

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 12/31/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430</p> <p>Based on observation, interview, and record review the facility failed to notify the physician of the deterioration of a wound and failed to provide wound care as ordered by the physician for one (R1) of three residents reviewed for wounds on the sample list of three.</p> <p>Findings include:</p> <p>The facility's Skin Condition Assessment & Monitoring Pressure and Non Pressure policy revised on 6/8/18 documents, Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each dressing change. This policy documents that the physician will be notified of any changes to the wound.</p> <p>R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact.</p> <p>On 12/31/24 at 9:00 AM, R1 stated she had a doctor's appointment on 12/19/24. R1 stated while in her doctor's appointment R1 transferred from her wheelchair to an exam table with assistance of office staff. R1 stated during the transfer R1 sustained a laceration from a piece of metal sticking out on the exam table. R1 stated she was sent to the local emergency room where they had to apply stitches to the laceration. R1 further stated the wound nurse and nurses at the facility are not changing R1's dressing. R1 stated they tell me they will do it at the end of their shift, and they leave without changing the dressing. R1 stated several nurses tell R1 that they don't have time to change R1's dressing.</p> <p>R1's Physician Order dated 12/19/24 documents R1 has 29 sutures to the right front shin as a result of trauma at a doctor's appointment. This order documents instructions for staff to cleanse the area with normal saline, pat dry, apply medical honey to an open area missing a suture, cover with an absorbent dressing, and wrap with an adhesive bandage every day shift.</p> <p>On 12/31/24 at 10:21 AM, V4 Registered Nurse changed the dressing to R1's right shin. R1's shin had a 16 centimeter by nine centimeter, V-shaped laceration with sutures. The sutures were not approximated on one area of the laceration. This area was purple in color and had a strong odor. At that time, V4 Registered Nurse stated he saw R1's wound for the first time two days ago. V4 stated the center of the wound is not healing well, and V4 made V2 Director of Nursing/Wound Nurse aware of his concerns two days ago. V4 stated V2 contacts the physician when staff have a concern with a wound or treatment. V4 stated the center of R1's wound edges are not approximated and there is a foul odor from the absorbent dressing that V4 removed which contained brown drainage.</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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Progress Notes do not document that the physician was notified of changes in R1's wound.</p> <p>R1's Progress Notes dated 12/20/24 to 12/26/24 do not contain documentation that R1's treatment to the right shin was completed.</p> <p>R1's electronic Treatment Administration Record does not document the treatment to the right shin was completed 12/20/24 to 12/26/24.</p> <p>On 12/31/24 at 12:24 PM, V3 Quality Assurance Nurse stated if a treatment is left blank with no documentation of completion on the electronic Treatment Record, then the dressing change was not done.</p>		