assistance with personal hygiene and transferring on and off the toilet. R1's Physician Order Sheet (POS) dated June 2024 documents a physician order dated 1/30/24 for R1 to wear Left Arm immobilizer at all times except for dressing and showering. R1's Care Plan documents a fall intervention dated 7/14/23 which documents R1 is to wear a Left Arm immobilizer due to Hemiparesis of Left Arm. This same care plan documents an intervention dated 1/30/24 for R1 to use a hemi-walker and a gait belt with assistance of two staff. R1's Post Fall Investigation dated 6/7/24 documents R1 had a witnessed fall at 9:05 PM while being transferred from the toilet to his wheelchair. This same report documents immediate interventions taken to prevent repeat fall as increased staff assistance assigned for care. This same report documents R1 obtained two separate skin tears on his Left Forearm during fall on 6/7/24. R1's Skin Evaluation dated 6/8/24 documents new skin concerns for R1's Left Forearm measuring 2.0 centimeters (cm) and a second skin tear to R1's Left Forearm measuring 3.0 cm. This same report documents bruising around both skin tears. R1's Nurse Progress Note dated 6/7/24 at 9:05 PM documents (R1) assisted to bathroom before bedtime tonight by (V5) Certified Nurse Aide (CNA). (R1) stood up to sit on toilet and his legs became unstable. (V5) CNA assisted (R1) to a sitting position on the ground and called for the nurse. (R1) reports he did not hit his head as well as (V5) CNA stating (R1) was slowly slid from standing to sitting on the ground with no head injury. (R1) assisted via lift (total body mechanical lift) with (V5 and V7 Registered Nurse/RN) off of the floor and onto his bed. (R1) Left Forearm has two skin tears which were cleansed, and steri-strips applied. R1's Electronic Medical Record (EMR) documents R1 as six feet four inches tall and weighs 275 pounds on 6/4/24. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 8:30 AM V4 (R1's Power of Attorney) stated V5 (CNA) was assisting R1 to the bathroom. V4 stated V5 was assisting R1 back off the toilet by herself when R1 fell towards the wall and slid to the floor. V4 stated R1 is supposed to have two people assisting him because of his size. V4 stated R1 told her that when he fell , he fell up against the wall/door area so that no one could get in or out. V4 stated V5 (CNA) had to pull R1 over to be able to get the door open so that another person could get into help. V4 stated (R1) is supposed to use two people for transferring. This is nothing new. (R1 ' s) Left Arm was bruised and he got skin tears because of this situation. On 6/21/24 at 8:10 AM R1 stated V5 (CNA) assisted R1 to the toilet on the evening of 6/7/24 by herself. R1 stated V5 used a gait belt, and he used his hemi-walker. R1 stated Once I was finished on the toilet, I had to stand four times to get up. That toilet is pretty low, and I am pretty tall. I finally got to standing and walked to my wheelchair which was just outside the bathroom door. My wheelchair doesn't fit in the bathroom with my walker because the bathroom is so small. I got to my wheelchair and the legs of my walker got caught in the spokes of the wheelchair. I leaned into (V5) and then (V5) and I both went down to the floor. I did fall but I slid down the inside of my entry door to my room. (V5) tried to help me but I tower over her. (V5) just wasn't strong enough to keep me from falling. I wouldn't say (V5) lowered me. I did fall but the door actually broke my fall. After that (V5) went and got help. (V7) Registered Nurse (RN) and another nurse (V16) used the lift (total body mechanical lift) to get me back up. I didn't hit my head that I know of. I wish it never would have happened. (V5) CNA kept apologizing to me. They (facility) just need more help. On 6/21/24 at 8:45 AM V7 (RN) stated on 6/7/24 V5 (CNA) notified V7 that R1 was on the floor in his room. V7 stated V7 went to investigate and found that R1 was directly inside R1's room behind the entry door blocking the entrance to R1's room. V7 stated (V5) CNA, (V16) RN and me had to push (R1's) door open enough to get into (R1's) room. We (V5, V7, V16) had to push (R1) over with the main door enough to be able to get in. Once we got in, I assessed (R1). (R1) had been sitting up against the inside of the entry door to (R1's) room but had fallen over to his Right side when (V5) left to get help. (R1) had his gait belt on and the wheelchair and his hemi-walker were shoved aside towards the end of his feet. (V5) was by herself transferring (R1) and he is a very large and tall person. (R1) should not be transferred with only one person. (R1) can't use his Left side due to his stroke (Cerebral Vascular Accident). That was quite a situation that night. (R1) is lucky he only got two skin tears and a couple of bruises. (R1) could have been seriously injured. On 6/21/24 at 8:50 AM V5 (CNA) stated V5 assisted R1 out of his bed, to the bathroom and then to his wheelchair by herself. V5 stated I used my gait belt. (R1) is a very tall and big man. Once (R1) started leaning I tried to catch him but (R1) is very large and I am only five foot four inches tall and 140 pounds. I think (R1) is twice my size. I did the best I could. After (R1) fell , I went to get help. I left (R1) in a sitting position inside his room door. When we (V5, V7, V16) came back to get (R1) up, he had fallen over to his Right side. We (V5, V7, V16) had to push the door open enough for me to crawl through. I was able to get through to (R1's) closet and then move through the closet to (R1's) roommate's side of the closet and then finally out to be able to face (R1). I was able to pull him up enough to get the door open so that (V7 and V16) could get through. That was quite a time! V5 stated V5 should have gotten help to assist R1 off the toilet. V5 stated I won't be doing that again. (R1) is such a nice guy. I hate that he had to go through that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/24 at 1:00 PM V2 (Director of Nurses) stated R1's fall investigation was not thorough. V2 stated the facility should have contacted V5 (CNA) since V5 was directly involved in R1's fall. V2 stated There are some changes that need to be made. We (facility) should always try to find out the entire story of what happened. In (R1's) case, we (facility) stopped short. I will be doing some in-servicing about falls with staff. The facility policy titled 'Fall Prevention Program' revised 11/21/2017 documents safety interventions will be implemented for each resident identified at risk.