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Form Approved OMB
No. 0938-0391

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	11/06/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40385 Based on observation, interview, and record review the facility failed to provide fingernail care for one (R1) of five residents reviewed for hygiene in the sample list of five. Findings include: The facility's Nail Care policy dated 1/25/18 documents to monitor fingernail and toenail condition and provide cleaning and trimming during bathing assistance. On 11/6/24 at 9:19 AM R1's fingernails were long, approximately 1/4 inch past R1's fingertips, and jagged. There was a black substance underneath R1's fingernails. R1's Minimum Data Set date 10/28/24 documents R1 has moderate cognitive impairment and requires supervision/touching assistance from staff for personal hygiene. R1's care plan dated 11/1/24 does not document R1 refuses cares. On 11/6/24 at 1:43 PM V10 Certified Nursing Assistant (CNA) stated R1 is cooperative with cares. V9 CNA stated R1 is scheduled for showers on Tuesdays and Fridays. V9 and V10 stated fingernail care is done by the CNAs. V10 stated the CNAs should be providing fingernail care as part of morning cares. At this time R1 self propelled his wheelchair to the nurse's station. R1's fingernails remained long and dirty, confirmed by V9. V9 stated V9 will get R1's fingernails taken care of right away. On 11/6/24 at 1:59 PM V2 Director of Nursing stated fingernail care is expected to be done as part of morning cares and on shower days.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview and record review the facility failed to have physician orders for urinary catheters and document and report changes in urinary condition for two (R1, R5) of three residents reviewed for urinary catheters in the sample list of five. Findings include: The facility's Urinary Catheter Care policy dated 2/14/19 documents the nurse will insert the smallest sized urinary catheter as ordered by the physician and record catheter insertion in the nursing notes and treatment record. The facility's Physician-Family Notification-Change in Condition policy dated 11/13/18 documents to notify the resident's representative/family and physician when there is a significant change in the resident's physical, mental or psychosocial status. 1.) On 11/6/24 at 9:19 AM R1 stated R1 no longer has a urinary catheter since it was removed last night/early this morning. R1 stated R1 did not like the urinary catheter and R1 had tried to pull it out. R1 stated R1's urine had been dark and bloody. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has moderate cognitive impairment. R1's Care Plan dated 10/23/24 documents R1 is on enhanced barrier precautions related to urinary catheter use. R1's Care Plan dated 11/4/24 documents R1's urinary catheter use and includes interventions to change catheter as ordered and to monitor for urinary tract infection symptoms including changes in urine characteristics. R1's active November 2024 Physician Orders does not include orders for urinary catheter size and frequency of catheter changes. R1's Progress Note dated 10/29/24, recorded by V5 Nurse Practitioner, documents per nursing staff R1 pulled out his urinary catheter yesterday, an eight hour voiding trial (bladder emptying) was attempted, R1 was unable to urinate after eight hours, the bladder scan showed greater than 1000 milliliters (ml) of urine in R1's bladder, and a urinary catheter was reinserted. R1's urine was cloudy with a significant amount of sediment. V5 ordered a urinalysis and a urology consult. R1's Nursing Note dated 11/3/2024 at 8:05 PM documents R1 opened his urinary catheter bag on his bed, which leaked dark/amber colored onto his bed. There is no documentation in R1's electronic medical record of R1 pulling out his catheter, voiding trial, and monitoring or changes of R1's urine besides V5's 10/29/24 note and R1's 11/3/24 nursing note. There is no documentation that R1's family (V16) was notified R1 removed R1's catheter, R1 failed a voiding trial, or V5's orders on 10/29/24. On 11/6/24 at 10:23 AM V3 Director of Nursing stated R1 doesn't have a urinary catheter because R1 pulled the catheter out last evening. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 10:36 AM V7 Licensed Practical Nurse stated R1 had ongoing dark/blood tinged urine since R1 kept trying to remove his catheter, so V5 referred R1 to urology. V7 stated within three days of admission R1 pulled out his catheter, we assisted him to the toilet and did a voiding trial. V7 stated the voiding trial was unsuccessful since the bladder scan showed 999 ml of urine in R1's bladder, so a urinary catheter was reinserted. V7 stated V7 reported this to V5, but did not notify V16 (R1's Family) that day. On 11/6/24 at 11:19 AM V6 Registered Nurse stated V6 cared for R1 two times last week, R1's urine has been tea colored with sediment and sometimes blood tinged/pink ,and V6 encouraged R1 to drink more fluids. V6 stated V6 had heard that R1 had pulled out his catheter which could have caused trauma and the pink urine. V6 stated V16 was concerned about R1's urinary trauma and blood tinged urine due to R1's history of anemia (low blood count), so V6 contacted the on call physician group, but did not receive a call back prior to the end of V6's shift. V6 stated V6 thought V6 documented this information in R1's nursing notes. On 11/6/24 at 1:59 PM V2 Director of Nursing (DON) stated if the facility is changing the resident's catheter, there should be physician orders for catheter changes and the catheter size. V2 confirmed staff should have been documenting R1's urine monitoring/changes and catheter removal in R1's nursing notes, and notified V16 of these changes. 2.) On 11/6/24 at 1:16 PM R5 was sitting in a wheelchair near the front lobby. R5's urinary catheter collection bag contained dark yellow urine. R5 stated R5 has been in the facility for about five months and has had the catheter for about that time. R5 stated R5 was unsure how often the catheter is changed. R5's MDS dated [DATE] documents R5 is cognitively intact and has a urinary catheter. R5's Care Plan dated 6/20/24 documents R5 uses a urinary catheter related to urinary retention, but does not document catheter size. R5's Physician Order dated 9/8/24 documents to change urinary catheter monthly, but there are no orders for the catheter size. R5's Nursing Note dated 10/8/2024 at 5:33 PM documents R5's urinary catheter was changed as ordered, but does not document the catheter size.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40385

Based on observation, interview, and record review the facility failed to have physician orders and care plans for oxygen, and monitor oxygen saturation levels for three (R1, R2, R4) of three residents reviewed for oxygen in the sample list of five.

Findings include:

The facility's undated Oxygen Therapy General Standard policy documents oxygen is administered according to physician's orders and there will be ongoing resident assessments for oxygen administration, including assessing oxygen saturation levels. This policy documents oxygen flow rate will be increased or decreased based on the physician's orders or protocol.

1.) On 11/6/24 at 9:19 AM There was an oxygen concentrator in R1's room. R1 was in R1's room and was not wearing oxygen. R1 stated R1 has been in the facility for a few weeks and has been using oxygen prior to today. R1 stated the facility has been trying to wean R1 off of oxygen.

R1's Nursing Note dated 10/23/2024 at 4:00 PM documents R1 admitted to the facility using oxygen at 4 liters per minute (l/min). There is no documentation that R1 had physician orders for oxygen use prior to 10/25/24.

R1's Physician Order dated 10/25/24 and stop date 10/29/24 documents oxygen at 2 l/min as needed for oxygen saturation (SPO2) less than 90%. R1's Physician Order dated 10/29/24 and stop date 11/1/24 documents to wean down oxygen to 2 l/min to keep SPO2 greater than 89% and check SPO2 every shift. R1's active physician order dated 11/1/24 documents oxygen goal to keep SPO2 90-95%, check every shift.

R1's October and November 2024 Medication/Treatment Administration Records (MARs/TARs) document administration of R1's oxygen orders, but does not indicate the oxygen flow rate or R1's SPO2. R1's ongoing SPO2 log only documents 12 recorded entries between 10/25/24 and 11/6/24. There are no entries prior to 10/25/24.

On 11/6/24 at 10:36 AM V7 Licensed Practical Nurse (LPN) stated R1 has used oxygen intermittently since admitting to the facility and R1 removes his oxygen at times.

On 11/6/24 at 12:10 PM V2 Director of Nursing (DON) confirmed R1 admitted to the facility with oxygen and should have had oxygen orders entered into his electronic medical record upon admission. V2 stated oxygen saturation should be checked every shift and documented on the MARs/TARs and vitals section of the resident's electronic medical record.

2.) On 11/6/24 at 9:26 AM R2 was lying in bed wearing oxygen at 3 l/min per nasal cannula. R2 stated R2 has been in the facility for about two weeks and R2 wears oxygen all of the time. R2 was unsure how often staff check R2's SPO2.

R2's Admission MDS dated [DATE] documents R2 has moderate cognitive impairment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Nursing Note dated 10/15/2024 at 9:47 PM documents R2 admitted to the facility after hospital admission for respiratory failure secondary to pneumonia, and R2 reported shortness of breath with exertion (physical effort). R2's Nursing Note dated 10/21/2024 at 10:54 AM documents R2 complained of not feeling well. R2's lung sounds were clear on the left and diminished on the right, and SPO2 was 87% on room air. Oxygen was implemented at 2 l//min per nasal cannula and SPO2 was 93%. R2's Nursing Note dated 10/27/24 at 5:54 PM documents R2 complained of not feeling well. R2 was on oral antibiotics for pneumonia and SPO2 was 93% on 3 l/min. R2 was transferred to the local hospital. R2's Nursing Note dated 10/28/24 at 12:37 AM documents R2 admitted to the hospital. R2's active November 2024 Physician Orders do not include orders for oxygen use or monitoring SPO2. R2's ongoing SPO2 log documents 18 recorded entries from 10/9/24-11/6/24, and oxygen use is noted on 10/21/24. R2's Care Plan dated 11/1/24 documents R2 has pneumonia and to monitor vital signs every shift and as needed. This care plan does not document oxygen use. 3.) On 11/6/24 at 9:53 AM R4 was in bed asleep wearing oxygen at 2 l/min per nasal cannula. At 12:00 PM R4 was in bed wearing oxygen at 2 l/min. R4 stated R4 wears oxygen at 2 l/min and it is mostly used at night. R4's MDS dated [DATE] documents R4 as cognitively intact. R4's Physician Order dated 12/24/23 documents to change oxygen tubing weekly and as needed. There are no physician orders for oxygen and the l/min needed. R4's ongoing SPO2 log documents R4 has used oxygen since October 2023. R4's Care Plan with last review date 8/9/24 does not document R4's oxygen use. On 11/6/24 at 1:02 PM V2 DON stated oxygen should be included in the resident's care plan. V2 confirmed residents who use oxygen should have physician orders for oxygen use.