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	09/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41002 Based on observation, interview, and record review the facility failed to implement interventions for a resident with a known history of falling, complete thorough fall investigations, complete accurate fall risk assessments and obtain complete neurological checks for residents with head injury post fall. These multiple failures affect two (R1, R2) residents reviewed for accidents on a sample list of three residents. Findings Include: 1. R2's Facility Census documents R2 was admitted to the facility on [DATE] and includes the following medical diagnoses; Cerebellar Stroke Syndrome, Aphasia, Asthma, Lack of Coordination, Abnormal Posture, Repeated Falls, Need for Assistance with Personal Care, Ataxic and Abnormalities of Gait and Mobility. R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview for Mental Status (BIMS) score 99, unable to participate in the interview, moderate cognitive impairment. R2's Care Plan dated 9/10/24 documents admitted [DATE] states R2 has a diagnosis of cerebellar syndrome increasing risk for falls. R2's medical record documents the following: 7/5/24 fall, new intervention of fall mat next to bed, fall risk score increased to 18 high risk for falls. 8/1/24 fall with head injury, no new intervention, no fall risk score, neuro checks incomplete. 8/15/24 fall with head injury, new intervention to increase safety checks, no fall risk score, no neuro checks. 8/17/24 fall new intervention to re-educate R2, no fall risk score. 8/23/24 fall with head injury, new intervention to do labs, fall risk score decreased to 16 high risk, neuro checks incomplete. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/27/24 fall with head injury, new intervention to stay in bathroom with resident during toileting, fall risk score decreased to 13 moderate risk, neuro checks incomplete. 9/5/24 fall new intervention states to increase toileting, fall score decreases to 11 low risk, no neuro checks. 9/9/24 fall new intervention to place call don't fall sign, fall risk score decreased to 9 no risk, neuro checks incomplete. R2's Facility Final Report dated 8/27/24 states R2 had unwitnessed fall and received 6 staples and 2 sutures to scalp laceration at local emergency department. R2's hospital records dated 8/27/24 documents R2 came into Emergency Department with complaints of bleeding from back of head and bruising around left elbow. Large left occipital hematoma with active bright red oozing blood on exam. Wound/clot burden debrided revealing a 1-2-centimeter stellate laceration to left occipital scalp. Ecchymosis overlaying lateral left elbow. Repaired with 2 sutures to deep dermal tissue and 6 staples to outer tissue. CT results from 8/27/24 indicate extensive soft tissue hematoma in left posterior parietal location. On 9/11/24 at 10:35 AM, V13 Certified Nurse Assistant (CNA) stated V13 found R2 on floor next to bed, no fall mat in place on 8/27/24. On 9/10/24 at 12:48 PM V2 Director of Nursing (DON) stated V2 investigates falls by making sure information in fall report is accurate and matches witness statements. V2 stated that V2 came get the witness statements, but never was able to provide them. On 9/10/24 at 2:45 PM V9 Registered Nurse stated R2 is to have a fall mat when R2 is in bed. On 9/10/24 at 1:30 PM R2 room no mat visualized in room. R2 returning from shower, no non-skid socks noted on feet. 2. R1's Facility census documents R1 was admitted to the facility on [DATE] and has the following medical diagnoses including: Cerebrovascular Disease, Morbid (Severe) Obesity, Osteoarthritis, Lack of Coordination, Weakness, Pain in Right Knee, HTN, Lymphedema, Pain in Left Knee, Difficulty in Walking, and Need for Assistance with Personal Care. R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview for Mental Status (BIMS) score 14, cognitively intact. This same MDS documents R1 required assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. R1's Fall Risk assessment dated [DATE] documents R1 at risk for falls. R1's Medical Record does not document a complete set of neurological assessments after R1's falls on 8/24/24 at 8:03pm. R1's Nursing Note dated 8/25/24 at 1:49am documents (late note) R1 observed on the floor in foyer area in front of R1's wheelchair lying on right side and arm. R1 noted to have bleeding on right side of head. R1 complaining of pain in head. Bruising noted to be on right hand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's emergency room Provider Notes dated 8/24/24 at 8:54pm documents R1 is a [AGE] year-old female with a history of hypertension, hyperlipidemia, and dementia brought by EMS from nursing home who presents with complaints of unwitnessed fall. R1 has hematoma to right forehead. Unable to tell doctor what happened or how R1 fell . Per nursing home, R1 is on 81 milligrams of aspirin on nursing chart review, no other blood thinners. Small laceration over right frontal scalp close to hairline with underlying hematoma. Computed scan of head and spine, no acute fractures. Laceration repair 2 staples right temporal. Positive for a Urinary tract infection. R1's Medical Record does not document a complete set of neurological assessments after R1's fall on 8/24/24 at 8:03pm. On 9/11/14 at 10:24am V2 Director of Nursing (DON) said, on 8/24/24 R1 had an unwitnessed fall and sustained 2 staples to R1's scalp and a subdural hematoma. V2 said, V2 started and investigation and interviewed V3 Licensed Practical Nurse and V11 Certified Nursing Assistant who were working the 6:00am-6:00pm shift. V2 said, V3 observed R1 15 minutes before the fall sitting in R1's wheelchair in the common area watching TV. V2 said, V2 did not interview the other 2 CNA's working the [NAME] Hall where R1 resides, nor did V2 interview any residents that were present at the time of the fall. V2 stated since V3 and V11 informed V2 what had happened, V2 didn't think that interviewing other staff or residents because they are mostly cognitively impaired. V2 stated neurological checks were implemented after R1's fall, but V2 is unable to locate R1's neurological form. V2 stated that after a resident has an unwitnessed fall and hits their head, 72-hour neurological checks should be initiated and should be documented in the residents' chart. V2 confirmed R1 and R2's neurological checks were initiated for each fall but were not complete as they should have been. On 9/11/24 at 1:53pm V1 Administrator confirmed that R1 and R2's fall investigations were not thorough and complete as they should be. V1 also confirmed that after R1 and R2 had falls and hit their heads, and a 72-hour neurological check assessment should have been initiated and documented in the resident's chart. Facilities Fall Prevention Program with a revision dated of 11/21/17 documents: Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Standards: Safety interventions will be implemented for each resident identified risk. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions. Fall/Safety intervention may include but not limited to: Nursing personal will be informed of residents who are at risk of falling. The fall risk interventions will be identified in the care plan.