STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004261	A. BUILDING: _____ B. WING _____	02/26/2025

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

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)5) 300.1220b)2)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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin

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breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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. The plan shall be reviewed at least every three months.

These requirements were not met as evidence by:

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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.

Findings include:

R63's undated Face Sheet documents R63 admitted to the facility on 10/23/24 with medical diagnoses as Metabolic Encephalopathy, Severe Protein Calorie Malnutrition, Lack of Coordination and Cognitive Communication Deficit.

R63's Minimum Data Set (MDS) dated 1/28/25 documents R63 as severely cognitively intact. This same MDS documents R63 requires maximum assistance for toileting, dressing, personal hygiene and bed mobility.

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.

R63's Physician Order Sheet dated February 2025 documents a physician order starting 2/14/25 with no end date to Cleanse Left Heel

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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.

R63's Pressure Ulcer Risk Assessment dated 10/23/24 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.

R63's Medical Record does not show any assessment of R63's Left Heel Pressure Ulcer 11/1/24-12/12/24.

R63's Skin Condition Report dated 10/31/24 documents R63 has no abnormal skin conditions.

R63's Skin Observation Report dated 11/1/24 documents R63's bilateral heels as areas of concern.

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."

R63's Medical Record documents the first review by a Registered Dietician was 1/26/25.

R63's Laboratory Results Report dated 2/11/25 documents R63's Left Heel wound culture was

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S9999	Continued From page 5 obtained on 2/6/25 with results of moderate growth of Methylicillin Susceptible Staphaureus (MSSA). 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. 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. 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. On 2/25/25 at 2:00 PM V4 Licensed Practical Nurse (LPN)/Wound Nurse stated R63 admitted to the facility on 10/23/24 with no pressure ulcers.	S9999		

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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.

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.

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

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S9999	Continued From page 7 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." 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 resdient's clinical record. A wound assessment for each identified open area will be competed and will include site location, size, stage of pressure ulcer, odor, drainage, description and date/initials of the individual performing the assessment. (A)	S9999		