

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Goldwater Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41970</p> <p>Based on interview and record review the facility failed to provide timely toileting for one (R4) resident resulting in an incontinence episode out of four residents reviewed for timeliness of cares in a sample list of four residents.</p> <p>Findings include:</p> <p>R4's undated Face Sheet documents R4's medical diagnoses as Muscle Wasting and Atrophy, Diabetes Mellitus Type II, Morbid Obesity, Chronic Obstructive Pulmonary Disease (COPD), Weakness, Dependence on Wheelchair, Left Above the Knee Amputation and Spinal Stenosis.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] documents R4 as cognitively intact. This same MDS documents R4 requires maximum assistance with toileting, bathing, dressing and personal hygiene.</p> <p>R4's Careplan intervention dated 3/11/24 documents R4 requires the assistance of two staff to transfer with a total body mechanical lift.</p> <p>Resident Council Minutes dated 7/2/24 document New business: Certified Nurse Aide (CNA)/Nursing Concerns Answer call buttons quicker (two residents said they waited two hours). CNA comes into the room to turn off the call button and leaves without helping.</p> <p>R4's Concern/Grievance Form dated 9/15/24 documents R4 waited two and a half hours to go the the bathroom on 9/14/24 at 9:30 PM. This same form documents R4's concerns was 'partially substantiated' due to call light check time of one hour and 20 minutes. This same form documents Educated staff on importance of timely response to call lights and that they are the responsibility of all staff not just your own assignment.</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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Goldwater Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 9:50 AM R4 stated I was so upset the other night. It was Saturday (9/14/24) night after supper. I normally eat supper, then use the bedpan and then go to bed. So, Saturday night, I ate my supper and told one of the Certified Nurse Aides (CNA) (V24) that I needed to use the restroom. There were only two CNA's (V23, V24) on duty that night for our whole unit. We (facility) really need more than that. The staff told me they were short handed that night. So, after I told (V24) I needed to use the bedpan, I went to my room and put on my call light. I had put on my call light four times that night and either (V23) or (V24) would come in, shut my light off and say they would be back but they would never come back so I would put my light back on. I know I am not the only person that needs help. I am willing to wait my turn but I can't hold my bladder that long. I have to wait for help because I only have one leg. I don't wet my pants unless I can't get help to the bedpan. That night (9/14) I had to wait two and a half hours before they (V23, V24) helped me to the bedpan. By that time, I had wet all over myself, my pants and it was all over my wheelchair. I smelled so bad of urine. I was just humiliated. (R4 had tears rolling down her cheeks as she was describing this incident). I should not have to wait so long. This isn't the first time this has happened. I had to wait four hours one time a couple of months ago. I talked to (V2) Director of Nurses (DON) about that one. That is why they (facility) moved me to this unit (West). I was told that the [NAME] unit had more staff to be able to help me. I have just had enough. Nothing is changing. This facility needs more staff so that I don't have to sit in my own urine for hours at a time.</p> <p>On 9/19/24 at 1:15 PM V2 Director of Nurses (DON) stated V2 was aware of R4's concern from 9/14/24. V2 stated I interviewed the staff and reviewed the call light time logs. (R4's) light was listed on that log as being activated for one hour and twenty minutes the late evening of 9/14/24. The staff should have not made (R4) wait that long to use the bedpan. I am sure that was embarrassing for (R4). I educated the staff about responding to call lights and/or resident requests for assistance timely. I have been working on getting staff to answer lights more timely. I will inservice again and again and it still happens.</p> <p>The facility policy titled Dignity revised 4/23/18 documents the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth.</p>		