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	07/28/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure timely medical treatment for one (R4) of three residents reviewed for change in condition on a sample list of 6. This failure resulted in R4 having an acute ischemic stroke resulting in receptive aphasia. The facility's Physician-Family Notification-Change in Condition Policy dated 11/13/2018 documents that 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: B) a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). On 4/11/2025 the facility held a nurse's meeting, and the V2 (Director of Nursing (DON)) educated the nurses on Documentation Guidelines for Change in Condition. A power point handout dated 2/28/2023 was provided and documents that nurses should always include the resident's signs and symptoms specific to the change in condition including vital signs. This education material also documents that nurses are not to monitor a change in condition without notifying the physician or nurse practitioner first. On 7/21/25 at 9:01 AM, V27 (R4 Family Member) stated that she called R4 on 7/1/25 around 8:00 AM and V27 stated R4's speech was garbled, and she was confused and kept asking V27 if she was there. V27 stated she reported this to V11(Licensed Practical Nurse) the nurse caring for R4 that morning.On 7/22/25 at 10:13 AM, V26 (Certified Nurse Assistant (CNA)) stated that she took care of R4 on July 1, 2025, and R4 wasn't acting right and wasn't making eye contact. V26 stated that R4 was transferring slower than normal and R4 couldn't hold her cup at breakfast and wasn't making sense when she talked.On 7/23/25 at 10:25 AM, V11 (Licensed Practica Nurse-LPN) stated that R4 seemed confused around mid-morning on 7/1/25 when she went to group therapy and V24 (Occupational Therapist (OT)) reported to V11 that R4 was acting nervous and confused. V11 stated that after lunch R4 continued to decline and was kept at the nurses' station for monitoring. Review of R4's electronic medical record does not include evidence that R4's vital signs were measured on 7/1/25. On 7/21/25 at 1:40 PM, V24 (OT) stated that R4 participated in a group therapy session on the morning of 7/1/25 and was having difficulty following one step commands. V24 stated that R4 exhibited confusion off and on during previous therapy sessions, but V24 stated this time it seemed more concerning. Speech Therapy note dated 7/1/25 documents that R4 was unable to effectively participate due to altered mental status.Physical Therapy note dated 7/1/25 documents that R4 needed max cueing for visual, verbal and tactile due to increase in confusion.On 7/22/25 at 10:39 AM, V12 (Nurse Practitioner) stated that she saw R4 the morning of 7/1/25 and resident was confused and seemed out of it. V12 stated she thought it was due to the medications R4 had received that morning but told V11 to monitor and call with any changes. V12 stated that V11 did not contact her that afternoon when R4 declined, and she said V11 should have called to report R4's change in condition and may have resulted in a more positive outcome for R4.On 7/23/25 at 11:57 AM, V2 (DON) stated she assessed R4 around lunch on 7/1/25 and R4 was giving goofy answers to her questions and kept saying that her daughter was at the facility. V2 stated that V11 should have got a set of vital signs on V11 and should have notified V12 when R4's condition worsened.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent a fall by failing to ensure fall precautions were in place and failed to minimize the risk of injury from a fall by failing to ensure interventions to reduce the risk of injury were in place. The facility also failed to ensure fall precautions and interventions were in place after a fall with injury for one (R1) of three residents reviewed for falls on the sample list of four. This immediate jeopardy began on [DATE] at 8:00 PM when this failure resulted in R1 having a high impact fall on [DATE] from an elevated bed onto the floor. This fall resulted in R1 sustaining a right leg fracture with shattered and displaced bone fragments. This fall contributed to R1's death five days later [DATE]. V1, Administrator was notified of the Immediate Jeopardy on [DATE] at 10:23 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. R1's undated Care Plan documents diagnoses including cerebral infarction, cerebral aneurysm, thrombocytopenia, dysarthria and anarthria, rheumatoid arthritis, type II diabetes mellitus with diabetic neuropathy, and pain in right knee. This care plan documents R1 requires maximum assistance of two people for bed mobility and sitting up and R1 requires a mechanical lift for transfers. R1's Fall Care Plan dated 3/2024 documents R1 has a history of falls and contains an intervention dated [DATE] to have fall mats on the floor next to the bed and for the bed to be in the low position when R1 is in bed due to the history of R1 rolling out of the bed onto the floor. This care plan documents R1 has fallen out of bed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].On [DATE] at 10:08 AM, R1 was lying in bed on a low air loss mattress. R1's bed was elevated three feet from the floor. Fall mats were not lying on the floor beside the bed. At this time R1 was unresponsive. R1 was breathing with mouth open, and breaths were irregular and labored. On [DATE] at 9:25 AM V31, Maintenance Director measured the height of R1's bed frame from the floor in standard position at 22 inches, then measured the bedframe from the floor at the position R1's bed was observed to be (on [DATE]) when R1 was in bed. This bed position measured 32 inches from floor. V31 stated the air mattress was at minimum 4 inches in height which would put R1 36 inches from floor when observed lying in bed. V31 verified this is a high position for bed. The Progress Note by V8 Registered Nurse (RN) dated [DATE] documents on [DATE] at 8:00 PM R1 was found on the floor next to the bed on his back after V13, Certified Nursing Assistant (CNA) heard his screams from another resident room. V8, documents that R1 fell from the bed in the high position with the low air loss mattress on and inflated. R1 complained of right knee pain and required four staff assist including the mechanical lift to transfer R1 to the bed. V8 documents R1's POA (V30) and hospice physician (V25) were notified, and orders were received to keep R1 comfortable with morphine and to not send R1 to the hospital at that time.The Incident Statement dated [DATE] documents, V13 CNA stated she was in another resident room when she could hear R1 screaming. R1's Progress Note dated [DATE] at 8:15 PM documents V32, LPN, contacted hospice staff stating R1 was having continued uncontrolled right knee pain after pain medication was administered as ordered, and staff cannot reposition R1 without extreme pain.R1's Physician Orders dated [DATE] document a new order for a 2-view x-ray of R1's right knee related to pain in the right knee and a one-time administration of 20mg of Morphine to be given for uncontrolled pain. At 3:07 PM on [DATE] V30, R1's Family Member stated she came to see R1 on Monday [DATE]. V30 stated she was notified of the fall on [DATE] around 9:00 or 9:30 PM. V30 stated she had not been in to see R1 all weekend but had called for updates on [DATE] and [DATE] and was told that R1 was just a little sore and bruised. V30 stated when she entered R1's room on [DATE] R1 was receiving a sponge bath from a CNA (unnamed). V30 stated R1 was not being moved but screaming in pain just from touch alone. R1's Biotech X-Ray report dated [DATE] at 11:22 AM documents R1 has an acute comminuted fracture distal femur with 3cm dorsal lateral displacement distal fragments noted. R1's progress notes dated [DATE] document R1 was sent to the local emergency department per family request. R1's Hospital Records dated [DATE] document R1 reported significant pain to the right hip area upon arrival on [DATE] and R1 had obvious gross deformity to the right lower extremity with significant enlargement of the right thigh. Right leg x-ray was completed at 3:32pm on [DATE] with results of acute comminuted fracture distal femoral Meta diaphysis just above prothesis with distal fragment displaced laterally and posteriorly by 4cm and right hip fracture cannot be ruled out. Records document R1's family declined surgical intervention due to R1's bleeding disorder and complications

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a comprehensive pain assessment after a fall with injury, failed to administer as needed pain medications as ordered by the physician when signs of symptoms of excruciating pain were present, and failed to notify the family and physician when a change in the level of pain was identified for one (R1) of three residents reviewed for pain on a sample size of four. This failure resulted in R1 suffering excruciating pain in which R1 was observed with facial grimacing, yelling and screaming for four days after sustaining a right leg fracture.R1's Progress Note dated [DATE] documents that on [DATE] at 8:00 p.m., R1 was found on floor next to bed on his back after V13, Certified Nursing Assistant (CNA) heard his screams while V13 was in another resident room. V8, Licensed Practical Nurse (LPN), documents that R1 fell from bed in high position with low air loss mattress on and inflated. R1 complained of right knee pain at 7/10 with no previous complaints of pain and required 4 staff assist including mechanical lift to place R1 back in bed. V8 documents V30, R1's family member, and hospice physician were notified, and facility was to keep R1 comfortable with morphine.R1's undated Care Plan documents diagnosis including cerebral infarction, cerebral aneurysm, thrombocytopenia, dysarthria and anarthria, rheumatoid arthritis, type 2 diabetes mellitus with diabetic neuropathy, and pain in right knee. This care plan also documents R1 has a potential for pain and is on pain medication therapy related to terminal diagnosis on hospice care with a start date of [DATE]; goals listed to have any complaint of pain controlled at acceptable level and to be free of discomfort. Interventions include to administer medications as ordered, assess for pain, and to notify physician if pain medication is non-effective.R1's Hospice Care Plan dated [DATE] documents R1 will be pain free or pain will be at tolerable level.R1's Medication Administration Record (MAR) dated [DATE] documents the following orders for Morphine Sulfate (Concentrate) Solution 20 milligrams(mg) per milliliter (ml) with a start date of [DATE]. -Give 0.25ml every 2 hours as needed (PRN) for pain rated 1-3 on a scale of 10.-Give 0.5 ml every 2 hours as needed (PRN) for pain rated 4-7 on a scale of 10.-Give 1.0 ml every 2 hours as needed (PRN) for pain rated 8-10 on a scale of 10.R1's MAR also documents scheduled order for 325mg of acetaminophen, 2 tabs three times a day, and every 4 hours as needed for pain, not to exceed 4000mg per day, with a start date of [DATE].V14, Hospice Registered Nurse (HRN), documented in R1's Hospice Progress Note dated [DATE] that V8, LPN called and stated R1 had fallen and was complaining of pain. V8, LPN stated R1 did not have any morphine in stock currently, and that she (V8) had no access to emergency box to pull bottle of morphine in facility stating, I'm new here. V8, LPN reported V30, R1's family member did not want R1 sent to hospital. Documents hospice attempted contact with V30 but was unable to verify V30's requests to not transport to local emergency department (ED). A new prescription for morphine was sent to the backup pharmacy and a hospice visit was scheduled for the next day, [DATE].V14, HRN, documented in R1's Hospice Progress Note dated [DATE] that V8, LPN called a second time stating R1 had now vomited three times. V14, HRN instructed V8, LPN to administer anti-emetic as ordered.R1's incident statement dated [DATE], documented V13 CNA stated she was in another resident's room when she could hear R1 screaming. V13 stated when she arrived to R1's room he was visualized in bed screaming in pain with several staff around.R1's Hospice Visit Notes dated [DATE], documented V14, HRN, stated R1 could be heard moaning in pain from down the hall. V14 documented having to wait for facility nurse V9, LPN to return from lunch break to get pain medications to relieve R1's acute pain. V14 stated she had to demand that R1 have medication for pain control as V9 stated no morphine had been retrieved from facility emergency backup supply box yet.R1's MAR dated [DATE] documented on [DATE] at 11:27 AM, Fifteen- and one-half hours post fall incident, 1st administration of PRN pain medication. R1 received ordered prn dose of 20mg/1ml Morphine indicated for pain score of 8-10 on pain scale with 10 being the worst pain. MAR documents sporadic administration of PRN morphine with continued high levels of reported pain until order for scheduled administration received on [DATE].R1's Progress Note dated [DATE], at 8:15 PM, documented V32, LPN, contacted R1's hospice stating R1 is having continued uncontrolled right knee pain after pain medication administered as ordered, and staff cannot reposition R1 without extreme pain.R1's Physician Orders dated [DATE] document new order for a 2-view x-ray of right knee related to pain in right knee and a one-time administration of 20mg of Morphine to be given for uncontrolled pain.R1's Hospital Records with print date of [DATE] documented R1 reported significant pain to right hip area upon arrival on [DATE]. R1 had obvious gross deformity to right lower