

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 08/17/2025
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)
F 0689 Level of Harm - Actual harm 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)

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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist one (R1) resident while eating causing R1 to spill hot coffee on her left hip and left thigh out of three residents reviewed for Accidents in a sample list of three residents. R1 obtained four separate blisters which required treatment from a Wound Physician. Findings include:R1's Electronic Medical Record (EMR) documents medical diagnoses as Hemiplegia and Hemiparesis following Cerebrovascular Disease affecting Right dominant side, Disorders of the Brain, Morbid Severe Obesity due to excess calories, Epilepsy, Traumatic Brain Injury, Colostomy, Chronic pain due to trauma and Legal Blindness. R1's care plan intervention dated 5/2/25 documents R1 is usually provided with one assist by staff to eat. R1's Visual Bedside Kardex Report dated 8/16/25 documents R1 is usually provided with one assist by staff to eat. This same Kardex documents R1's call light should be within reach. R1's Physician Order Set (POS) dated August 2025 documents a physician order starting 4/22/25 to provide a regular consistency diet with thin liquids. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 requires moderate assistance with eating and is dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. This same MDS defines moderate assistance as Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.R1's Nurse Progress Note dated 8/4/25 at 8:00 AM documents R1 called out and stated she spilled her coffee in bed. R1's Skin Condition Report dated 8/4/25 documents R1 called out after spilling coffee on her Left Lateral Hip and Thigh while in bed eating breakfast at 8:00 AM. This same report documents the hot coffee spill caused a large red, blanchable area measuring 15.0 centimeters (cm) long by 10.0 cm wide with no depth. This same report documents at 1:00 PM R1's Left Hip and Left lateral thigh were re-assessed and found to have four separate intact blisters measuring blister 1 as 4.0 cm long by 2.0 cm wide, blister 2 as 3.0 cm long by 1.0 cm wide, blister 3 as 3.0 cm long by 1.0 cm wide, and blister 4 as 3.5 cm long by 1.0 cm wide. This same report documents R1 complained of moderate pain to area and pain medication order was increased.R1's Wound Initial Evaluation and Management Summary dated 8/7/25 documents R1's Left Lateral Hip wound was from a hot liquid burn that resulted in a ruptured blister. This same report documents R1's Left Lateral Hip burn wound measures 1.0 centimeters (cm) wide by 2.0 cm long by 0.2 cm deep with moderate serous drainage, 100% thick adherent devitalized necrotic tissue with an estimated time to heal as one to two months. R1's Final Report to the State Agency dated 8/10/25 documents R1 stated she was laying in bed, drinking coffee in her personal tumbler and her cup slipped from her hand spilling coffee on her outer left hip/thigh. This same report documents R1 initially was assessed to have a blanchable red area to her Left outer Hip/Thigh which was left open to air. This report documents upon reassessment, R1 had four blisters that had formed on her outer Left Hip/Thigh requiring a medicated treatment with Silvadene cream. This same report documents V12 Wound Physician assessed R1 on 8/7/25 and changed R1's treatment order. This same report documents R1 is moderately cognitively impaired. R1's Wound Evaluation and Management Summary dated 8/14/25 documents R1's Left Lateral Hip burn wound measures 1.0 cm long by 3.5 cm wide by 0.1 cm deep with moderate serous drainage and 100% thick adherent devitalized necrotic tissue.On 8/16/25 at 8:55 AM V6 Licensed Practical Nurse (LPN) and V8 Certified Nurse Aide (CNA) completed a skin check for R1. R1's Left Hip showed three separate open areas. R1's upper Left Hip showed a dime sized open area with a pink wound bed and dark pink periwound, middle Left Hip was the largest of the three open areas, showed an irregular shaped open wound a few inches wide with attached yellow slough, dark red periwound and moderate yellow drainage and R1's medial Left Hip area showed a triangle shaped open area with a pink wound base and pink periwound. R1's dressing did not cover the medial nor the top open areas. On 8/16/25 at 9:10 AM V8 Certified Nurse Aide (CNA) set up R1's breakfast tray. The top of R1's meal ticket was highlighted in green. V8 CNA stated she did not know what the green highlighting meant. V9 CNA entered R1's room and stated she was not sure what the green highlighting meant but thought it may mean R1 was independent in eating. On 8/16/25 at 9:20 AM R1 was laying in her bed with head of bed up 60 degrees eating her breakfast. R1's call light was connected to the far side rail and laying under the fitted sheet. R1 stated she could not reach her call light and did not know where it was. There were no staff in R1's room. R1 stated This is just like the time when I couldn't get them (staff) to answer my call light when I spilled my coffee. On 8/16/25 at 9:25 AM V10 Certified Nurse Aide (CNA) entered R1's room</p>		