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	04/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review the facility failed to provide proper transport and privacy while transporting a resident to the shower room for one resident (R5) of four residents reviewed for quality of care in a sample of 16. B. Based on observation, interview and record review the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for three residents (R7, R8, and R14) of four residents reviewed for quality of care in a sample of 16. Findings Include: A. On 04/06/26 at 09:50AM V3, Certified Nursing Assistant (CNA), was observed transporting R5 from the shower room to R5's room using a shower chair with R5 wrapped in a top sheet. During the transport R5 was heard exclaiming to V3 I am cold, slow down V3 responded by saying I am going slow, R5 then stated No you're not, you always go to fast. I am cold. R5's Care Plan dated 01/30/2023 with multiple revision dates documents an admission date of 1/24/2023. The Care Plan documents diagnoses of Thoracic, Thoracolumbar and Lumbosacral Intervertebral Disc Disorder, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus Without Complications, Anxiety Disorder, Depression, Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations. The same record documents under ADL (Activities of Daily Living) care for R5's Bathing: I require partial/moderate assistance with showers. Date Initiated: 08/12/2023 Revision on: 09/15/2025. R5's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates R5 is cognitively intact. The same MDS Section GG subcategory E documents R5 requires partial to moderate assist with bathing. On 04/06/26 at 10:00AM V3, Certified Nursing Assistant (CNA), confirmed V3 took R5 to and from the shower room using the shower chair. On 04/06/26 at 10:05AM V4, License Practical Nurse (LPN), confirmed V3 transported R5 in the hallway to and from the shower room using the shower chair as the transport chair. V4 stated the shower chair should not be used as the chair to transport residents to the shower room from or to their room. V4 stated the resident should be clothed in their personal clothing not wrapped in a sheet. On 4/7/26 at 10:10am R5 stated V3, CNA, took R5 to and from his room to the shower room in the shower chair in the hallway wrapped in a thin white sheet. R5 stated this has caused him to feel embarrassment and some increased anxiety. R5 stated this is not the first time R5 has been transported in a sheet up and down the hallway and prefers to be dressed and transported to and from the shower room in his personal wheelchair not the shower chair. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/26 at 2:15pm V2, Director of Nursing, confirmed R5 was transported to the shower room and back to the resident room wrapped in a top sheet using the shower chair as the mode for transport by V3 on 4/6/26 at 10:00AM. V2 stated staff should not be using the shower chair as a transport chair. V2 stated the resident should be properly clothed not wrapped in a top sheet alone. The Bathing – Shower and Tub Bath policy dated 1-31-18 documents the Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. The document further states under subsection shower: Assist resident to undress and place in shower chair/transfer device. Assist resident when bathing is completed and make sure they are well dried. Assist to dress resident, as necessary. The Dignity policy dated 4-23-18 documents under section Guidelines: 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. The same policy further documents Maintaining a resident's dignity should include but is not limited to the following: Encouraging and assisting residents to dress in their own clothes, rather than hospital- type gowns, and appropriate footwear for the time of day and individual preferences. B. R14's undated Care Plan documents an admission date to the facility of 3/10/2025 with the following diagnoses: Unspecified Protein-Calorie Malnutrition, Dysthymic Disorder, Anxiety Disorder, Epilepsy, Chronic Migraine Without Aura, Insomnia, Sleep Apnea, Spastic Hemiplegia Affecting Left Nondominant Side, Chronic Pain, Hypertension, Pain In Left Shoulder, Myalgia, Age-Related Osteoporosis, Overactive Bladder, Depression, Chronic Kidney Disease, Constipation. R14's undated Care Plan documents R14 has Activities of Daily Living self-care assistance needs related to epilepsy, chronic pain, and myalgia with an intervention of R14 requires substantial/maximal assistance for toilet transfer and is encouraged to use call light for assistance. R14's Minimum Data Set (MDS) section C dated 3/26/2026 documents R14 has moderate cognitive impairment. On 04/08/2026 at 9:20 AM, R14 stated she experiences prolonged wait times after activating the call light, which at times results in episodes of incontinence. R14 reported that these episodes cause her to feel embarrassed. R5's Minimum Data Set (MDS) Set dated March 16, 2026, documents a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates R5 is cognitively intact. The same MDS Section GG subcategory E documents R5 requires partial to moderate assist with bathing. On 04/07/2026 at 10:10 AM, R5 activated the call light. The call light remained active until 10:25 AM, at which time the surveyor exited the resident's room. No staff response was observed during this time period. R7's undated Care Plan documents an admission date to this facility of 3/30/2023 with the following diagnoses: Chronic Obstructive Pulmonary Disease, Thrombocytopenia, Diastolic Heart Failure, Personal History Of Transient Ischemic Attack Hypertension, Gastro-Esophageal Reflux Disease Without Esophagitis, Peripheral Vascular Disease, Obstructive Sleep Apnea, Anxiety Disorder, Insomnia, Hyperlipidemia, Major Depressive Disorder, Hypokalemia, Presence Of Cardiac Pacemaker, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Dominant Side. This Care Plan documents R7 having an Activities of Daily Living self care deficit related to history of Cerebral Vascular accident and diagnosis of left sided hemiparesis. R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/7/2026 at 11:15 AM R7 stated it takes sometimes up to 30 minutes for her call light to be answered. R8's undated Care Plan documents an admission date to the facility of 6/09/2025 with the following diagnoses: Neuromuscular Dysfunction Of Bladder, Paraplegia, Hyperlipidemia, Major Depressive Disorder, Stiff-Man Syndrome. R8's Minimal Data Set section C dated 2/16/2026 documents R8 as cognitively intact. On 4/8/2026 at 11:00 AM R8 stated he pressed his call light last night and it took someone over thirty minutes to respond to R8's call light. The Resident Council Meeting Minutes dated 4/7/2026 document residents' concerns regarding call light response times taking too long. The facility's Call Light Policy dated 11/28/2012 documents: Resident's call lights will be answered in a timely manner. On 4/8/2026 at 10:42 AM V2 Director of Nursing (DON) stated it is her expectation for call lights to be answered within five to fifteen minutes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were administered and central line dressings were changed according to physician orders for two (R4 and R6) of three residents reviewed for quality of care, in a total sample of 16.Findings Include: 1.R4's Medical Record documents R4 discharged from the facility on 3/7/26. R4's Medication Administration Record dated 2/13/2026 printed on 4/7/2026 documents Vancomycin HCl-Sodium Chloride (antibiotic) 200 milliliters (ml) intravenously every 48 hours at 9:30 AM related to subacute osteomyelitis, left ankle and foot per physician's order.R4's Medication Administration Audit Report printed on 4/7/2026 documents R4 received the Vancomycin HCl-Sodium Chloride 200 milliliters (ml) on 2/13/2026 at 5:12 pm, 2/15/2026 at 6:37pm, 2/19/2026 at 12:20 pm, 2/25/2026 at 11:31 am, 3/3/2026 at 4:04 pm, and at 3/5/2026 at 5:40 pm instead of 9:30 am. R4's Electronic Medical Record does not document notification to the physician the medication was not administered on time. On 4/9/26 at 11:02 AM V2 DON confirmed this documentation.R4's Medication Administration Record 3/12/2026 (late entry) documents a physician order for a Peripherally Inserted Central Catheter (PICC) line site dressing change every week in the morning every Thursday for PICC care. R4's Electronic Medical Record does not document the PICC line dressing was changed since R4 was admitted to the facility on [DATE]. On 4/9/26 at 11:02 am V2 DON confirmed this documentation.On 4/6/2026 at 11:11 am, V9 R4's family member verbalized concern about the care provided to R4 during R4's stay at the facility including the care related to the PICC line, particularly the dressing not being changed.2.R6's Medication Administration Record dated 4/5/2026 printed on 4/6/2026 documents Daptomycin (antibiotic) 700 mg intravenously in the morning at 8:00 am and Ceftriaxone Sodium Injection Solution Reconstituted (antibiotic) 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously in the evening for infection at 5:00 pm.R6's Medication Administration Audit Report Documents Daptomycin 700 mg was administered on 4/5/2026 at 2:06 pm and on 4/6/26 at 9:51 pm. The Audit documents Ceftriaxone Sodium 2 gram was administered on 4/5/2026 at 9:34 pm and on 4/6/2026 at 9:51 pm. There is no documentation the two IV medications were administered on 4/4/2026. R6's medical record does not document physician and resident's representative notification of the omitted medications or the late medications. On 4/9/26 at 11:02 am V2 DON confirmed this documentation.On 4/6/2026 at 10:16 am R6 was in his room seated in a wheelchair. An intravenous (IV) pole was behind R6 containing an empty IV bag labeled Ceftriaxone 2 gram (gm). R6 stated he had not received his IV medication this morning. R6 had a peripherally inserted central catheter (PICC) line in R6's right arm.On 4/6/2026 at 10:32 am V4 Licensed Practical Nurse stated R6 is on Daptomycin IV every morning and Ceftriaxone IV in the afternoon. V4 stated Daptomycin is scheduled for 8:00 am but not been administered at this time and V4 already notified V2 Director of Nursing (DON). V4 stated she is an LPN and not able to administer the IV medication. V4 stated she will just change the order to 7am-10am to give the RN more time.On 4/6/2026 at 2:54pm V17 Physician stated he did not receive any phone call regarding R6 at this time.On 4/6/2026 at 1:30 pm V11 R6's family member stated she visited R6 yesterday (4/5/2026) and noticed the two IV medications were administered late in the day and were given back-to-back. R6 stated they have not changed R6's IV dressing since he was admitted to the facility on [DATE]. R4's IV line observed to right arm covered with a dressing dated 5/4 (later determined wrong date).On 4/6/2026 at 10:37 am. V2 Director of Nursing (DON) stated nurses need to notify the physician and resident's representative for late medication administration and should have an order before changing the orders. V2 stated the information should be documented in resident's medical record.On 4/6/2026 at 1:30 p.m. V2 DON clarified R6's IV line dressing was from the hospital, and the date was wrong since R6 was admitted to the facility on [DATE]. V2 stated IV dressings are to be changed every three days.The Facility's Medication Administration General Guidelines (undated) document medications are to be administered in accordance with written orders of the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications are administered within one hour before and after scheduled time unless specified by the prescriber.