Illinois State Department of Health

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 08/17/2025

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 Facility Reported Incident of 8/4/25-2589182	S0000		08/18/2025
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to assist one (R1) resident while eating causing R1 to spill hot coffee on her left hip	S9999		08/18/2025

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

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S9999	Continued from page 1 and left thigh out of three residents reviewed for Accidents in a sample list of three residents. R1 obtained four separate blisters which required treatment from a Wound Physician. Findings include: R1's Electronic Medical Record (EMR) documents medical diagnoses as Hemiplegia and Hemiparesis following Cerebrovascular Disease affecting Right dominant side, Disorders of the Brain, Morbid Severe Obesity due to excess calories, Epilepsy, Traumatic Brain Injury, Colostomy, Chronic pain due to trauma and Legal Blindness. R1's care plan intervention dated 5/2/25 documents R1 is usually provided with one assist by staff to eat. R1's Visual Bedside Kardex Report dated 8/16/25 documents R1 is usually provided with one assist by staff to eat. This same Kardex documents R1's call light should be within reach. R1's Physician Order Set (POS) dated August 2025 documents a physician order starting 4/22/25 to provide a regular consistency diet with thin liquids. R1's Minimum Data Set (MDS) dated 7/26/25 documents R1 as moderately cognitively impaired. This same MDS documents R1 requires moderate assistance with eating and is dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. This same MDS defines moderate assistance as Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. R1's Nurse Progress Note dated 8/4/25 at 8:00 AM documents R1 called out and stated she spilled her coffee in bed. R1's Skin Condition Report dated 8/4/25 documents R1 called out after spilling coffee on her Left Lateral Hip and Thigh while in bed eating breakfast at 8:00 AM. This same report documents the hot coffee spill caused a large red, blanchable area measuring 15.0 centimeters (cm) long by 10.0 cm wide with no depth. This same report documents at 1:00 PM R1's Left Hip and Left lateral thigh were re-assessed and found to have four separate intact blisters measuring blister 1 as 4.0 cm long by 2.0 cm wide, blister 2 as 3.0 cm long by 1.0 cm wide, blister 3 as 3.0 cm long by 1.0 cm wide, and blister 4 as 3.5 cm long by 1.0 cm wide. This same report documents R1 complained of moderate pain to area	S9999		

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S9999	Continued from page 2 and pain medication order was increased. R1's Wound Initial Evaluation and Management Summary dated 8/7/25 documents R1's Left Lateral Hip wound was from a hot liquid burn that resulted in a ruptured blister. This same report documents R1's Left Lateral Hip burn wound measures 1.0 centimeters (cm) wide by 2.0 cm long by 0.2 cm deep with moderate serous drainage, 100% thick adherent devitalized necrotic tissue with an estimated time to heal as one to two months. R1's Final Report to the State Agency dated 8/10/25 documents R1 stated she was laying in bed, drinking coffee in her personal tumbler and her cup slipped from her hand spilling coffee on her outer left hip/thigh. This same report documents R1 initially was assessed to have a blanchable red area to her Left outer Hip/Thigh which was left open to air. This report documents upon reassessment, R1 had four blisters that had formed on her outer Left Hip/Thigh requiring a medicated treatment with Silvadene cream. This same report documents V12 Wound Physician assessed R1 on 8/7/25 and changed R1's treatment order. This same report documents R1 is moderately cognitively impaired. R1's Wound Evaluation and Management Summary dated 8/14/25 documents R1's Left Lateral Hip burn wound measures 1.0 cm long by 3.5 cm wide by 0.1 cm deep with moderate serous drainage and 100% thick adherent devitalized necrotic tissue. On 8/16/25 at 8:55 AM V6 Licensed Practical Nurse (LPN) and V8 Certified Nurse Aide (CNA) completed a skin check for R1. R1's Left Hip showed three separate open areas. R1's upper Left Hip showed a dime sized open area with a pink wound bed and dark pink periwound, middle Left Hip was the largest of the three open areas, showed an irregular shaped open wound a few inches wide with attached yellow slough, dark red periwound and moderate yellow drainage and R1's medial Left Hip area showed a triangle shaped open area with a pink wound base and pink periwound. R1's dressing did not cover the medial nor the top open areas. On 8/16/25 at 9:10 AM V8 Certified Nurse Aide (CNA) set up R1's breakfast tray. The top of R1's meal ticket was highlighted in green. V8 CNA stated she did not know what the green highlighting meant. V9 CNA entered R1's room and stated she was not sure what the green highlighting meant but thought it may mean R1 was independent in eating. On 8/16/25 at 9:20 AM R1 was laying in her bed with	S9999		

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S9999	Continued from page 3 head of bed up 60 degrees eating her breakfast. R1's call light was connected to the far side rail and laying under the fitted sheet. R1 stated she could not reach her call light and did not know where it was. There were no staff in R1's room. R1 stated "This is just like the time when I couldn't get them (staff) to answer my call light when I spilled my coffee." On 8/16/25 at 9:25 AM V10 Certified Nurse Aide (CNA) entered R1's room. V10 CNA moved R1's bed away from the wall to be able to reach her call light. V10 CNA then stated R1 wouldn't be able to reach her call light due to it was under her fitted sheet and out of R1's reach. On 8/16/25 at 12:30 PM R1 was laying in her bed with the head of the bed up 60 degrees eating her lunch. R1's pink tumbler cup was on R1's bedside table within her reach. There were no staff present in R1's room. On 8/16/25 at 8:35 AM V6 Licensed Practical Nurse (LPN) stated R1 likes to have coffee in the morning. V6 LPN stated R1 likes to drink her coffee from her own personal tumbler. V6 LPN stated she was R1's nurse on 8/4/25 and heard R1 yelling out from her room. V6 LPN stated when she arrived, R1 had spilled hot coffee 'all over' her Left Hip and Left Lateral Thigh area causing the 'entire' area to be red. V6 LPN stated she removed the wet clothing, cleaned up the coffee and applied a cold washcloth to R1's Left Hip and lateral thigh area. V6 LPN stated later on that afternoon, R1 had developed several blisters from the hot coffee burn. On 8/16/25 at 9:00 AM R1 stated she likes to drink her coffee from her own cup (pointing to a tall pink tumbler with a slide lid and side handle). R1 stated someone set up her breakfast tray that morning (8/4/25) and then left R1 by herself to eat her breakfast. R1 stated she was trying to reach for her cup and couldn't reach it due to the handle was on the far side from her. R1 stated she activated her call light, but no one answered so she tried again to reach for her coffee and ended up spilling it 'all over' her. R1 stated it hurt a little bit when it first happened and hurt ‘a whole lot’ later in the day. R1 stated it hurts when V12 Wound Physician ‘cuts on it’. R1 stated “He (V15) slices and dices on my hip and boy does it hurt!”. On 8/16/25 at 9:15 AM V9 Certified Nurse Aide (CNA) stated R1’s Kardex and care plan documents R1 is usually one assist with eating. On 8/16/25 at 11:30 AM V3 Minimum Data Set (MDS) nurse stated R1’s MDS section for eating, R1’s care plan Activity of Daily Living (ADL) section for eating and	S9999		

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S9999	Continued from page 4 R1's Kardex do not match. On 8/16/25 at 12:10 PM V4 Assistant Director of Nurses (ADON)/Wound Nurse stated R1 spilled hot coffee on herself the morning of 8/4/25. V4 stated the staff alerted V4 and she went to R1's room to assess R1. V4 Wound Nurse stated R1 had a large, reddened area on her outer Left Hip and Thigh which later blistered. V4 Wound Nurse stated R1 did not have any prior wounds that were being treated by the facility. On 8/16/25 at 1:50 PM V13 Certified Nurse Aide (CNA) stated staff have to get R1 set up just like R1 wants or R1 won't be able to manage eating by herself. On 8/16/25 at 2:45 PM V15 Certified Nurse Aide (CNA) stated V14 CNA served R1 her breakfast tray on 8/4/25. V15 CNA stated R1 ended up spilling her hot coffee on her Left Hip. V15 CNA stated he heard R1's call light sounding but not sure how long. V15 CNA stated the staff are all very busy at that time of morning trying to get everyone ready for breakfast. V15 CNA stated R1 needs set up assistance with her meals but 'the staff never stay in the room' with R1. On 8/16/25 at 3:00 PM V1 Administrator stated R1's Minimum Data Set (MDS) assessment does not match R1's care plan and R1's Kardex. V1 Administrator confirmed R1's Electronic Medical Record (EMR) does not include any documented refusals from R1 of staff being present for meals to assist R1 if necessary. V1 Administrator stated the facility does not have a policy on serving hot liquids to cognitively impaired residents. On 8/16/25 at 3:40 PM V2 Director of Nurses (DON) stated staff should follow the MDS and care plan. V2 DON confirmed R1's MDS, care plan and Kardex do not match which could be confusing for staff. V2 DON stated R1 should have been assisted with setting up her tray so that she could manage the drinks which would have prevented her from being burned. V2 DON stated the staff were in-serviced due to R1 being burned and will also in-service the staff on documenting refusals of care. (B)	S9999		