

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 02/26/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to provide timely call light response for six (R7, R11, R22, R26, R35, R226) of nine residents reviewed for call light response times in the sample list of 41.</p> <p>Findings include:</p> <p>1. On 2/24/25 at 10:33 AM, a resident council meeting was held. During the meeting R22 stated it takes a long time for call lights to be answered, R22's room mate (R26) cries and calls out, so R22 turns the call light on for R26. R22 stated R22 has had to go looking for staff because no one responds to the call light. R22 stated R22's/R26's room gets overlooked because it is in the corner and not on the main part of the hallway. R35 stated R35 has waited for over an hour for R35's call light to be answered and especially during breakfast and when staff are giving showers. R7 stated R7 turns the call light on for R7's room mate, R11, since a lot of times R11 isn't able to find the call light. R7 stated R11 waits a long time for the call light to be answered and often ends up getting out of bed by herself, but R11 is suppose to have assistance from staff. R7 stated R11 can't wait and ends up taking herself to the bathroom. These residents stated call light wait times has been an ongoing issue brought up in the resident council meetings that hasn't been resolved.</p> <p>On 2/24/25 at 11:34 AM V11 Activity Director confirmed call lights has been an ongoing concern brought up in the resident council meetings. V11 stated call light audits have been conducted and the longest has been about 30 minutes.</p> <p>The Resident Council Minutes dated 10/1/24, 11/5/24, 12/4/24-12/6/24, 1/15/25, and 2/4/25 document concerns with call light response times taking too long.</p> <p>R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. R11's MDS dated [DATE] documents R11 has moderate cognitive impairment and requires supervision/touching assistance from staff for toileting and transfers.</p> <p>R35's MDS dated [DATE] documents R35 as cognitively intact and R35 requires substantial/maximal assistance of staff for transfers, toileting, dressing and hygiene.</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R22's MDS dated [DATE] documents R22 as cognitively intact and requires setup/clean up to supervision/touch assistance from staff for Activities of Daily Living. R26 MDS dated [DATE] documents R26 as cognitively intact and is dependent on staff for toileting, transfers, hygiene, and dressing.</p> <p>2. On 02/23/25 at 9:20 AM R226 stated on an unidentified date R226's call light was on for 45 minutes.</p> <p>R226's Admission MDS dated [DATE] documents R226 as cognitively intact and requires partial/moderate assistance from staff for hygiene, dressing and transfers and supervision/touch assistance for walking.</p> <p>The facility's Call Light policy dated 2/2/18 documents all staff should assist in answering call lights and to answer call lights promptly.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were assessed for self-administration of medication. This failure affects two (R24 and R36) of two residents reviewed for self-administration of medication on the sample list of 41.</p> <p>Findings include:</p> <p>1. The facility Self-Administration of Medications Policy dated August 2020 documents residents will have a self-administration of medication assessment, a physicians order to self-administer medication, and this will be care planned.</p> <p>On 2/23/25 at 9:14 am, a medicine cup containing R24's morning medications was observed on R24's bedside table. R24's last name was written on said medicine cup. This medicine cup contained the following medications: Glimperide 2 milligrams (mg); Multivitamin; Omeprazole 20 mg; Plavix 75 mg; Potassium Chloride 20 milliequivalent (mEq); Tamsulosin 0.4 mg; Gabapentin 600 mg and Carbidopa-Levodopa 25-100 mg (two tabs). No licensed nursing staff were present in R24's room during this time.</p> <p>On 2/23/25 at 9:15am, R24 stated, those are my morning meds. I'll take them here shortly.</p> <p>R24's Comprehensive assessment dated [DATE] documents R24 is cognitively intact.</p> <p>R24's Physician Order Sheet (current) does not document an order for self-administration of medication.</p> <p>R24's Electronic Medical Record does not contain a self-administration of medication assessment.</p> <p>R24's Care Plan (current) does not document R24 is able to self-administer medication.</p> <p>40385</p> <p>2.) On 2/23/25 at 9:20 AM R226 was sitting in a recliner in R226's room and there was a medication cup containing two white pills on R226's overbed table. R226 stated R226 thought the pills were iron pills. R226 stated the nurses don't always wait for R226 to take R226's medications prior to leaving the room.</p> <p>On 2/23/25 at 9:32 AM V12 Licensed Practical Nurse stated the pills at R226's bedside were two probiotic pills that V12 administered this morning. V12 stated V12 probably should have waited to make sure R226 took all of R226's medications. V12 confirmed there would be a physician's order if R226 was able to self administer medications.</p> <p>R226's February 2025 Medication Administration Record documents Lactobacillus (probiotic) give two tablets daily at 8:00 AM. There are no orders, assessment, or care plan in R226's medical record that documents R226 has been assessed for the ability to self administer medications.</p> <p>(continued on next page)</p>		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 1:07 PM V2 Director of Nursing stated there needs to be a physician's order for residents to self administer medications. V2 confirmed there is no order for R226 to self administer medications. V2 stated the nurses should not be leaving medications at the bedside for residents to take, the nurses should stay with the resident to observe the resident consume the medications.		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>40385</p> <p>Based on observation, interview, and record review the facility failed to ensure resident rooms were equipped with call lights and failed to provide an appropriate call light for three (R7, R11, R66) of three residents reviewed for accommodations of needs in the sample list of 41.</p> <p>Findings include:</p> <p>The facility's Call Light policy dated 2/2/18 documents the nurse call light system will be available at all times and within easy accessibility for residents who have the ability to use a call light. This policy documents to report call light system problems to to the maintenance department for servicing.</p> <p>1. On 02/24/25 at 10:33 AM, during the resident council meeting, R7 stated R7 doesn't have a call light and hasn't had one since moving into the room that is shared with R11. R7 stated a lot of times R7 has to find R11's call light because R11 is unable to find it. R7 stated R11 needs staff assistance for transfers, but R11 self transfers because staff don't answer the call light timely.</p> <p>On 2/24/25 at 11:27 AM, R7's/R11's room contained only one call cord with one call light that was attached to R11's bed. There was a desk bell on R11's overbed table. R7's side of the room did not contain a call light or bell. R11 was asked about the call light and bell, R11 was confused and did not understand. At 11:28 AM V19 Certified Nursing Assistant (CNA) stated R7's/R11's call light box only allows for one cord and R7 uses a bell as a call light. V19 stated R7 and R11 shared the call light.</p> <p>On 2/24/25 at 11:32 AM, V19 Maintenance stated V19 was not aware that R7's/R11's room only has one call light. V19 stated the staff should have notified the maintenance department. V19 confirmed each resident should have their own call light.</p> <p>On 2/24/25 at 2:22 PM, V18 Maintenance Director stated V18 had been working on R7's/R11's call light and trying to find call light cords since both residents were moved into the room together. V18 confirmed that R7 and R11 began sharing the room in October 2024 and there has only been one call light in that room since then.</p> <p>On 2/25/25 at 9:13 AM V2 Director of Nursing and V4 Assistant Director of Nursing in January 2025 they became aware that R7 and R11 were sharing a call light and were told by maintenance staff that parts had been ordered.</p> <p>R7's Census and R11's Census document R7 and R11 have shared a room since 10/21/24.</p> <p>2. On 2/23/25 at 8:58 AM R66 was lying in bed and R66's flat, touch pad style call light was on the floor mat beside R66's bed, out of R66's reach. On 2/23/25 at 12:16 PM R66 was in bed and R66's call light was on the floor. On 2/23/25 at 1:04 PM V15 and V16 CNA turned R66 in bed, dressed R66, and transferred R66 with a full mechanical lift into a geriatric chair. R66 had no functional movement of R66's arms and did not assist the staff during these cares.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/23/25 at 9:31 AM V16 CNA stated R66 isn't able to use the call light since R66 is unable to use R66's arms. V16 stated R66 isn't able to activate the call light with R66's chin or head. At 12:50 PM V16 confirmed R66's call light was on the floor, out of R66's reach. At 1:21 PM V16 stated R66 yells out to alert staff that R66 is in pain and when R66 wants pain medication.</p> <p>On 2/24/25 at 2:48 PM V14 stated R66 isn't able to use R66's call light, staff have tried positioning it near R66's head and feet, and no other style of call light has been used. R66 agreed with V14's statement. R66 stated R66 just yells out for staff or asks R66's room mate to turn on the call light. V13 and V14 CNAs used wedge cushions to position R66 onto R66's side at a 90 degree angle to the mattress and placed the call light next to R66's hand. R66 attempted to activate the touch pad call light and was inconsistently able to activate the call light by poking it with R66's finger. R66 stated R66 is only able to activate the call light when lying in this exact position due to R66's limited hand movement.</p> <p>On 2/24/25 at 3:18 PM V3 Licensed Practical Nurse stated staff tried using a bell as a call light for R66, but R66 wasn't able to use it. V3 stated R66 said R66 would use a mouth type call light that is activated by blowing into it, which is what R66 used at the hospital, but this facility does not have that style of call light.</p> <p>On 2/24/25 at 9:13 AM V2 Director of Nursing confirmed R66 has not had any other call lights attempted or trialed besides the flat touch pad style. V2 stated V2 was not aware that there are other styles of call lights that could be used.</p> <p>R66's MDS 1/13/25 documents R66 as cognitively intact, has impaired range of motion to both upper and lower extremities, is dependent on staff assistance for activities of daily living, and has frequent pain. R66's Care Plan dated 1/9/25 documents R66 has limited physical mobility related to quadriplegia and to ensure call light is within reach and encourage use.</p> <p>R66's Progress Note dated and recorded by V22 Nurse Practitioner 1/9/25 documents R66 is a new admission following a fall at home with cervical ligament injury and disc fracture of C4-C5 and associated cord compression of C3-C4. R66 underwent a laminectomy and developed cord compression and quadriplegia and was transferred to a hospital rehabilitation center prior to admitting to current facility.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>41970</p> <p>Based on observation, interview and record review the facility failed to ensure four residents (R19, R65, R24, R226) had physician orders for medications which were in residents rooms out of four residents reviewed for qualified persons in a sample of 41 residents.</p> <p>Findings include:</p> <p>1. R65's undated Face Sheet documents medical diagnoses of Rhabdomyolysis, Metabolic Encephalopathy and Cognitive Communication Deficit.</p> <p>R65's Physician Order Sheet (POS) dated February 2025 does not document a physician order for Magnesium Oxide 500 milligrams (mg). This same POS does not document a physician order for R65 to have medications left at his bedside.</p> <p>On 2/23/25 at 10:40 AM R65 had a bottle of Magnesium Oxide 500 mg sitting on his bedside dresser.</p> <p>On 2/25/24 at 1:30 AM R65 had a bottle of Magnesium Oxide 500 mg sitting on his bedside dresser.</p> <p>On 2/23/25 at 10:45 AM R65 stated the bottle of Magnesium Oxide belongs to him. R65 stated he buys the Magnesium Oxide and keeps it in his room.</p> <p>On 2/25/25 at 1:40 PM V2 Director of Nurses (DON) stated R65 has been known to go to a store, buy over the counter medications and leave them in his room. V2 DON stated the facility was not aware that R65 had the bottle of Magnesium Oxide and will remove it promptly due to R65 is not supposed to have medications kept at his bedside.</p> <p>2. R19's undated Face Sheet documents medical diagnoses of Bilateral Primary Osteoarthritis of Knee, Alzheimer's Disease, Morbid Obesity and Obstructive Sleep Apnea.</p> <p>R19's Physician Order Sheet (POS) dated February 2025 does not document a physician order for Zeasorb Antifungal powder nor another bottle of antifungal powder 1%. This same POS does not document a physician order for R19 to have medications left at her bedside.</p> <p>On 2/23/25 at 11:08 AM one bottle of Zeasorb antifungal powder was sitting on R19's bedside dresser.</p> <p>On 2/23/25 at 1:25 AM one bottle of Zeasorb antifungal powder and another bottle of antifungal powder 1% was sitting R19's bedside dresser.</p> <p>On 2/23/25 at 11:10 AM R19 stated she occasionally gets gaulded under her breasts and the staff will put the antifungal powder on. R19 stated They (staff) all know it is there. They use it and then leave it in here so they have it handy the next time.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/25/25 at 1:45 PM V2 Director of Nurses (DON) stated R19 does not have an order to self administer medications and should not have any medication left at her bedside. V2 DON stated all medications should have a physician order and only the residents with self administration assessments and have a physician order to keep their medication at the bedside should have them sitting in the resident room. V2 DON stated other residents could have access to medications left unattended.</p> <p>40385</p> <p>3.) On 2/23/25 at 9:11 AM there was a tube of menthol topical gel on R36's bed. R36 stated the staff apply the gel to R36's shoulders as needed and R36 always keeps this medication in R36's room.</p> <p>R36's medical record did not contain an active order for the menthol gel or that the medication may be stored at R36's bedside. R36's February 2025 Medication Administration Record does not document an order or administration of the topical menthol gel.</p> <p>On 2/23/25 at 11:22 AM V12 Licensed Practical Nurse stated R36 uses the topical menthol gel and it is applied by staff. V12 stated R36 used to have an order to keep that medication in R36's room. V12 confirmed R36 does not have an active order for this medication or that it may be kept at the bedside.</p> <p>On 2/25/25 at 1:07 PM V2 Director of Nursing confirmed all medications administered should have an active order. V2 stated medications should be stored in the medication cart/medication room unless there is an order to keep the medication in the resident's room.</p> <p>38780</p> <p>4. On 2/23/25 at 9:14am, R24 was sitting in a recliner in R24's room. An open bottle of Calcium Carbonate Ultra Strength 1000 milligrams (mg) was observed on a table next to R24's recliner. No licensed nursing staff were present in R24's room during this time.</p> <p>On 2/25/25 at 9:15am, R24 was sitting in a recliner in R24's room. An open bottle of Calcium Carbonate Ultra Strength 1000mg was observed on a table next to R24's recliner. No licensed nursing staff were present in R24's room during this time.</p> <p>On 2/25/25 at 9:16am, R24 stated R24 takes the Calcium Carbonate when needed for heartburn.</p> <p>R24's Physician Order Sheet (current) does not document an order for Calcium Carbonate 1000mg.</p> <p>The facility Medication Storage Policy dated 7/2/19 documents the facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20892</p> <p>Based on interview and record review the facility failed to complete a discharge summary for one resident (R75) out of one resident reviewed for discharge in a sample list of 41 residents.</p> <p>Findings include:</p> <p>The facility was not able to provide a policy in regards to documentation upon a resident being discharge to home or to another facility. V1 stated at 11:18 AM on 2/26/25 was We only have this policy about transferring or discharging a resident. No information about what needs to be documented in the discharge summary or recapitulation of stay.</p> <p>R75 Electronic Medical Record (EMR) documents R75 admitted to facility on 11/6/24 and discharged on [DATE].</p> <p>R75's Electronic Medical Record does not include a discharge summary or recapitulation of stay while here at the facility.</p> <p>R75's Care Plan initiated 11/16/24 documents R75 wishes to return to her home in (Local City) and son whom she lives with. The careplan continues to document: to establish a pre-discharge plan with me/family/caregivers and</p> <p>evaluate progress and revise plan as needed.</p> <p>On 2/25/25 V2 at 11:30 AM V2, Director of Nursing, stated V2 finished documenting on R75, the nurse who discharges the resident should have documented the information in the Progress notes of EMR. V2 stated she did the part for the nurses but the other disciplines did not chart any information.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to provide services to address a decline in walking and transfer ability for one (R42) of 24 residents in the sample of 41.</p> <p>Findings include:</p> <p>On 2/23/25 between 10:30 AM and 4:00 PM and on 2/24/25 between 8:32 AM and 4:00 PM intermittent random observations were conducted of R42 who was sitting in a wheelchair near the nurses' station on R42's unit.</p> <p>On 2/25/25 at 10:33 AM V14 Certified Nursing Assistant (CNA) and V3 Licensed Practical Nurse (LPN) transferred R42 out of bed into a wheelchair and propelled R42 out into the hallway.</p> <p>On 2/25/25 at 3:12 PM R42 walked approximately 50 feet with wheeled walker and extensive assistance from V13 and V14 CNAs and V3 LPN. V3 had hold of the front of R42's walker to apply resistance pressure while walking backwards. V13 used a gait belt and assisted R42 with walking while V14 followed with the wheelchair. R42's gait was unsteady and R42 leaned forward with feet outstretched trailing behind R42. V3 stated if V3 did not apply resistance on R42's walker, R42 would fly forward. V14 stated staff doesn't walk with R42 due to not having enough time. V13 stated staff only walk with R42 occasionally/as needed if R42 looks like R42 is getting restless.</p> <p>On 2/25/25 at 10:57 AM V10 Registered Nurse stated within the last two months R42 has declined, R42 no longer walks, R42 has been using the wheelchair and needs extensive assistance from staff for transfers.</p> <p>On 2/25/25 at 11:44 AM V3 stated R42's balance and physical ability has declined within the last three weeks. V3 confirmed the wheelchair is R42's primary mode of locomotion.</p> <p>R42's Minimum Data Set, dated dated [DATE] documents R42 has short and long term memory impairment, R42 used supervision/touch assistance from staff for transfers and walking up to 150 feet, and a walker was the only mobility device used during the look back period. R42's Care Plan (current) documents R42 has an activity of daily living self performance deficit related to disease process of Huntington's Disease. This care plan documents an intervention dated 3/31/24 that R42 is independent with supervision for transfers and ambulation and sometimes needs one assist. This care plan has not been updated with R42's current level of functioning.</p> <p>R42's Nursing Notes document R42 fell on [DATE], 1/14/25 and 2/15/25. There is no documentation that therapy or restorative nursing services were offered or implemented to address R42's decline in walking and transfers.</p> <p>On 2/25/25 at 9:13 AM V2 Director of Nursing and V4 Assistant Director of Nursing stated R42 has not had therapy offered or implemented recently after R42 started using the wheelchair. V2 stated the facility does not have restorative nursing programs implemented/documented. At 9:56 AM V2 stated R42 last received therapy services on 7/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Restorative Nursing Program dated 1/4/19 documents the purpose of the program is to promote each resident's ability to maintain or regain the highest degree of independence as safely possible. This policy documents residents will be screened for restorative nursing needs upon admission, annually, quarterly and with significant changes in condition, and will be determined by the interdisciplinary team as needed and/or may be determined as a continuation of care following therapy services. This policy documents restorative programs will include individualized goals and measurable objectives that are documented on the resident's plan of care, implementation of interventions will be documented, and resident's progress will be periodically reviewed by the nurse.</p>		

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NAME OF PROVIDER OR SUPPLIER Goldwater Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Walnut Bloomington, IL 61701	

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to provide showers as scheduled for one (R35) of two residents reviewed for showers in the sample list of 41.</p> <p>Findings include:</p> <p>On 2/24/25 at 10:33 AM during the resident council meeting, R35 stated R35 is suppose to have showers twice per week, but has only been getting showers five or six times per month.</p> <p>R35's MDS dated [DATE] documents R35 is cognitively intact and requires substantial/maximal assistance from staff for bathing. R35's shower task documents R35 is scheduled for showers on Mondays and Thursdays and does not document that R35 was offered a shower after 2/17/25.</p> <p>On 2/25/25 at 2:36 PM V27 Certified Nursing Assistant (CNA) stated We work with four CNAs on the [NAME] Hall, which is not enough because we don't always get showers done. It would be nice to have a shower aide.</p> <p>On 2/24/25 R35's February 2025 shower documentation was requested. V2 provided R35's shower sheets dated 2/2/25, 2/11/25 and 2/14/25. On 2/24/25 at 12:43 PM V2 confirmed all February 2025 shower documentation was provided for R35 and confirmed R35 should receive showers twice weekly as scheduled.</p> <p>The facility's Bathing- Shower and Tub Bath policy dated 1/31/18 documents the purpose of the policy is to ensure resident's cleanliness to maintain proper hygiene and dignity. This policy documents bathing will be offered according to resident's preferred frequency or twice per week and document bathing in the resident's electronic medical record.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to provide and implement activities of interest for one (R42) of 24 residents reviewed for activities in the sample list of 41.</p> <p>Findings include:</p> <p>On 2/23/25 between 10:30 AM and 4:00 PM and on 2/24/25 between 8:32 AM and 4:00 PM intermittent random observations were conducted of R42 who was sitting in a wheelchair near the nurses' station on R42's unit. There was an overbed table in front of R42 with snacks and drinks. Staff provided feeding assistance for meals. R42 did not participate in any individual or group activities.</p> <p>R42's Minimum Data Set (MDS) dated [DATE] documents R42 has cognitive impairment. R42's MDS dated [DATE] documents reading books/magazines/newspapers, listening to music, doing things with groups of people, and spending time outdoors are R42's preferred activities.</p> <p>R42's Care Plan (current) documents R42 has a diagnoses of Huntington's Disease and R42 enjoys spending time in R42's room, time with family/friends, going outside, going to group activities with snacks and R42 prefers to observe when attending group activities. This care plan includes interventions to allow R42 to use the outside area for leisure time; encourage R42 to attend group activities such as movies, snacks, and live music; paint nails when allowed; provide additional one to ones as needed; and provide assistance with visual telecommunication with family.</p> <p>On 2/25/25 at 10:33 AM V3 Licensed Practical Nurse stated R42 didn't go to any group activities yesterday since R42 doesn't like BINGO. V3 stated R42 likes music, watching television and enjoys snacks, but staff have to assist R42 with these things. V3 confirmed staff did not provide any of these activities for R42 yesterday while R42 sat near the nurse's station.</p> <p>On 2/25/25 at 11:02 AM V11 Activity Director stated R42 did not attend any group activities on 2/24/25 since R42 doesn't like BINGO. V11 stated R42 likes socialization and to sit and talk with staff. V11 stated yoga, BINGO, coloring, and current events were the group activities offered yesterday. V11 stated V11 sat and talked with R42 for about 15 minutes on 2/23/25, and that was the only activity provided for R42 that day. At 11:10 AM V17 Activity Aide stated R42 loves to listen to music and enjoys coffee. V17 stated V17 sat and talked with R42 for about 10-15 minutes on 2/24/25 at approximately 9:00 AM. V17 stated that was the only activity provided for R42 on 2/24/25. V17 stated R42 sits near the nurses station since staff have to keep a close eye on R42 will fall. Both V11 and V17 confirmed the weather was appropriate and neither offered to take R42 outside.</p> <p>On 2/25/25 at 1:07 PM V2 Director of Nursing stated R42 fell outside on the patio in June 2024 and the intervention was to lock the patio so that R42 could not go outside unattended. V2 stated activity staff used to provide one to one activities with R42, but they no longer do that.</p> <p>(continued on next page)</p>		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Activities Program dated 11/7/19 documents the purpose of this policy is to provide an ongoing activity program that is appealing to residents' interests and to enhance the residents' highest practicable level of physical, mental, and psychosocial well-being. This policy documents to identify and involve each resident in activities of interest, including activities that promote educational and intellectual thought, are useful/purposeful, relate to previous work, and are physically active. This policy documents the activity program will include four to seven organized activities daily and a combination of large and small groups, one to ones, and self-directed activities based on resident's interests, and adjust as needed in order to meet the needs of the residents.		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to assess, monitor, implement careplan interventions, obtain treatment orders and failed to prevent cross contamination during wound care for one (R63) resident's facility acquired Left Heel Pressure Ulcer. This failure resulted in R63's Left Heel Pressure Ulcer deteriorating leading to surgical debridement and infection requiring two antibiotic therapies.</p> <p>Findings include:</p> <p>R63's undated Face Sheet documents R63 admitted to the facility on [DATE] with medical diagnoses as Metabolic Encephalopathy, Severe Protein Calorie Malnutrition, Lack of Coordination and Cognitive Communication Deficit.</p> <p>R63's Minimum Data Set (MDS) dated [DATE] documents R63 as severely cognitively intact. This same MDS documents R63 requires maximum assistance for toileting, dressing, personal hygiene and bed mobility.</p> <p>R63's Careplan initiated 10/30/24 does not document R63's Left Heel Stage 4 Pressure Ulcer, Left Heel wound infection and antibiotic therapies prescribed for R63's Left Heel Stage 4 Pressure Ulcer. R63's careplan intervention dated 11/1/24 instructs staff to complete weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.</p> <p>R63's Physician Order Sheet dated February 2025 documents a physician order starting 2/14/25 with no end date to Cleanse Left Heel with normal saline pat dry, apply Gentamicin Sulfate Ointment 0.1 % to wound bed, and then Calcium Alginate cover with non-adherent pad, and absorbent pad and then wrap foot with gauze, change daily and (PRN) as needed. This same POS documents a physician order starting 2/6/25 and ending 3/6/25 to administer Doxycycline Hydrochloride 100 milligrams (mg) twice daily for 28 days for Osteomyelitis. This same POS documents physician orders to apply pressure relieving boots and float heels starting 12/12/24.</p> <p>R63's Pressure Ulcer Risk assessment dated [DATE] documents R63 as not at risk for obtaining pressure ulcers. The facility was unable to provide Pressure Ulcer Risk Assessments for R63 from 10/28/24-12/3/24.</p> <p>R63's Medical Record does not show any assessment of R63's Left Heel Pressure Ulcer 11/1/24-12/12/24.</p> <p>R63's Skin Condition Report dated 10/31/24 documents R63 has no abnormal skin conditions.</p> <p>R63's Skin Observation Report dated 11/1/24 documents R63's bilateral heels as areas of concern.</p> <p>R63's Skin Condition Report dated 11/13/24 documents R63's Left Heel was pressure wound black, Right Heel non blanchable redness. Float heels when in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R63's Medical Record documents the first review by a Registered Dietician was 1/26/25.</p> <p>R63's Laboratory Results Report dated 2/11/25 documents R63's Left Heel wound culture was obtained on 2/6/25 with results of moderate growth of Methylicillin Susceptible Staphaureus (MSSA).</p> <p>R63's Wound Evaluation and Management Summary dated 2/12/25 documents R63's Left Lateral Heel Stage 4 Pressure Ulcer measured at 2.2 cm (centimeters) long by 1.8 cm wide by 0.4 cm deep. This same report documents V21 Wound Physician surgically debrided R63's Left Heel Pressure Ulcer to a Stage 4. This same report documents a wound culture was obtained from R63's Left Lateral Heel Stage 4 Pressure Ulcer.</p> <p>R63's Wound Evaluation and Management Summary dated 2/19/25 documents R63's Left Lateral Heel Stage 4 Pressure Ulcer's wound culture showed Methicillin Susceptible Staph Aureus (MSSA). This same report documents R63 is currently on Doxycycline antibiotic and will be started on Gentamycin Sulfate ointment.</p> <p>On 2/24/25 at 9:30 AM V4 Licensed Practical Nurse (LPN)/Wound Nurse completed the dressing changes for R63's Left Heel. V4 LPN/Wound Nurse placed R63's dressing supplies directly on R63's bedside table that had multiple areas of dried spilled liquids and unknown food debris. V4 LPN then used those same supplies to apply to R63's Left Heel. V4 LPN placed her scissors on R63's contaminated bedside table and then used the contaminated scissors to cut a piece of Calcium Alginate to apply to R63's open Stage 4 Left Heel Pressure Ulcer.</p> <p>On 2/25/25 at 2:00 PM V4 Licensed Practical Nurse (LPN)/Wound Nurse stated R63 admitted to the facility on [DATE] with no pressure ulcers. V4 stated R63 is very compliant with whatever the staff asks her to do. V4 LPN stated cross contaminating R63's Left Heel Stage 4 Pressure Ulcer could cause an infection or cause R63's current wound infection to become worse.</p> <p>On 2/26/25 at 1:00 PM V22 Nurse Practitioner (NP) stated the facility should have included R63's Pressure Ulcer in her careplan, assessed R63's Left Heel weekly and documented all necessary information. V22 NP stated V21 Wound Physician was asked to assess R63's Left Heel Pressure Ulcer after it had opened. V22 NP stated V21 Wound Physician doesn't normally look at closed wounds. V22 NP stated R63's Left Heel was soft prior to it opening.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/26/25 at 2:00 PM V2 Director of Nurses (DON) stated R63 admitted to the facility with no pressure ulcers. V2 Director of Nurses (DON) stated she reviewed R63's 11/1/24 shower sheet. V2 DON stated she assessed R63's heels on 11/1/24 and noted that they were 'soft and mushy'. V2 DON stated she should have implemented careplan interventions at that point but did not. V2 DON stated R63 was first noted to have 'boggy' heels on 11/13/24. V2 DON stated V10 Registered Nurse (RN) had noticed on 11/13/24 that R63's heels both had pressure ulcers but did not obtain any physician orders or update R63's careplan. V2 DON stated V21 Wound Physician first saw R63 on 12/12/24 and ordered the moon boots and to float her heels. V2 DON stated the staff should have been floating R63's heels prior to that. V2 DON stated the staff should have been completing weekly assessments of R63's Left Heel Pressure Ulcer from the first time it was noted. V2 DON stated the facility has provided all of the information available but there are Pressure Ulcer Risk Assessments and Skin Evaluations missing and R63's careplan should have been updated. V2 DON stated We (facility) should have caught (R63's) risk for obtaining pressure ulcers earlier. It's really all my fault from the beginning because I didn't do anything from her 11/1/24 shower sheet when we (staff) first noticed (R63) had problems with her heels. We will be inservicing all the nursing staff about pressure ulcers.</p> <p>The facility policy titled Pressure Injury and Skin Condition Assessment revised 1/17/18 documents a skin condition assessment and pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending Physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. Conduct hand washing in accordance with facility standard/universal precautions. Pressure ulcers and other ulcers will be measured at least weekly and recorded in centimeters in the resident's clinical record. A wound assessment for each identified open area will be completed and will include site location, size, stage of pressure ulcer, odor, drainage, description and date/initials of the individual performing the assessment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to provide supervision to prevent falls and thoroughly investigate falls for one (R42) of one resident reviewed for falls in the sample list of 41.</p> <p>Findings include:</p> <p>R42's Minimum Data Set (MDS) dated [DATE] documents R42 has severe cognitive impairment, requires substantial/maximal staff assistance for toileting and supervision/touch assistance for transfers and walking, and R42 had had two ore more falls without injuries since the last assessment. R42's MDS dated [DATE] documents R42 uses a walker for mobility, is dependent on staff for toileting and supervision/touch staff assistance for eating, transfers and walking, and R42 had two or more falls without injury and two or more falls with minor injury since the last assessment.</p> <p>R42's Nursing Notes document the following: On 6/9/24 at 10:00 AM R42 had an unwitnessed fall outside in the gated patio and R42 was transferred to the emergency room for evaluation. On 6/10/2024 the interdisciplinary team (IDT) reviewed R42's fall. R42 had been sitting outside in the patio area just a few minutes prior to coming through the patio door with two small abrasions to R42's chin and ear. Steristrips were applied. The root cause of the fall was Huntington's Disease, Unsteady Gait, Supervision. The post fall intervention was for R42 to have supervision when ambulating to the patio and [NAME]-walker will be discussed with R42's family. On 1/14/25 at 7:15 PM R42 had an unwitnessed fall when R42 was found next to R42's bed after leaving the dining room without assistance. On 2/15/25 at 10:40 PM R42 had an unwitnessed fall in R42's room.</p> <p>R42's Fall Report dated 6/9/24 does not document when R42 was last toileted prior to the fall. R42's Fall Report dated 1/14/25 documents R42 was last observed eating in the dining room just prior to the fall. There is no documentation as to when R42 was last toileted prior to the fall. This report documents R42's disease process continues to play a major role in R42's balance and ambulation and staff have started introducing the possibility of R42 using a wheelchair.</p> <p>R42's Fall Report dated 2/15/25 documents R42 had a shower, staff assisted R42 to bed and R42 attempted to self transfer. This report documents the IDT discussed this fall, R42 is becoming more unsteady due to Huntington's Disease and R42 will be encourage to use a wheelchair as R42's balance continues to decline. This investigation does not document when R42 was last toileted and checked on prior to the fall.</p> <p>On 2/25/25 at 10:57 AM V10 Registered Nurse stated R42 had an unwitnessed fall in June 2024 while outside on the patio. V10 stated there was no staff outside with R42 when the fall occurred and R42 was bleeding from R42's chin and was sent to the hospital. V10 stated R42 has declined within the last two months, R42 needs supervision and to be near the nurse's station.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/25/25 at 2:50 PM V23 Licensed Practical Nurse stated R42 is unbalanced when R42 walks and V23 likes to check on R42 when V23 comes on duty at 6:00 pm. R42 is often still eating in the dining room at that time. V23 stated R42 doesn't like the wheelchair and tries to use the wheeled walker. R42 has rigid movements and tries to be independent. V23 stated V23 brings R42 to the East wing to be closely monitored and was unsure if there was any staff present in the dining room when R42 left the dining room and fell while self transferring in R42's room. V23 confirmed R42's fall was unwitnessed. V23 stated one to one supervision would help prevent R42 from falling, but V23 is unsure if the facility is able to accommodate that. V23 stated R42 does not tell staff when R42 needs to be toileted/changed and staff have to check/change R42 every two hours.</p> <p>On 2/25/25 at 9:13 AM V2 Director of Nursing stated V2 completes the fall investigations. V2 confirmed V2 had no additional documentation to provide for R42's fall investigations for falls on 6/9/24, 1/14/25 and 2/15/25. V2 stated the nurses are suppose to complete a fall packet, but one was not completed for these falls. V2 stated V2 has to track staff down to get statements and sometimes it is hard because the facility uses agency staff. V2 confirmed the fall packets included forms that request information on when the last time the resident was checked on, what they were doing at that time, and the last time toileted prior to the fall. V2 stated R42 fell on [DATE] while out on the patio and no staff was present with R42 at that time. V2 stated R42's falls on 1/14/25 and 2/15/24 were also unwitnessed and the root cause was R42 fell while trying to self transfer.</p> <p>The facility's Falls Folder documents to complete all documents in the folder for each fall and give to the Director of Nursing at the end of the shift. This folder includes a form with questions including if the resident fell near a bed, toilet or chair; how the resident was positioned when found; a description of the surrounding area and floor; who was in the area when the resident fell ; and if any assistive devices were used. This folder includes a form titled CNA (Certified Nursing Assistant) Post Fall Report that asks for when the last time the resident was checked on and toileted prior to the fall and the residents activity when he or she was last checked on.</p> <p>The facility's Fall Prevention Program dated 11/21/17 documents safety interventions will be implemented for each resident at risk for falls and the fall incident report will be reviewed by the IDT to ensure appropriate care and services were provided and to determine possible safety interventions. This policy documents residents will be checked approximately every two hours or as care planned to assure they are in a safe position.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care and urinary catheter care, failed to have physician's orders for catheters and catheter care, and failed to provide appropriate catheter care for three (R66, R28, R63) of four residents reviewed for urinary care in the sample list of 41.</p> <p>Findings include:</p> <p>The facility's Urinary Catheter Care policy dated 2/14/19 documents hand hygiene should be performed prior to handling urinary catheters, position the catheter below the level of the bladder to prevent back flow of urine into the bladder or tubing, and to use a bag or similar device to prevent the catheter bag from touching the floor and other surfaces. This policy documents to record catheter insertion in the nursing notes and treatment record.</p> <p>The facility's Incontinence Care policy dated 4/20/21 documents use a clean part of a soapy cloth when wiping genitalia and move in downward strokes between the labia for female residents. This policy documents to change gloves and perform hand hygiene after providing incontinence care and to avoid touching clean surfaces while wearing soiled gloves.</p> <p>1. On 2/23/25 at 8:58 AM, R66 was in bed, the bed was positioned low to the floor, and R66's urinary catheter was uncovered and lying on the floor mat next to the bed. R66 stated R66 had a urinary tract infection approximately three weeks ago.</p> <p>On 2/23/25 at 1:04 PM, V15 and V16 Certified Nursing Assistants (CNAs) dressed R66 and transferred R66 with a full mechanical lift into a geriatric chair. R66's catheter bag was connected to the strap of the mechanical lift sling, approximately a foot above R66's bladder, during the transfer. At 1:21 PM V15 pushed R66 in the geriatric chair down the hallway with R66's catheter bag trailing behind directly on the floor, confirmed with V16. On 2/23/25 at 1:21 PM V16 confirmed R66's urinary catheter bag was attached to the mechanical lift sling, positioned above R66's bladder during R66's transfer. V16 stated that is where staff are suppose to hang the urinary catheter bag during mechanical lift transfers. V16 confirmed R66's urinary catheter bag was not in a protective bag/privacy bag. V16 stated V16 has not received any training on whether catheter bags should be covered. V16 stated urinary catheter bags should not be touching the floor.</p> <p>On 2/24/25 at 2:48 PM, V14 CNA provided R66's incontinence and urinary catheter care and was assisted by V13 CNA. R66 was incontinent of large soft bowel movement. V14 cleansed R66's buttocks and did not remove R66's contaminated gloves prior to applying a clean brief. V14 applied a new pair of gloves and cleansed R66's catheter. V14 did not perform hand hygiene between changing gloves, prior to R66's catheter care. R66's bed was lowered to the floor and R66's urinary catheter was touching the floor. On 2/24/25 at 3:00 PM V14 stated V14 thought it was acceptable to move from soiled to clean when providing incontinence cares and that there was no need to perform hand hygiene between glove changes.</p> <p>R66's Discharge Instructions dated 1/7/25 document to follow up with urology within four weeks.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R66's Progress Note dated 1/9/25, recorded by V22 Nurse Practitioner, documents R66's urinary catheter was inserted on 12/12/24 and will need to be changed every 30 days next due on 1/11/25. R66's medical record does not contain active physician's orders for R66's urinary catheter size or changes, documentation that R66 has seen a urologist, or documentation that R66's urinary catheter has been changed since admitting to the facility.</p> <p>R66's Urine Culture dated 2/6/25 documents R66's urine contained Escherichia coli (bacteria found in bowel movement) and Enterococcus faecalis (bacteria), both greater 100,000 colony forming units per milliliter, indicating infection.</p> <p>On 2/25/25 at 1:03 PM, V3 Licensed Practical Nurse/LPN, stated R66's catheter is not changed at the facility due to difficulty with insertion at the hospital prior to admission. V3 stated there should be active physician's orders for catheters including size.</p> <p>On 2/25/25 at 1:07 PM, V2 Director of Nursing confirmed V14 should have changed gloves prior to applying a clean brief. V2 stated V14 should have either washed V14's hands or used an alcohol based hand sanitizer prior to applying gloves and providing R66's urinary catheter care. V2 confirmed R66 does not have an active order for catheter size and changes. On 2/26/25 at 10:24 AM V2 stated R66's hospital discharge orders included to schedule a urology follow up appointment, but V2 was unable to find information that an appointment was ever made. V2 stated V2 had to obtain R66's urinary catheter size from R66's hospital records.</p> <p>20892</p> <p>2. The Electronic Medical Record under the section Medical Diagnoses documents the primary diagnosis for R28 is Non-Surgical Orthopedic/Musculoskeletal with the date of 1/9/2020 and Urinary Tract Infection (UTI) with the date of 1/2/2025.</p> <p>On 2/24/25 at 10:59 AM, V5, CNA, performed incontinence care for R28. V5 used no-rinse peri wash and sprayed R28's peri area directly on the skin and then took the dry washcloth and proceeded to clean between the vaginal folds. When V5 saw there was BM (bowel movement) on the cloth she proceed to change the area on the cloth and went between the vaginal folds again. V5 moved the bedside table with the same gloves she was wearing after cleaning R28. V5 went to the bathroom, washed her hands, donned on another pair of gloves and asked R28 to turn to her left side and face the wall so V5 could continue with care. V4 LPN (Licensed Practical Nurse) was in the room assisting V5 with R28's incontinence care. V5 continued with cleaning R28 until there was no visible BM on the cloth. V5 then turned R28 back onto her back and cleaned the perineal area again and still there was visible BM on the wash cloth after washing between the labia.</p> <p>On 2/24/25 at 11:13Am, V4 LPN, stated I don't remember (R28) having an UTI maybe she had it while at the hospital.</p> <p>On 2/24/25 at 11:36 AM, R28 stated I don't remember because I took lots of medication while I was at the hospital.</p> <p>41970</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Goldwater Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Walnut Bloomington, IL 61701	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. R63's undated Face Sheet documents medical diagnoses as Metabolic Encephalopathy, Severe Protein Calorie Malnutrition, Lack of Coordination and Cognitive Communication Deficit.</p> <p>R63's Minimum Data Set (MDS) dated [DATE] documents R63 as severely cognitively intact. This same MDS documents R63 requires maximum assistance for toileting, dressing, personal hygiene and bed mobility.</p> <p>On 2/24/25 at 9:55 AM V4, LPN, completed incontinence care for R63. V4 LPN applied no rinse wash to a dry washcloth. R63 was incontinent of urine and feces. V4 used the dry washcloth to wipe over R63's perianal area several times using the same parts of the washcloth. V4 LPN did not dry R63's skin after providing incontinence care.</p> <p>On 2/25/25 at 2:50 PM V4 Licensed Practical Nurse (LPN) stated the water in the resident rooms takes a long time to warm up. V4 stated R63 might have decided to refuse incontinence care if she had to wait for the water to warm up, so V4 used a dry washcloth with no rinse wash. V4 stated she did not think she needed to dry R63's skin after washing due to she used a no rinse wash. V4 stated she should have warmed up the water first so that R63 would not have to wait for warm water. V4 stated she should have used another dry washcloth to pat dry R63's skin. V4 LPN stated she should have used a clean area of the washcloth to cleanse R63's perianal area. V4 LPN stated cross contamination could cause an infection.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to assess pain for one (R66) of two residents reviewed for pain in the sample list of 41.</p> <p>Findings include:</p> <p>The facility's Pain assessment dated [DATE] documents a pain assessment tool will be utilized to determine a resident's pain level and pain will be assessed upon admission, as indicated by diagnoses, and when as needed (PRN) pain medications are administered. Pain assessments will be documented in the nursing notes or on the Medication Administration Record (MAR).</p> <p>On 2/23/25 at 8:46 AM R66 stated R66 takes muscle relaxers that don't really help R66's pain. R66 stated R66 has quadriplegia and muscle spasms throughout R66's body. R66 stated R66 rates R66's pain on a 0 to 10 scale as a 10 even after medications are administered, but R66 stated R66 does not want to be drowsy for therapy. At this time R66's legs spasmed and R66's legs drew up toward R66's waist.</p> <p>On 2/23/25 at 1:04 PM V15 and V16 Certified Nursing Assistants dressed R66 and used a full mechanical lift to transfer R66 from the bed into a geriatric chair. R66's arms and legs spasmed while V15 and V16 assisted R66 with dressing.</p> <p>On 2/23/25 at 1:21 PM V16 stated R66 yells out to alert staff if R66's is in pain, which is usually about twice per day. V16 stated the nurse administers pain medications which seems to help R66's pain.</p> <p>R66's Minimum Data Set, dated dated [DATE] documents R66 as cognitively intact and R66 had frequent pain within the last five days that affects sleeping and participating in activities of daily living. R66 rated R66's pain as a 10 on a 0-10 scale.</p> <p>R66's Physician Order dated 1/9/25 documents to assess pain six times daily.</p> <p>R66's February 2025 MAR documents R66 receives Baclofen 25 milligrams (mg) by mouth daily at bedtime, Baclofen 10 mg by mouth twice daily, Baclofen 10 mg by mouth daily PRN, Acetaminophen 650 mg by mouth every four hours as needed for pain rated 1-3, Gabapentin 100 mg by mouth three times daily, and Tizanidine Hydrochloride 2 mg by mouth daily at bedtime. Acetaminophen was administered 10 times and PRN Baclofen was administered five times. There are no documented pain assessments before and after PRN Baclofen administration. This MAR does not document R66's order for pain assessment monitoring six times per day was implemented until 2/24/25.</p> <p>R66's nursing notes document R66's complaints of pain, but does not record R66's pain rating.</p> <p>On 2/25/25 at 1:07 PM, V2 Director of Nursing stated pain assessments should be documented on the MAR and completed every shift as well as before and after PRN pain medication administration.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40385</p> <p>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for four (R66, R28, R33, R49) of four residents reviewed for infection control in the sample list of 41.</p> <p>Findings include:</p> <p>The facility's Enhanced Barrier Precautions policy dated 5/7/24 documents EBP is an intervention designed to reduce the transmission of multidrug-resistant organisms by using gowns and gloves during high contact resident care activities for residents with indwelling medical devices or chronic wounds.</p> <p>The Centers for Disease Control and Prevention Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated June 2021 documents Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE (Personal Protective Equipment) required and defining high risk resident care activities. Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room).</p> <p>1. On 2/23/25 at 8:58 AM there was an EBP sign posted on R66's room door that indicated to wear gown and gloves for high contact resident care activities that included toileting, dressing, and transfers. There was no PPE cart containing gowns near R66's room.</p> <p>On 2/23/25 at 12:50 PM V16 Certified Nursing Assistant (CNA) entered R66's room and emptied R66's catheter. V16 was not wearing a gown while handling R66's urinary catheter bag. On 2/23/25 at 1:04 PM V16 and V15 CNAs dressed R66, handled R66's urinary catheter bag, and transferred R66 from the bed into a geriatric chair with a full mechanical lift. V15 and V16 were not wearing gowns during R66's care.</p> <p>On 2/23/25 at 1:21 PM V16 was asked about EBP and V16 stated V16 was unsure what that was.</p> <p>On 2/24/25 at 2:48 PM V13 and V14 CNAs provided R66's incontinence care and urinary catheter cleaning/care. V13 and V14 were not wearing gowns during R66's care. V13 confirmed EBP signage posted on R66's room door and that neither V13 or V14 wore gowns during R66's observed care. V13 stated a gown is suppose to be worn for the cares listed on the sign. V13 stated V13 did not know if the sign was posted for R66 or R66's room mate and was unsure the reason why EBP was needed. V13 stated it is confusing to know if the resident is on contact precautions or EBP.</p> <p>On 2/24/25 at 3:29 PM V14 CNA stated V14 has to ask the nurses about who is on transmission based precautions (TBP), because sometimes signs aren't posted. When asked about EBP, V14 stated that is used for influenza, COVID-19, and we wear gown, gloves and mask. When asked about EBP, stated that is used for influenza, COVID, and we wear mask, gown, gloves. Asked about difference between EBP and TBP and V14 was unsure. V14 stated the facility has not provided any training on EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R66's Physician Order dated 1/10/25 documents EBP due to urinary catheter.</p> <p>20892</p> <p>2. February 23, 2025 at 9:00 AM while doing the facility tour R28, R33 and R49 rooms door's had signage for Enhance Barrier Precaution (EBP) and there was no equipment carts outside the rooms for the staff to have access to gowns, gloves or masks to don before entering the rooms.</p> <p>R28's Electronic Medical Record (EMR) section titled Diagnosis documents R28 on 1/2/25 has the diagnosis of Urinary Tract Infection (UTI) and this is the reason for her EBP status.</p> <p>R33 EMR documents R33 receives hospice services and has incontinence of both bowel and bladder and has had skin breakdown, reason for his EBP status</p> <p>R49 EMR documents R49 has the need for enhanced barrier precautions related to presence of chronic wounds, nonpressure.</p> <p>V4, Infection Control Preventionist stated on 2/24/25 at 11:13 AM, The reason we did not have the equipment carts outside the rooms is because the residents would run right into the cart. The staff knows the gowns, gloves and masks are available to them in the Utility room on each unit.</p>