

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/10/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide care and services in accordance with physician orders for ordered daily weights, failed to implement and document ordered blood glucose monitoring and diabetic management, and failed to assess, monitor, and provide ordered wound care following hospitalization and/or fall-related injuries for four (R10, R12, R80, R88) of four residents reviewed for post-hospitalization on a sample list of 39 residents. Findings include: Record review revealed R10 had diagnoses that included Dementia, Chronic Kidney Disease, Congestive Heart Failure, Seizure Disorder, and recurrent falls. R10 sustained multiple falls on 05/10/2026, 06/04/2026, and 06/05/2026. Following a fall on 06/04/2026, R10 sustained a scalp laceration requiring emergency department evaluation and staple placement and returned to the facility on [DATE]. Review of physician orders and clinical documentation failed to demonstrate ongoing wound assessments, staple site monitoring, or completion of ordered wound care interventions following R10's return to the facility. R10's review of weight monitoring records from April 2026 through June 2026 also failed to demonstrate completion of ordered daily weights. On 06/09/2026 at 9:36 AM, V14 Certified Nursing Assistant (CNA) stated R10 and R12 were weighed monthly. During observation of care, V14 noted a staple site on R10 and stated they were unaware that R10 had a staple. On 06/09/2026 at 9:40 AM, V15 Certified Nursing Assistant (CNA) again stated they were unaware of the staples and searched through R10's hair before locating the staple site. On 06/08/2026 at 1:35 PM, V3 Assistant Director of Nursing (ADON) confirmed no wound assessments had been completed following R10's return from the emergency department on 6/5/26, no monitoring had been completed based on emergency department discharge instructions on 6/5/26. V3 stated V3 was unaware that R10 had a staple in place. Record review revealed R12 had diagnoses including Chronic Diastolic Heart Failure, Acute-on-Chronic Heart Failure, Chronic Kidney Disease, COPD, Epilepsy, Chronic Pain Syndrome, and Obesity. R12 returned from hospitalization with physician orders for daily weights. Review of records from 04/07/2026 through 06/03/2026 of nursing documentation and Medication Administration Records failed to demonstrate consistent completion of weight monitoring. (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 - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed R80 had physician orders on 5/9/26 that documents requiring ongoing blood glucose monitoring following hospitalization. R80's blood sugars obtained in the clinical documentation from 5/9/2026 to 5/15/2026 failed to demonstrate completion of ordered monitoring and there was no evidence of R80's refusal, physician notification, or follow-up blood sugar checks. On 06/09/2026 at 11:01 AM, V2 Director of Nursing (DON) confirmed there were no documented weights, blood glucose checks, or wound assessments completed as ordered for the R10, R12 and R80. V2 DON further confirmed documentation and reporting related to the fall injury had not been completed and reported to the state agency. On 06/07/2026 at 10:05 AM, R88 was observed sitting in a recliner with R88's feet elevated. R88 stated R88 was admitted to the facility after developing a sore on R88's buttocks while residing in an assisted living facility. R88 reported R88 had been using pillows for comfort while sitting and stated R88 slipped off the pillows and fell to the floor. R88's Electronic Health Record (EHR) documents diagnoses including an Unspecified Open Wound of the Right Lower Leg and a Stage 3 Pressure Ulcer of the Left Buttock. R88's Care Plan dated 6/2/26 documents a risk for impaired skin integrity related to poor mobility, with a goal to prevent further alteration in skin integrity. R88's wound physician visit note dated 6/4/26 documents recommendations for a Dietician consultation and initiation of Vitamin C 500 milligrams (mg) by mouth twice daily, a multivitamin by mouth daily, Zinc 220 mg by mouth daily for 14 days, and a protein supplement twice daily or as directed by the Dietician. R88's Medication Administration Record (MAR) dated June 2026 does not include the physician-recommended orders from the 6/4/26 wound physician visit. On 6/10/26 at 10:34 AM, V3 Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated R88 was seen by the wound physician on 6/4/26 and stated the recommendations were missed and not initiated as they should have been. V3 stated the Dietician is scheduled to be in the facility on 6/17/26 and will review the recommendation for protein supplementation at that time.		