STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

(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) COMPLETE DATE
S 000	Initial Comments First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 6 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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: 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 provide resident assistance in bed mobility resulting in a fall for one (R3) of one resident reviewed for falls in a sample of eight. Findings include: The facility's Fall Prevention Program, dated 11/21/17, documents "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures	S9999		

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S9999	Continued From page 1	S9999		

which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness...Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions...Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet."

On 7/30/24, at 10:02am, R3 was in a bariatric bed in his room. R3 stated the following: "The CNA (Certified Nursing Assistant/V14) said she was going to get me washed up and was in the bathroom getting hot water. I was trying to take my gown off. I have a 30 pound hernia which fell, then my leg fell off the bed, then the rest of me, and I weigh almost 500 pounds. I got knocked up pretty bad; hematoma on my left leg and I landed face down."

R3's Minimum Data Set/MDS Assessment, dated 5/13/24, documents "Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed"; R3 requires "Partial/Moderate assistance." Partial/moderate assistance is defined as "Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort."

R3's current Care Plan includes "I have an ADL (Activities of Daily Living) self-care performance deficit with a varying level of assistance needed" with interventions including but not limited to: "Roll left and right/Bed Mobility: The resident is

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	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

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S9999	Continued From page 2	S9999		

usually provided with partial moderate to substantial max assist by staff." These interventions also include: "Shower/bathe self: The resident is usually provided with Dependent assist by staff."

On 7/31/24, at 9:47am, V3 MDS Coordinator stated the following: The interventions for (R3's) self-care deficit means that it is (R3's) usual performance. It is his normal to need partial moderate to substantial max assist by staff to roll/move in bed.

R3's Fall Initial Occurrence Progress note, dated 6/3/24, documents "Un-witnessed fall, neurological checks initiated. Alert and oriented to time, person, place and situation. No changes in range of motion from normal baseline. New injury observed. Swollen and bruises noted on left calf."

R3's Fall investigation, dated 6/3/24, documents Nursing Description as "CNA (Certified Nursing Assistant) came up to desk asking for assistance, upon entering room observed pt (patient/R3) lying on the floor next to bed." This same form documents Resident Description as "(R3) stated 'I was trying to boost myself up in bed and I fell out.' Stated he did not hit his head. Fell out of bed onto knees. Fell to left side and was lying along side of bed."

On 7/30/24, at 3:10pm, V14 CNA stated the following: "I remember the fall. I went to go wash (R3) up for the day. (R3) was going to move himself over in the bed so he was moving to the left side of his bed. I asked (R3) to hang on a moment to empty his urinal. While I was in the bathroom (R3) started yelling. That is when I noticed he had fallen. When that happened the other CNA heard my yell for help and I asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

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S9999	Continued From page 3	S9999		

them to go get the nurse." V14 continued to state that (R3) moving himself depends on if it is a good day for him or not and if he wants to do it himself and be more independent even though we tell him we need to be there in case something was to happen. V14 stated "I probably should have brought another aid in there or waited to empty (R3's) urinal after washing him up and made sure he was centered in the bed." V14 stated that (R3) is not a two person assist for washing up but usually is for moving him in bed.

(B)

Licensure Violations 2 of 6

300.3250a)

Section 300.3250 Communication and Visitation

a) Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. (Section 2-108 of the Act)

These REQUIREMENTS are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a private area for resident telephone calls for one (R2) of one resident reviewed for Communication in a sample of eight.

Findings include:

The facility's Resident Rights policy, dated 8/23/17, documents "Purpose: To promote the exercise of rights for each resident, including any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 4	S9999		

who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: Use a telephone in privacy."

On 7/30/24, at 9:37am, R2 sat in a wheelchair in his room and stated "There is no way to make a private call. There is a phone at the nurses' station and in the dining room. Sometimes I would like to call my sister or family and not have people listening. There is a little bit of privacy in the dining room but still could be people sitting nearby."

R2's Minimum Data Set/MDS Assessment, dated 8/6/23, documents R2's preference for using a phone in private is "Somewhat important."

On 7/31/24, at 11:45am, the facility's main dining room has a telephone on a table with a chair in a corner partially partitioned off with a folding woven screen on one side. There are tables and chairs less than five feet away from the open entrance to this telephone area where residents have been seated at various times of this investigation for meals and activities. There is a table and chair directly on the back side of the woven screen.

On 7/31/24, at 9:32am, V11 Certified Nursing Assistant/CNA stated "When the residents want to make a private phone call we take them to the dining room behind the shield thing. There might still be people around. When they get phone calls that is where we take them."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

On 7/31/24, at 9:36am, V12 CNA stated "For a private phone call there is a spot in the dining room with a closable privacy screen or up at the Nurses' station but that's not really private. I don't consider the area in the dining room to be private. Everyone can hear they just can't see them. There could be residents sitting right next to them who are completely with it."

On 7/31/24, at 9:49am, V13 Licensed Practical Nurse/LPN stated "Residents can make a private phone call in the area of the dining room with the privacy screen in the back corner with a phone, table and chair. Sometimes there are people in the area. Many have their own phones. Or they can make a call here up at the desk." V13 confirmed there are no portable phones.

On 7/31/24, at 2:33pm, V2 Director of Nursing/DON confirmed that the area in the dining room with a screen divider is their area for private resident phone calls. V2 confirmed that the screen divider is not a sound barrier. V2 stated "I have had a couple of residents ask to make a phone call elsewhere rather than in there, so I let them use my office phone, leave and close the door." V2 confirmed that, unlike the area of the dining room, being behind a closed door allows for privacy.

(C)

Statement of Licensure Violations 3 of 6
300.1210a)
300.1210b)
300.1210c)
300.1210d)2

Section 300.1210 General Requirements for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6 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 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. 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain daily weights, change and label oxygen tubing, humidification	S9999		

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	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 7	S9999		

bottles and hand held nebulizer per their policy, and apply compression stockings per physician orders for four (R4, R5, R6, and R7) of seven residents reviewed for their daily plan of care in a sample of eight.

Findings include:

Facility "Licensed Practical Nurse/LPN and Registered Nurse/RN" job description, created 5/2/17, documents "Responsible for providing direct nursing care to the residents, and to supervise/direct the day to day nursing activities/functions performed by the nursing assistants."

Facility "Certified Nursing Assistant/CNA" job description, created 5/2/17, documents "The CNA is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare, and safety of all residents. Essential duties and responsibilities: Maintain resident stability by checking weights. Provide for resident comfort by utilizing resources and materials."

Facility "Weights" policy, dated 11/14/12, documents "Each resident shall be weighed in accordance with physician orders or plan of care."

Facility "Oxygen and Respiratory Equipment Changing/cleaning" policy, revised 1-7-19, documents "1. Hand Held Nebulizer (HHN) and Mask, if applicable. A. The hand held nebulizer should be changed weekly and PRN (as needed). B. A clean plastic bag with a zip loc or draw string, etc will be provided with each new set up, and will be marked with the date the set up was changed and 4. Oxygen Humidifiers. A. Oxygen humidifiers should be changed weekly or as

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	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

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GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

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S9999	Continued From page 8	S9999		

needed and will be dated when changed. Nasal Cannulas are to be changed once a week and as needed. It will be dated with the date the tubing was changed."

1. R4's "Census List" report documents R4 has not been out of the facility for over 24 hours since her admission on 3/2/24.

R4's Diagnoses include the following: "Hemiparesis (paralysis) right side, Edema, AFIB/Atrial Fibrillation, HTN/hypertension/high blood pressure, and CKD/Chronic Kidney Disease Stage 3."

a. R4's current physician orders for July 2024 documents "Daily weight (order in the MAR/Medication Administration Record) Notify MD/NP (Medical Doctor/Nurse Practitioner) if resident has a weight gain of three pounds in a day or five pounds in a week every day shift for CHF/Congestive Heart Failure Program related to edema (swelling)" with an order start date of 4/19/24.

R4's July 2024 MAR under the weight daily documents the following: 7/3, 7/4, 7/16, and 7/26/24 are blank; 7/5, 7/7, and 7/8/24 see progress notes; 7/9, 7/13-7/15, 7/17-7/19, 7/24, and 7/27-7/28/24 have N/A (not applicable) in the box.

R4's weight summary for July 2024 was also reviewed with no documentation of weights for the above dates.

R4's notes, dated 7/5/2024 at 4:19PM by V16 RN documents "Weight list given to CNA, no weights received."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

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S9999	Continued From page 9	S9999		

R4's notes, dated 7/7/2024 at 4:52PM by V13 LPN documents "unavailable."

R4's notes, dated 7/8/2024 at 2:56PM by V16 RN documents "Weight list given to CNA, no weights received."

On 7/31/24 at 1:50PM, V15 Registered Nurse verified she gives the daily weight list to the CNAs at the beginning of her shift and expects them to complete the weights. At that same time V15 verified R4's MAR was missing weights.

On 7/31/24 at 1:50PM, V11 CNA stated, "Daily weights are given to me by the nurse for me to complete." Shown the surveyor her daily weight list and verified R4 was on the daily weight list.

b. R4's current physician orders for July 2024 documents "(Name of Compression Stockings) BLE/bilateral lower extremities every day shift for edema (swelling)" with an order start date of 5/16/24.

R4's physician progress note, dated 7/18/24, documents "Two plus bilateral lower extremity swelling."

R4's cardiology follow up visit, dated 7/24/24, documents "Two plus bilateral lower extremity edema (swelling)."

On 7/31/24 at 1:50PM, R4 was in her room in bed, no compression hose on her legs, and her legs were swollen and shiny. At that same time, R4 stated, "Socks not on."

On 8/1/24 at 8:30AM, resident is in the dining room and no compression hose on just socks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

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S9999	Continued From page 10 On 7/31/24 at 1:50PM, V11 CNA stated "(R4) does not have her (compression) hose on today and her legs are really swollen. She usually wears her (compression) hose." 2. R5's "Census List" report documents R5 has not been out of the facility for over 24 hours since 5/22/24. R5's Diagnoses include the following: "Edema, Sleep related hypoventilation, Obstructive Sleep Apnea, Chronic Respiratory Failure, COPD/Chronic Obstructive Pulmonary Disease, and Pulmonary HTN/Hypertension." a. On 7/30/24 at 10:30AM, R5's oxygen in the room had no date on the tubing or the humidifier bottle. On 7/31/24 at 1:50PM, R5 was in her room in bed with oxygen on 4 liters via nasal cannula. R5 was alert and oriented, and stated she uses oxygen all the time. R5's current physician orders for July 2024 documents "O2 (oxygen) at 4LNC (liters nasal cannula) when up in chair and when in bed" with an order start date of 6/2/24. R5's medical record has no orders to change and date the oxygen tubing and humidifier bottle weekly, and nothing is documented on R5's MAR/Medication Administration Record, TAR/Treatment Administration Record, or nurses notes. On 7/31/24 at 1:50PM, V15 RN verified that the facility is to change and date oxygen tubing and humidifier bottles.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 11	S9999		

b. R5's current physician orders for July 2024 documents "Weigh Daily-notify provider of weight gain of three pounds in 24 hours and five in one week. Notify cardiovascular institute every day shift related to acute on chronic diastolic (congestive) heart failure; and generalized edema" with an order start date of 3/21/24.

R5's July 2024 MAR under the weight daily documents the following: 7/5/24 see progress notes; 7/9, 7/13-7/15, 7/18-7/19, and 7/24 have NA/not applicable in the box; 7/10, 7/16, and 7/26 are blank; and 7/27/24 has an X in the box on the MAR.

R5's weight summary for July 2024 was also reviewed with no documentation of weights for the above dates.

R5's notes, dated 7/5/2024 at 5:42PM by V16 RN documents "List given to CNA no weights done."

On 7/31/24 at 1:50PM, V15 RN verified she gives the daily weight list to the CNAs at the beginning of her shift and expects them to complete the weights. At that same time V15 verified R5's MAR was missing weights.

On 7/31/24 at 1:50PM, V11 CNA stated "Daily weights are given to me by the nurse for me to complete." At this time, V11 showed the surveyor her daily weight list and verified R5 was on the daily weight list.

3. On 7/30/24 at 10:00am, R6's Oxygen concentrator was bled into the Bi-pap (bilevel positive airway pressure) and the humidifier bottle on the oxygen concentrator was dated 7/2/24, and the tubing was not dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

(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) COMPLETE DATE
S9999	Continued From page 12 On 7/31/24 at 9:00am, R6 stated that the nursing staff change the oxygen tubing and humidifier bottle about every three months. R6's medical record has no orders to change oxygen tubing, or humidifier bottles weekly. 4. On 7/30/24 at 10:30am, R7's Nebulizer was in the top drawer of the bedside table with no date, and not in a bag. R7's medical record has no orders to change R7's hand held nebulizer's weekly. (B) Statement of Licensure Violations 4 of 6 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

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(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) COMPLETE DATE
S9999	Continued From page 13 This requirement is NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to change gloves and perform hand hygiene during wound care per facility policy for two (R7 and R2) of two residents reviewed for wound care in a sample of eight. Findings include: Facility Policy Hand Hygiene/Handwashing, revised 1-10-18, documents "Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing) is after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. If hands will be moving from a contaminated body site to a clean body site during patient care and after glove removal." Facility Policy for Glove Use-Nursing, revised 1-31-18, documents "5. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface and 7. Hand hygiene will be performed after removing gloves. When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting. Soap and water are recommended for cleaning visibly dirty hands." 1. R7's Physician orders, dated 7/22/24, documents "Right lower back cleanse with wound cleanser. Apply skin prep peri wound. Apply collagen sheet and fold in half and press to wound bed (do not moisten), then cover with bordered gauze two times a week and PRN/as needed every dayshift on Tuesday and Friday." On 7/31/24 at 9:45am, V15 (RN, Registered	S9999		

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	IL6006308	A. BUILDING: _____ B. WING _____	08/01/2024

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S9999	Continued From page 14	S9999		

Nurse) performed wound care to pressure wound on R7's back. V15 (RN) did not change gloves between removal of dirty dressing and cleaning of the wound.

On 8/1/24 at 9:45am, V17 stated that during wound care gloves should be removed between the removal of dirty dressing and replaced with new gloves prior to cleansing of the wound.

2. On 7/30/24, at 12:56pm, R2 was in his room. V8 Registered Nurse/RN washed her hands, donned gloves, then began wound care for R2's right toe wounds. V8 removed R2's soiled dressing from his right foot. Without performing hand hygiene, V8 changed gloves then cleansed the wounds. Without performing hand hygiene, V8 changed gloves then patted R2's wounds dry and applied the physician ordered medicine to each wound area. V8 then removed her gloves and washed.

On 7/30/24, at 1:08pm, V8 RN stated, "I only wash or use hand sanitizer between glove changes if going from dirty to clean." V8 confirmed at this time that V8 did not perform hand hygiene in between all glove changes.

On 7/31/24, at 2:30pm, V2 Director of Nursing/DON stated that staff should change gloves and perform hand hygiene in between glove changes during wound care.

(C)

Statement of Licensure Violations 5 of 6

300.1620a

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S9999	Continued From page 15 Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These REQUIREMENTS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer Lovenox per physician orders for one (R6) of seven residents reviewed for medications in a sample of eight. Findings include: Facility Job description for Registered Nurse and Licensed Practical Nurse, dated 5/2/17, documents: "Prepare and administer medications as ordered by the physician." R6's Progress notes, dated 7/24/24, from V18 (Nurse Practitioner) documents "Start Lovenox 260mg/milligrams twice a day on 7/28/24 (two of the 100mg syringes plus one of the 60mg syringes)." Facility pharmacy provider packing slip, dated 7/24/24 (facility nurse signed 7/25/24),	S9999		

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S9999	Continued From page 16	S9999		

documents that facility received 40 Enoxaparin 100mg/ml syringes, and six Enoxaparin 60mg/0.6ml syringes.

R6's Physician orders, dated 7/28/24, documents "Lovenox (Enoxaparin Sodium) 100mg/ml inject two syringes subcutaneous two times a day with Lovenox (Enoxaparin Sodium) 60mg/0.6ml 1 syringe two times a day."

R6's Electronic MAR has no documentation R6 received Lovenox on the night of 7/29/24.

On 7/31/24 at 9:00am, R6 stated that he did not receive his scheduled night dose of Lovenox on 7/29/24 because facility did not have his medication supply, and he is taking it for an upcoming surgical procedure on 8/1/24.

On 7/31/24 at 3:20pm, V17 (RN, Registered Nurse) stated she did not give R6 his scheduled dose of Lovenox because the only dose on hand was the 60mg/0.6ml syringes.

(B)

Statement of Licensure Violations 6 of 6

300.3210a)

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act).

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S9999	Continued From page 17 These REQUIREMENTS are not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a urinary catheter privacy bag for one resident (R8) of one resident reviewed for dignity in a sample of eight. Findings include: The facility's Resident Rights Policy dated 8/23/17 documents "Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement." The (State) Ombudsman Program Resident Rights, Dated 11/2018, documents, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life"; and, "Your facility must provide services to keep your physical and mental health, at their highest practical levels." R8's current Care Plan documents: "I have Suprapubic Catheter: obstructive Uropathy. Suprapubic catheter in place. Staff assist with toileting needs and hygiene." On 8/1/24 at 8:40am, R8 sat in his (reclining wheelchair) in the facility's dining/common area. R8's urinary catheter bag and tubing were attached to the underside of R8's reclining wheelchair; R8's catheter bag was approximately half filled with yellow urine, visible to the public and not contained in a privacy bag. On 8/1/24 at 8:40am, R8 stated, "Don't make me	S9999		

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S9999	Continued From page 18 feel good about it (catheter bag) being visible; but still I have rights too. Would like it to be covered so that no one else notices it." On 8/1/24 at 8:45am, V3 Minimum Data Set/MDS/Care Plan Coordinator stated, "I saw (R8's) catheter was uncovered in the dining room and brought him in here so I could put his catheter in a privacy bag; it should have been covered." On 8/1/24 at 8:45am, V15 Registered Nurse/RN stated that she was the nurse for R8. V15 RN stated, "I did not know that his catheter was not covered; it should have a privacy bag on it to cover. The night shift got him up; and the CNAs/Certified Nursing Assistants today missed it." (C)	S9999		