Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER PONTIAC NURSING HOME	1225 SOUTH EWING DRIVE , PONTIAC, Illinois, 61764

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S0000	Initial Comments Annual Certification Survey Facility Reported Incident of 7/1/25/IL6005573 - F602, F609	S0000		08/21/2025
S9999	Final Observations Statement of Licensure Violations :300.610a) 300.1210b)1)2) 300.1220b)3) 300.1630d) 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. 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 needs of the resident. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered	S9999		08/21/2025

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

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S9999	Continued from page 1 as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. These regulations were not met as evidence by: Based on observation, interview, and record review the facility failed to develop and implement monitoring and interventions for diuretic use and treatment of edema for one of one resident (R34) reviewed for hospitalizations in the sample list of 35. This failure resulted in R34 developing critically low hypokalemia (low potassium) that required hospital treatment. The facility also failed to follow their bowel management protocol and failed to have physician's orders for heat therapy for two of three residents (R2, R6) reviewed for pain in the sample list of 38. Findings Include: 1.) On 8/18/25 at 9:58 AM, R34 was in R34's room in a wheelchair with her legs dependent and not elevated. R34 did not remember R34's hospitalization on 7/21/25. R34's lower legs and ankles were swollen. On 8/19/25 at 9:15 AM R34 was in a stationary chair in R34's room . R34's legs were not elevated, R34 was not wearing compression stockings, and R34's legs were swollen. R34 stated R34 recently started taking a diuretic that has not helped much with R34's edema. R34 stated staff don't elevate R34's legs as often as they should and R34 does not wear compression stockings. On 8/19/2025 at 3:56 PM R34 was sitting in her recliner, with feet dependent and was not wearing compression stockings. R34 was wearing short ankle socks and R34's	S9999		

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S9999	Continued from page 2 calves, ankles, and feet were swollen. V27 Certified Nursing Assistant (CNA) stated R34's legs were elevated earlier, but then R34 went to an activity with V34. V27 stated R34 does not wear compression stockings. R34's Minimum Data Set (MDS) dated 7/10/25 documents R34 is cognitively intact and R34 requires partial/moderate assistance from staff with lower body dressing. R34's active Care Plan documents R34 admitted to the facility 6/12/25, has a diagnosis of Chronic Kidney Disease Stage Three, and receives chemotherapy and radiation treatment for cancer. This care plan and includes a problem area dated 8/3/25 for diuretic use related to edema and interventions include monitoring laboratory results as ordered and monitoring for effectiveness and side effects. There is no documentation that a care plan regarding diuretic use and edema was developed prior to 8/3/25. R34's Hospital Discharge Summary dated 6/4/25-6/12/25 documents R34's Potassium level was 4.6 on 6/12/25, within normal limits. R34's Nursing Note dated 6/27/25 at 10:37 AM documents V26 Physician ordered hydrochlorothiazide (potassium depleting diuretic) 25 milligrams (mg) daily. R34's Progress Notes dated 6/28/25 and 7/5/25, recorded by V26, are not comprehensive and do not document a review of laboratory results or medications, these areas are left blank on the prepopulated form. R34's Nursing Note dated 7/10/25 at 4:25 PM documents "Note Text: The system has identified a black box warning for the following order: Lasix Oral Tablet 20 MG (Furosemide) Give 2 tablet by mouth two times a day for BLE (bilateral lower extremity) Edema Black Box Warning: Warning: Furosemide is a potent diuretic that, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule must be adjusted to the individual patient's needs." R34's active Physician's Orders documents an order dated 7/10/25 for Comprehensive Metabolic Panel (CMP) and an order dated 7/9/25 to apply compression stockings to BLE daily. R34's July 2025 Medication Administration Record (MAR) documents R34 received Hydrochlorothiazide 25 mg by mouth daily as of 6/28/25, and Lasix 40 mg twice daily 7/11/25-7/21/25, ordered by V9 Nurse Practitioner. This record documents R34 was given Zofran (nausea medication) on 7/16/25 and 7/17/25. There is no documentation that R34 was prescribed potassium medication after starting on two potassium depleting diuretics. There is no documentation in R34's medical record that R34's compression stockings are applied daily or that R34's laboratory values are routinely monitored to evaluate electrolytes and kidney function related to diuretic use. R34's Nursing Note dated 7/21/2025 at 4:36 PM documents R34 was taken to the	S9999		

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S9999	Continued from page 3 hospital by ambulance while R34 was out for an appointment at the cancer center. R34's Family, V25, reported that R34's labs were critical and R34 had persistent vomiting. R34's Hospital Admission and Physical dated 7/21/25 documents R34 presented to the emergency room from cancer clinic for hypokalemia, with Potassium level 1.9. Attempts to replace the potassium was met with a slow response and required continued replacement through the night. R34's Oncology Note dated 7/22/25 documents R34 was admitted to the hospital with severe hypokalemia likely secondary to diuretic use and poor oral intake, as well as acute kidney injury on chronic kidney disease, which has improved with intravenous fluids. R34's Oncology Progress Note dated 7/25/25, and signed by V8 Nurse Practitioner, documents R34's Family, V25 called with concerns that R34's hospital orders, facility orders, and oncology orders do not all match. This note documents V25 thought R34's Lasix and Potassium were stopped, but hospital discharge orders say to continue Lasix but no Potassium is ordered. This note documents Potassium was 5.1 while at the hospital, with the recommendation to continue oral Potassium and hold Lasix pending follow up laboratory results followed by primary care physician at the nursing home. This note also includes to elevate lower extremities and consider trying compression stockings. R34's Progress Note dated 8/2/25, recorded by V26, does not document a comprehensive review or R34's diagnoses, laboratory results, and medications; and does not mention R34's recent hospitalization for hypokalemia. R34's active Physician Orders document R34 receives Lasix 10 mg twice daily as of 8/11/25, Hydrochlorothiazide 25 mg daily as of 6/28/25, and Potassium Chloride Extended Release 20 Milliequivalents once daily as of 8/8/25. There are no active orders to routinely monitor CMP, other than the order dated 7/10/25, which does not specify a frequency. There is no documentation in R34's medical record that a CMP was drawn after R34 returned from the hospital on 7/24/25. On 8/19/2025 at 11:31 AM, V6 Licensed Practical Nurse (LPN) stated R34 was out for appointments the day she was hospitalized. R34 had been nauseated for a few weeks once radiation was started, and was given Zofran and Compazine. V6 stated R34's potassium was found to be low at the hospital, R34 returned with decreased Lasix dosage and supplemental Potassium. V6 stated V6 was not the nurse who entered R34's initial diuretic orders, but has never really correlated Potassium with Lasix. On 8/19/2025 at 3:59 PM, V6 LPN stated R34 does not wear compression stockings. V6 confirmed R34 has an order to wear compression stockings daily. V6 stated the order was entered as an "other" order and therefor it did not populate to document on the Treatment Administration	S9999		

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S9999	Continued from page 4 Record. On 8/19/2025 at 11:37 AM, V25 stated the facility started R34 on diuretics with no potassium and R34 was nauseated and not wanting to eat/drink the Friday (7/18/25) before R34's oncology appointment on 7/21/25. V25 stated labs were drawn while R34 was at the oncology appointment and was found to have Potassium level of 2.1 and poor kidney function, and R34 was sent to the hospital. On 8/19/2025 at 11:59 AM, V2 Director of Nursing (DON) stated R34 didn't have an order for Potassium after Hydrochlorothiazide and Lasix were initially started. V2 stated V26 ordered Hydrochlorothiazide and V9 ordered Lasix on 7/10/25. V2 confirmed R34 did not have a CMP or BMP (Basic Metabolic Panel) drawn between 6/25/25 and 7/21/25. V2 stated R34 had started chemotherapy and radiation, with nausea and vomiting that probably affected her Potassium level. V2 stated laboratory results are evaluated prior to ordering Potassium supplements. On 8/19/25 at 12:23 PM, V9 Nurse Practitioner stated R34 had bilateral lower extremity edema, with R34's diagnoses of Chronic Kidney Disease there should be monitoring of kidney function and electrolytes, including Potassium, which would be part of a CMP, when receiving diuretics' such as Lasix and Hydrochlorothiazide. V9 stated R34 was started on Potassium on 8/7/25. V9 stated the facility should have drawn the CMP the day after the order was entered. V9 stated V9 would review any Potassium levels that were done within a few weeks, if none documented then V9 would order this test prior to ordering Potassium. V9 stated if critically low potassium is left undetected/untreated, it can lead to heart attack, abnormal heart rate, respiratory failure, and even death; and symptoms include muscle spasms, fatigue, and weakness. V9 confirmed poor appetite and decreased fluid intake could also contribute to decreased potassium levels and confirmed R34's hospitalization could have been avoided if there was monitoring of R34's kidney function and electrolytes. On 8/19/25 at 12:55 PM, V7 Assistant DON stated R34 does not have any active orders for routine monitoring of CMP or BMP. V7 stated there is no documentation in R34's medical record that a CMP or BMP has been drawn while at the facility. On 8/19/25 at 3:50 PM, V1 Administrator stated R34's labs are drawn at the oncology appointments and V26 has access to view the results. V1 stated V1 is obtaining	S9999		

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S9999	Continued from page 5 copies of R34's laboratory results. V1 provided a copy of R34's CMP dated 8/14/25, that documents R34's Potassium level was 3.1, normal range 3.5-5.1, and these results were sent via electronic facsimile from the oncology office to the facility on 8/19/25 at 4:26 PM. On 8/20/2025 at 10:37 AM, V2 DON confirmed there is no documentation in R34's medical record that compression stockings are applied. V2 stated the CNAs are responsible for applying compression stockings, but the task did not prompt for documentation in R34's medical record, so V2 fixed that today. V2 confirmed R34's care plan did not address edema or diuretic use prior to 8/3/25 and confirmed V26's progress notes are incomplete and not comprehensive. The facility's Physician Notification of Laboratory/Radiology/Diagnostic Results policy dated 3/14/18 documents it is the nurse's responsibility to ensure the laboratory is notified of the physician's orders for testing and monitoring the receipt of test results, and test results should be reporting to the provider who ordered them. 2.) R6's MDS dated 5/19/25 documents R6 has severe cognitive impairment. R6's active Care Plan documents R6 is at risk for consitipation and includes interventions to record bowel movements daily, follow facility's bowel protocol, monitor/document/report side effects of medications and symptoms of constipation, and inform the physician. R6's August 2025 MAR documents R6 receives Fentanyl (opioid) 12 microgram per hour patch applied once every three days since 9/1/24 and R34 received Senna S (stool softener) 8.6-50 mg one tablet by mouth daily 3/29/25-8/10/25, when it was changed to once daily PRN (as needed). R6's July and August 2025 MARs document R6 received 41 doses of Norco (opioid) 5-325 mg one tablet between 7/20/25 and 8/19/25, and did not receive any of the following ordered medications: Senna S PRN, Bisacodyl 10 mg rectal suppository once daily PRN, and (saline) enema 7-19 gram/118 milliliter daily PRN. R6's Bowel Tracking dated 7/19/25-8/20/25 documents R6's last recorded bowel movement (BM) was on 8/17/25 and R6 did not have bowel movements 7/26-7/29/25, 8/6-8/8/25, and 8/14-8/25/25. R6's July and August 2025 Nursing Notes do not document assessment or monitoring of R6's constipation or that any treatment was offered.	S9999		

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S9999	Continued from page 6 On 8/20/2025 at 11:37 AM R6 stated R6 is constipated today, and has not had a BM yet today. On 8/20/2025 between 11:25 AM and 11:46 AM the following staff were interviewed. V15 and V16 CNAs stated R6's biggest complaint is constipation, which happens often and the nurses give R6 medications, which sometimes helps. V15 stated R6 complained of constipation today. V18 Registered Nurse (RN) stated today is the first day R6 has voiced complaints of constipation. V18 stated bowel movements are documented by the CNAs, and the nurses keep a list of residents who haven't had BMs for a couple days to offer bowel medications. V19 LPN stated V19 administered Senna S this morning to R6 and R6 voiced relief. At this time V16 CNA stated R6 had not yet had a BM. On 8/20/2025 at 12:03 PM, V2 DON stated the facility has a bowel regimen to follow, and V2 would have to refer to the policy to see when medications should be given. V2 stated residents should have PRN bowel medications ordered and bowel tracking is documented as part of the CNAs tasks. On 8/20/25 at 12:55 PM, V7 ADON reviewed the facility's bowel protocol. V7 stated the nurses should document assessment and monitoring of constipation and offered interventions in the nursing notes. V7 confirmed there is no documentation of assessment/monitoring/interventions of R6's constipation in R6's nursing notes, other than R6 refused Senna S on 8/5/25 due to loose stools. The facility's Bowel Elimination Protocol dated 5/31/19 documents the CNAs record resident BMs; if no BM for 48 hours observe/assess for signs/symptoms of constipation, review record, and may offer nonpharmacological interventions such as prune juice, natural laxative, or increased fluids; if no BM for 72 hours consider pharmacological interventions or increased nonpharmacological interventions, if no BM after additional interventions then notify the physician. 3.) On 8/18/2025 at 1:55 PM, R2 was sitting in the dining area of the 300 unit. R2 stated R2 has pain to his left shoulder due to cancer and medications don't really help, but the facility keeps it under control. R2 asked V30 CNA to heat up his "bean bag". R2 handed V30 a home-made cloth bag that was filled with beans, that did not include a label or instructions for use. R2 stated R2 uses the heated bean bag for his shoulder. V30 heated the bean bag in the microwave located in the dining area. At 1:57 PM V30 stated V30 heats R2's bean	S9999		

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S9999	Continued from page 7 bag in the microwave for two minutes and R2 applies the heated bean bag himself. On 8/20/25 at 11:05 AM, V18 RN administered R2's medications near the nurse' station. V18 told R2 that V18 had R2's hot pack, V18 removed R2's bean bag from the microwave and gave it to R2 to apply to his left shoulder. R2's active physician's orders as of 8/20/25 do not include an order for the application of a heat pack. R2's Care Plan dated 5/6/25 documents R2 admitted to the facility on 5/3/24, has chronic pain and swelling related to pain syndrome and cancer, and interventions include providing nonpharmacological interventions such as a heat or cold pack. On 8/20/2025 at 11:11 AM, V18 stated R2 takes pain medications and also gets hot packs as needed, which V18 heats in the microwave for two minutes. V18 confirmed there are no physician's orders for the use of the heated bean bag. On 8/20/2025 at 12:03 PM, V2 DON stated V2 was aware that R2 uses a heat pack. V2 was unsure if there should be a physician's order for this treatment and was unsure if this is something the CNAs should be applying or only the nurses. V2 stated V2 will have to see if the facility has a policy on the use of heat packs. On 8/20/25 at 2:50 PM, V1 stated the facility does not have a policy regarding the use of heat packs. (B)	S9999		