STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	620 Warrington Avenue Danville, IL 61832

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on record review and interview, the facility failed to provide a quarterly financial statement to two of three residents (R7 and R8) reviewed for resident funds on the sample list of 10. Findings include: 1.) R7's Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview of Mental Status (BIMS) score as 15 out of a possible 15, indicating R7 has no cognitive impairment. On 6/26/24 at 4:10 pm R7 stated she had not received a quarterly statement since the new company took over the facility ownership last year. R7's Medicaid/Medicaid Pending/Responsible Party form dated 11/20/2019 and signed by R7, documents R7 agreed to make the facility representative payee to manage R7's income. R7's Quarterly Statement For The Period Of 12/30/23- 3/29/24 was signed by R7 during this survey, dated 6/26/24. 2.) R8's MDS dated [DATE] documents R8's BIMS score as 15 out of a possible 15, indicating R8 has no cognitive impairment. On 6/26/24 at 1:44 pm R8 stated R8 has never received a financial statement of her funds from the facility. R8's form dated 12/19/23 and signed by R8, documents R8 agreed to make the facility representative payee to manage R8's income. R8's Quarterly Statement For The Period Of 12/30/23- 3/29/24 was signed by R8 during this survey dated 6/26/24. On 6/26/24 at 4:25 pm, V1, Administrator/Registered Nurse, V21, Regional Nurse Consultant, and V7, Regional Financial Coordinator confirmed the residents are to receive quarterly statements regarding their resident funds. V1 stated she will have to find confirmation that the quarterly statement were provided to R7 and R8. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 9:25 am, V1 Administrator stated she was unable to find documentation to confirmed R7 and R8 had received their quarterly financial statement therefore, R7 and R8 were provided the quarterly financial statement on 6/26/24 (documented above). The facility policy Resident Funds dated 10/01/22 documents The individual financial records must be available to the resident through quarterly statements and upon request.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on interview and record review the facility failed to notify a physician/provider of a significant bruise for one of five residents (R2) reviewed for falls/injury of unknown source in the sample list of 10. Findings include: R2's Physician Order Summary Report Sheet (POS) dated 5/29/24 documents R2 was admitted to the facility on this same date. R2's POS also documents the following diagnoses: Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing. Unspecified Dementia and a History of Falling. R2's (MDS) Minimum Data Set, dated dated dated [DATE] documents R2's (BIMS) Brief Interview of Mental Status score as seven out of a possible 15, indicating severe cognitive impairment. On 6/24/24 at 4:47 pm V22, R2's Family Member stated R2 had a bruise on R2's knee that was of unknown origin. On 6/27/24 at 12:15 pm V17, Registered Nurse/Wound Nurse provided R2's Wound Assessment Detail Report dated 6/17/24. R2's assessment documents R2 had a left knee bruise, dark purple in color, that measure 11 centimeters long, by 12 centimeters wide, and zero (superficial) in depth. R2's same assessment included pictures that document R2's dark purple bruise that encapsulated R2's left patella, extended above the patella to the distal aspect of R2's upper leg, and around the medial aspect of R2's left knee which incorporated partial bruising to the back of R2's distal upper leg. The report does not document that a physician was notified. V17 stated I did not notify the physician of (R2's) bruising, but I should have, since it was just identified. I did not find that anybody else had notified the physician either. On 6/27/24 at 4:40 pm V6, Medical Director/Physician stated R2's new bruise to the left knee was likely related to R2's recent left hip surgery. V6 confirmed that (V4 or V16) Nurse Practitioners should have been notified of the new bruise, so it could be assessed by a provider.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observations, interviews and record review, the facility failed to maintain a wheelchair free of sharp edges to prevent injury during a mechanical lift transfer and failed to implement fall interventions to prevent falls for three of five residents (R2, R9 and R10)reviewed for injury of unknown origin/falls on the sample list of 10. Findings include: 1.) R10's Diagnoses Sheet updated 5/27/24 documents the following: Dementia, Unspecified Severity Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, Peripheral Vascular Disease, Unspecified, Restless Leg Syndrome, Spinal Stenosis Lumbar Region Without Neurogenic Claudication, and Muscle Weakness. R10's Minimum Data Set (MDS) dated [DATE] documents R10 has severe cognitive impairment. R10's Health Status Note dated 6/18/2024 at 3:08 pm, documents the following: Note Text: IP (V17, Registered Nurse/Wound Nurse/ Infection Control Preventionist) was notified by CNA (unidentified Certified Nursing Assistant) of noticing a bruise to residents(R10) Rt (right) calf, upon examination noted linear purple bruise 11x3cm (centimeters) on posterior RLE (right lower extremity), also noted a dressing to LLE (left lower extremity) lateral leg, upon removal, noted triangular shaped skin tear 2x2cm, with skin flap loss. Area was cleansed and Xeroform gauze & silicone dressing placed, NP (unidentified Nurse Practitioner) and HCPOA (Healthcare Power of Attorney) notified, IP will cont (continue) to monitor until resolved. On 6/27/24 at 3:50 pm V17, Infection Control Preventionist/Wound/ Registered Nurse reviewed R10's injury/ progress note dated 6/18/24. V17 stated I heard in morning meeting R10 had bruise and skin tear that I needed to look at. (R10's) left lower leg skin tear and right lower leg bruise were not injury of unknown origin but occurred during a (name brand, full body mechanical lift) transfer. (R10) wheelchair had sharp edges on both footrest areas. That was the cause of her injuries. On 6/27/24 at 3:55 pm V17 walked down to R10's room. R10's wheelchair had compressed foam type padding to both footrest attachment sites. V17 removed the adhesive tape from the compressed foam type padding wrap and exposed the metal of the wheelchair, below the wheelchair seat. R10's bilateral wheelchair footrest had approximately one half inch of protruding metal with visible sharp edges. 2.) R2's Physician Order Summary Report Sheet (POS) dated 5/29/24 the day of R2's admission to the facility, documents the following diagnoses: Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing. Unspecified Dementia and a History of Falling. R2's Minimum Data Set, dated dated dated [DATE] documents R2's Brief Interview of Mental Status score as seven out of a possible 15, indicating severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Care Plan updated 6/6/24 documents the following: I (R2) have had an actual fall with no injury, and a history of falls prior to admission with significant injury with Poor Balance, Unsteady gait, Left Hip Fx (fracture) and Osteoarthritis of the knee (unidentified). I will resume usual activities without further incident through the review date. 06/05/2024: Ensure wheelchair is placed right next to bed in locked position as I will attempt to self-transfer. Continue to educate me on calling for staff assistance. Bed height to be placed where my feet are flat on the floor. Date Initiated: 06/06/2024. R2's Fall IDT (Interdisciplinary Note) dated 6/5/2024 at 1:49 pm, documents the following Summary of the fall: Resident was attempting to transfer without staff assist to wheelchair. Resident is alert and oriented with intermittent confusion (per MDS above has severe cognitive impairment) and appears to have more confusion toward the evening hours. Resident has some weakness and unsteady gait and should be assisted by staff. Wheelchair was a little distance from the bed which made it a more difficult task. Root cause of fall: Resident does not alert staff to needs and was attempting to self-transfer. Wheelchair could have been placed closer to bed. Intervention and care plan updated: Resident continues to want to remain independent with transfers and does not request staff assistance, ensure that wheelchair is in locked position and placed right next to her bed to provide a safer transfer. Continue to educate resident to request assistance. R2's same IDT note fails to document the elevated height of the bed. The Care Plan documented above included an intervention after R2's fall 6/4/24 that included R2's bed height to be placed where R2's feet are flat on the floor. On 6/27/24 at 9:30 am V13, Certified Nursing Assistant (CNA) stated V13 was taking care of R2 the day she fell [DATE]. (R2's) bed was not in the low position, as it should have been, but was not all the way up either. It was high enough that she could not touch the floor when she tried to transfer herself. Her wheelchair was some distance from the foot of the bed. Too far for her to get to it safely. I can't remember if (wheelchair) was locked. I came in at 3:00 pm and (R2) was in bed asleep. Day shift did not give me report. Day shift is bad about that. I had not been told when she went to the bathroom last. I would have taken her to the bathroom when I started my shift, had she been awake. I always took her to the bathroom before dinner. She (R2) frequently would try to get up on her own. Usually, to go to the bathroom. Her alarm would sound to alert us. I was in the room next to hers, because another resident (unidentified) with an alarm, sounded. He (unidentified resident) was trying to stand from his wheelchair. I was taking care of him. I went into (R2's) room right away after I made sure the other resident was safe. (R2's) alarm was sounding. She was on the floor and an RN (unidentified Registered Nurse) came in to assess (R2). She wasn't hurt. 3.) R9's Current Physician Order Summary Report Sheet documents the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transfer with STS (Mechanical Stand Lift) Lift and two assist; w/c (wheelchair) for mobility. R9's Diagnoses Sheet dated as revised 11/12/23 documents the following: Polyosteoeoarthritis, Unspecified, Chronic Fatigue Unspecified, Unspecified Symptoms and Signs Involving Cognitive Functions and Awareness, Doralagia, and Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung, and Other Epilepsy, Not Intractable, With Status Epilepticus. R9's Minimum Data Set, dated dated dated [DATE] documents R9's Brief Interview of Mental Status score as three out of 15, indicating severe cognitive impairment. R9's Care Plan updated 5/5/24 documents the following: Falls, I am at risk for falls r/t (related to) poor safety awareness, and weakness, pain, fatigue. Do not leave unattended in wheelchair while in room. Date Initiated: 05/05/2024 Ensure all my needs are met and items I use frequently are within reach to help reduce my need to get up unassisted. Date Initiated: 04/16/2021. I use both a BA (bed alarm) and CA (chair alarm) to remind me not to attempt to transfer myself. Date Initiated: 05/27/2022. R9's Fall-Initial Occurrence Note dated 5/4/2024 at 2:24 pm documents the following: Fall Description: Resident had an un-witnessed fall 05/04/2024, 1:00 PM Location of Fall: resident room. On the floor in front of wheelchair laying on left side. on 05/04/2024 1:00 PM Resident statement(if applicable): When asked what happened resident did not reply and unable to write statement. Assessment: Un-witnessed fall, neurological checks initiated. Alert and disoriented per usual baseline. No changes in range of motion from normal baseline. No s/s (signs or symptoms of) pain while this nurse checked ROM (range of motions). No injuries observed. Actions Taken: Assessed for pain and injury. Neuro checks initiated. Assisted from floor with mechanical lift. R9's Un-witnessed Fall report signed by V15, Licensed Practical Nurse (LPN), dated 5/4/24 does not documents R9's fall chair alarm was sounding. The same note documents R9 was incontinent. R9's Fall IDT (Interdisciplinary) Note dated 5/5/2024 at 11:44 pm documents the the followingSummary of the fall: Left resident in his bedroom after lunch and resident was attempting to self transfer from chair to bed. Root cause of fall: Wanting to go to the bed attempting to self-transfer from chair and fell . Intervention and care plan updated: Don't leave resident unattended in his bedroom in his chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 12:30 pm V15, LPN stated she was the nurse working when R9 fell on [DATE] around 1:00 pm. I (V15) was really upset. Staff all know (R9) is going to try to get up on his own. That is why we have to watch him close. Either at the nurse station to watch tv (television), or in bed with his alarm. (V20) CNA had brought (R9) back to (R9's) room and just left him (R9) next to his (R9's) bed. (V20, CNA) knew (R9) was supposed to be changed after his (R9's) lunch and put to bed. I found him (R9) on the floor, in front of his wheelchair. (R9) is supposed to have a chair alarm. It was not in his chair like it is supposed to be. (V20, CNA), knows that too. (R9) was incontinent of urine. (R9) can't really tell us what happen, but I asked him anyway. It was obvious he fell from his chair trying to get into bed. It was obvious his chair alarm was not in his chair. I did a full assessment and he was not hurt. I started neuros (neurological assessment) and we used the (name brand full-body mechanical lift) to get him in bed. On 6/27/24 at 1:35 pm V20, Certified Nursing Assistant confirmed he is aware and usually does put R9 to bed after meals, and makes sure R9 has his chair and bed alarm on. V20 also stated I (V20) have seen, a few times, where someone else got (R9) up and forget to put (R9's) alarm in his chair. V20 stated he does not remember R9's fall on 5/4/24 and therefor could not confirm if R9's alarm was or was not in his chair on 5/4/24. On 6/27/24 at 5:40 pm V1, Administrator/ Registered Nurse stated confirmed R9 should have had an alarm in his wheelchair and should have been assisted to bed after his meal on 5/4/24 to prevent the fall. Both are interventions. V1 also stated V1 became aware that R2's wheelchair was not within her reach, but V1 was not aware her bed was elevated to an unsafe level. Safety interventions to prevent further falls should consistently be implemented. The facility policy Fall Prevention Program dated as revised 11/21/2017 documents the following: Purpose: 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 to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.