STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE BLOOMINGTON	700 EAST WALNUT , BLOOMINGTON, Illinois, 61701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2566510/2562754 2566530/2564550	S0000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1010h) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

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S9999	Continued from page 1 ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: 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	S9999		

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S9999	Continued from page 2 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	S9999		

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S9999	Continued from page 3 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. (B) 2 of 2 300.610a) 300.1010h) 300.1210b) 300.1210d)1) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and	S9999		

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S9999	Continued from page 4 Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by A. 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. B. 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. Findings include: R1's undated Care Plan documents diagnoses including cerebral infarction, cerebral aneurysm,	S9999		

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S9999	Continued from page 5 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. 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 1/22/24; 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 Fall Care Plan dated 3/2024 documents R1 has a history of falls and contains an intervention dated 3/15/22 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 11/16/21, 1/12/22, 4/22/22, 4/25/22, 7/14/23, 1/15/24, 3/14/24, and 7/11/25 On 7/16/25 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 and appeared to be actively dying. R1 was breathing with mouth open, and breaths were irregular and labored. On 7/23/25 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 7/16/25) 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 7/16/25 documents on 7/11/25 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	S9999		

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S9999	Continued from page 6 comfortable with morphine and to not send R1 to the hospital at that time The Incident Statement dated 7/11/25 documents, V13 CNA stated she was in another resident room when she could hear R1 screaming. R1's Progress Note dated 7/13/25 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 7/13/25 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 7/22/25 V30, R1's family member stated she came to see R1 on Monday 7/14/25. V30 stated she was notified of fall on 7/11/25 sometime 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 7/12/25 and 7/13/25. V30 stated both times she was told that R1 was "just a little sore and bruised". V30 stated she entered R1's room on 7/14/25 and observed R1 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 7/14/25 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 7/14/25 document R1 was sent to the local emergency department per family request. R1's Hospital Records dated 7/16/25 document R1 reported significant pain to the right hip area upon arrival on 7/14/25 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 7/14/25 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	S9999		

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S9999	Continued from page 7 disorder and complications associated with surgery and that R1 was placed in a knee immobilizer and returned to the facility. R1's Nurse Practitioner Visit Note dated 7/15/25 documents R1 fell out of bed (7/11/25) Friday night when trying to reach something at the request of his roommate. R1 had significant pain throughout the weekend. X-ray's obtained yesterday (7/14/25) confirmed R1 had an acute comminuted distal femur fracture of the right femur just above the prosthetic. R1 considered high risk for surgery and would have required transfer to different hospital. Family opted for conservative treatment. Added scheduled morphine due to R1's pain level in addition to current as needed ordered morphine. Family wishes to continue to focus on comfort. R1's progress note dated 7/16/25 at 10:50 AM documents R1 expired at facility. R1's death certificate dated 7/18/25 documents Immune Thrombocytopenic Purpura with contributing factors of ischemic heart disease and fracture of femur related to fall listed as cause of death. Manner of death listed as accident. On 7/23/25 at 1:51 PM, V34, Deputy Coroner, stated R1's cause of death was listed as Immune Thrombolytic Purpura (ITP) which is a low platelet count, this contributed to R1 being unable to have surgery to set his fracture. V34 stated this was an extensive traumatic fracture and that it contributed to R1's death with manner of death as an accident. V34 stated the significant pain R1 suffered caused stress to his heart and was also a significant factor attributing to his death. On 7/22/25 at 12:33 PM, V15 Certified Nurse Assistant (CNA) stated that she was working the night that R1 fell but was not R1's assigned to care for R1. V15, CNA stated she was in a resident's room when the fall occurred. V15, CNA stated when she entered R1's room after his fall, R1 was screaming out in pain stating his right knee hurt requesting staff to rub it. V15, CNA stated V13, CNA and herself were performing care for R1 after his fall and R1 was verbalizing and exhibiting signs of excruciating pain evidenced by facial grimacing and crying out in pain. V15 stated that 2 days later, 7/13/25, between 8 pm and 10 pm,	S9999		

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S9999	Continued from page 8 herself and un-named agency CNA were providing incontinence care for R1, and she felt something move in R1's knee. V15 stated she heard a pop sound, and R1 continued to be in significant pain at this time which she reported both pain and shifting pop in right leg to V8, RN after care completion. On 7/16/25 at 2:20 PM, V8 stated R1 was on his back on the floor, no mat, when she was called into the room by R1's cries. V8 stated R1 stated a CNA was just in the room prior to the fall. V8 stated R1 asked staff to "stretch" his leg out after transferring R1 to bed and that is when R1 screamed out in pain several times. On 7/22/25 at 10:30 AM, V12 Nurse Practitioner (NP), stated she was not aware of R1's fall on Friday, July 11th but was notified the following Tuesday, July 15th. V12 stated she found out about the entire event on the morning of 7/15 during the scheduled IDT (Interdisciplinary Team) meeting. V12 stated prior to R1's fall he was stable with minimal intermittent confusion, "a pleasant man who she enjoyed caring for." V12 stated that had R1 not fallen he would have lived longer. V12 stated she has never observed fall mats in R1's room. V12 stated she was disappointed in how the staff managed the resident's care over the weekend after his fall. V12 stated they didn't do much for him. V12 stated that she met with R1's wife and son on Tuesday, July 15th to discuss the plan and at that point V12 recommended scheduled morphine as well as PRN and a Foley catheter. On 7/22/25 at 2:09 PM, V2 Director of Nursing (DON), confirmed that R1's Care Plan included an intervention to have fall mats on the floor next to the bed and at the time of the fall he did not have the mats. V2 stated the mat should have been in place to reduce the risk of R1's injury due to his history of rolling out of bed. R1's Hospice Care Plan dated 10/11/24 documents R1 will be pain free or pain will be at tolerable level. R1's Medication Administration Record (MAR) dated July 2025 documents the following orders for Morphine Sulfate (Concentrate) Solution 20 milligrams(mg) per milliliter (ml) with a start date of 1/8/2024. -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	S9999		

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S9999	Continued from page 9 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 1/16/2023. V14, Hospice Registered Nurse (HRN), documented in R1's Hospice Progress Note dated 7/11/25 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, 7/12/25. V14, HRN, documented in R1's Hospice Progress Note dated 7/11/25 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 7/11/25, 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 7/12/25, 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 July 2025 documented on 7/12/25 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	S9999		

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S9999	Continued from page 10 on 7/15/25. R1's Progress Note dated 7/13/25, 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 7/13/25 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 Progress Notes dated 7/14/25 at 9:54 PM documented R1 in extreme pain after return from hospital. R1's Progress Notes dated 7/15/25 at 8:30 AM documented R1 complains of severe pain in right leg with "little positioning." On 7/16/25 at 11:40 AM, V2 DON stated that V8 did have access to the emergency medication box (E-box) to pull morphine, and that she had already educated V8 on E-box procedure for R1. V2 stated V8 should have pulled order morphine the night of the fall to provide R1 pain relief. The facility fall policy dated 11/21/17 document's the purpose is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions, and to provide necessary supervision, that assistive devices are utilized as necessary. Facility policy titled Pain Management Program dated 7/6/18 documents the purpose to effectively manage pain to remove effects of unrelieved pain. (A)	S9999		