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Form Approved OMB
No. 0938-0391

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	11/27/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to ensure nursing staff honored a resident's right for their choice of life-sustaining treatment preferences. This failure affected one of three residents (R1) reviewed for Advance Directives on the sample list of three. Findings Include: The Advance Directive Policy dated [DATE] documents the purpose of the policy is to ensure all residents or resident representatives are informed concenring the right to accept or refuse medical treatment and formulate an Advanced Directive. If a resident or health care representative indicates an Advanced Directive regarding Cardio Pulmonary Resucitation or Scope of Treatment (Practitioner Orders for Life-Sustaining Treatment POLST), the appropriate forms will be completed. Advanced Directive(s) shall be included in the resident's plan of care, and will be reviewed during the care plan meeting with the resident and/or the resident's legal representative when present. R1's Progress Note dated [DATE] documents R1 was diagnosed with Esophageal Cancer, Dysphagia, Choking in Adult, and History of Esophageal Stricture. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is severely cognitively impaired. R1's Care Plan dated [DATE] documents R1 had a Do Not Resuscitate (DNR) order in place. Staff are to follow advance directives on R1's chart, honor R1's choices, and notify the physician of changes in R1's condition. R1's Practitioner Order for Life Sustaining Treatment (POLST) form dated [DATE] documents R1 wished to have no Cardiopulmonary Resuscitation performed however did wish to have Selective Treatment including but not limited to non-invasive forms of positive airway pressure, intravenous fluids, antibiotics, vasopressors, or antiarrhythmics. R1 wished to be transferred to the hospital if indicated. R1's Progress Note dated [DATE] documents R1 was observed in the dining room during the noon meal, unable to cough up phlegm or verbalize words. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Note: Skilled Nursing Facility Acute Note dated [DATE] documents at 12:30 PM that day, R1 was found coughing and choking on secretions. V7 Family Caregiver was with R1 at the start of the incident. V18 Advanced Practice Registered Nurse went into R1's room to find staff attempting oral suction for R1. R1 was in his wheelchair and hypoxic with oxygen at 50%, heart rate at 120, respiratory rate at 40. R1 was pale and diaphoretic with grossly congested lungs. V18 APRN took over suctioning, switched to nasotracheal suctioning and retrieved copious amounts of dark tan secretions. R1 however did not improve. R1 was placed on oxygen support at 10 liters via non-rebreather mask. R1 expired later that same day. On [DATE] at 3:50 PM V4 Licensed Practical Nurse (LPN) stated V7 (R1's Caregiver) came up to her with R1 in the wheelchair and told her R1 had aspirated and was having trouble breathing. V7 took R1 back to his room. V4 stated she alerted other staff and got help with locating the suctioning machine. V4 stated she did not call Emergency Medical Services (EMS), did not notify V6 (R1's) Health Care Power of Attorney, or V18 Advcance Practice Registered Nurse. V4 confirmed the first time she spoke with V18 was when she came into R1's room and the first time she spoke with V6 was when she arrived at the facility. On [DATE] at 2:00 PM V22 Minimum Data Set Nurse confirmed on [DATE] he attempted to assist in providing emergency care to R1 when he was in respiratory distress. V22 stated even if R1 had a DNR order in place, staff could still call Emergency Medical Services to assist due to his emergent respiratory distress related to aspiration. On [DATE] at 2:16 PM V6 (R1's) Health Care Power of Attorney/Niece stated even through R1 had a DNR order in place she would have wanted the facility to call EMS when R1 began having trouble breathing. V6 stated she feels the facility was negligent. V6 stated she was only called concerning the situation by V7 (R1's Personal Care Taker) a little before 1:00 PM. V6 stated she could hear all the commotion in the background and V7 told R1 V6 was coming. V6 stated she got there about ten minutes later. V6 stated when she arrived in R1's room, R1 was still struggling to breath but he was no longer able to speak, he was not making eye contact, or acknowledging her presence. V6 stated she knew he was not going to make it at that point. V6 stated she made a comment in the past (when he seemed to be declining naturally) that if R1 was comfortable and calm, they did not need to send him to the hospital but V6 stated- that does not mean that if there was an emergency situation, and R1 was gasping for air and needed emergent care that they should not get him the help he needed. V6 stated R1 deserved better than this and the facility should have done better.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to provide timely emergency airway management and suctioning for a resident in respiratory distress during a medical emergency. This failure affected one of three residents (R1) reviewed for emergency airway management and has the potential to affect all 77 residents residing in the facility. This failure resulted in R1's subsequent death. The Immediate Jeopardy began on [DATE] when R1 aspirated and could not maintain adequate oxygenation. Staff could not locate the suctioning equipment, made multiple trips in and out of R1's room getting missing equipment, and could not get the suctioning equipment functioning therefore delaying emergency airway management and respiratory treatment for R1. V4 Licensed Practical Nurse (LPN) did not notify Emergency Medical Services or V18 Advanced Practice Registered Nurse regarding R1's medical emergency. V2 Human Resources Director was notified of the Immediate Jeopardy on [DATE] at 9:32 AM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings Include: R1's Progress Note dated [DATE] documents R1 was diagnosed with Esophageal Cancer, Dysphagia, Choking in Adult, and History of Esophageal Stricture. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is severely cognitively impaired, requires partial/moderate assistance with eating, holds food in his mouth, and coughs or chokes during meals. R1's Physician Order Sheet dated [DATE] documents R1 is prescribed a regular diet, pureed texture, and thin liquids. R1's Care Plan dated [DATE] documents R1 is at risk for aspiration due to difficulty eating and coughing noted with meals. Staff are to monitor for choking or coughing with meals or liquids. The same Care Plan documents on [DATE] R1 was placed on a Regular diet, Pureed texture, Thin Liquid consistency. Resident placed on a puree diet temporarily related to mucus, choking, and Barrettes Esophagus. The same Care Plan documents R1 had a Do Not Resuscitate (DNR) order in place. Staff are to follow advance directives on R1's chart, honor R1's choices, and notify the physician of changes in R1's condition. R1's Practitioner Order for Life Sustaining Treatment (POLST) form dated [DATE] documents R1 wished to have no Cardiopulmonary Resuscitation performed however did wish to have Selective Treatment including but not limited to non-invasive forms of positive airway pressure, intravenous fluids, antibiotics, vasopressors, or antiarrhythmics. R1 wished to be transferred to the hospital if indicated. R1's Progress Note dated [DATE] documents R1 was observed in the dining room during the noon meal, unable to cough up phlegm or verbalize words. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R1's Progress Note dated [DATE] documents R1 expired with family at the bedside in the facility. Time of death was 5:55 PM. R1's Progress Note: Skilled Nursing Facility Acute Note dated [DATE] documents at 12:30 PM that day, R1 was found coughing and choking on secretions. V7 Family Caregiver was with R1 at the start of the incident. V18 Advanced Practice Registered Nurse went into R1's room to find staff attempting oral suction for R1. R1 was in his wheelchair and hypoxic with oxygen at 50%, heart rate at 120, respiratory rate at 40. R1 was pale and diaphoretic with grossly congested lungs. V18 APRN took over suctioning, switched to nasotracheal suctioning and retrieved copious amounts of dark tan secretions. R1 however did not improve. R1 was placed on oxygen support at 10 liters via non-rebreather mask. R1's Death Certificate dated [DATE] documents R1's expired on [DATE]. R1's cause of death listed: Acute Hypoxic Respiratory Failure, Acute Aspiration of Stomach Content, Esophageal Dysphagia/History of Esophageal Cancer. At [DATE] at 8:09 AM V7 Family Caretaker stated she arrived at the facility around 11:50 AM on [DATE]. R1 was propelling himself down the hall in his wheelchair. V7 stated she came up to R1 and could audibly hear phlegm rattling in the back of his throat. V7 stated she took R1 to the dining room and he was served his lunch tray. V7 stated R1 took one bite of his mashed potatoes. V7 stated he was having trouble with all the extra phlegm in his throat and V7 then took him to V5 Licensed Practical Nurse (LPN) for some cough medicine. V5 gave R1 cough medicine and V7 took him back to the dining room. V7 stated R1 sat at the table for a few minutes not eating or drinking when she saw him start to struggle to breath. V7 stated she took off with R1 in his wheelchair to the nurses station and found V5 LPN. She told V5 R1 was choking on his phlegm and needed suctioning. V5 told V7 to take R1 back to his room. V7 stated R1 was struggling to breath, was visibly scared, was gasping for air, had audible gurgling sounds, and was anxiously flailing his arms around. V5 LPN could not find the suctioning equipment. V7 stated V5 asked other staff to assist and help find the suctioning equipment. V13 Certified Nurses Assistant (CNA) brought in the suctioning machine. V7 stated more staff came into R1's room and multiple staff were attempting to get the suctioning equipment put together and working. V7 stated after about 15 minutes R1 stopped moving around and went limp in his wheelchair however he was still gasping for air. V7 stated one staff member (V22 Registered Nurse) went in and out of the room multiple times to get items the suction machine was missing. V7 stated eventually V3 Registered Nurse was called from another unit to come and help get the suctioning machine working. V3 RN came and got the machine working and began to suction R1 orally however nothing much came out. A couple minutes later V18 Advanced Practice Registered Nurse (APRN) came into the room and assessed R1 and requested a different suctioning catheter. Staff ran out of the room again to retrieve what she had requested. V18 APRN was then able to suction R1 and got quite a lot of phlegm out however R1 did not seem to improve at all. V7 stated R1 was left in his wheelchair the entire time and was only placed in his bed after V18 had suctioned him. V7 stated forty minutes passed between the time she realized R1 had aspirated in the dining room until V18 Advanced Practice Registered Nurse began to suction R1. V7 stated R1's status never improved and he passed away later that same evening. V7 stated R1 was very scared of choking and it was horrible to witness someone so scared of choking end up aspirating and then no one was able to provide him the help he needed for such an extended period of time. V7 stated she had asked V24 Director of Nurses at the time if anyone had called for an ambulance and V24 stated R1 was not supposed to be transferred to the hospital. V7 stated that was not true. (continued on next page)

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F 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

On [DATE] at 3:50 PM V4 Licensed Practical Nurse (LPN) stated V7 (R1's Caregiver) came up to her with R1 in the wheelchair and told her R1 had aspirated and was having trouble breathing. V7 took R1 back to his room and V4 called for help. V4 stated she did not know where the suctioning machine was located and V13 Certified Nurses Assistant located the suctioning machine for her and brought it to R1's room. V22 and V23 MDS Nurses came into R1's room and attempted to help get the suctioning working. V24 (DON at the time) also came into the room. V22 had to run in and out multiple times to get supplies needed for the suctioning equipment. V4 stated even when they had all the equipment needed they could not get the machine to work. V4 stated she called V3 Registered Nurse from another unit to come and help. V3 came over and was able to get the suctioning working and suctioned R1 orally. V18 APRN came in the room and asked for a different suctioning catheter. V18 then began to suction R1 and asked for a non-rebreather mask and oxygen. V4 stated she went to retrieve the oxygen supplies. V4 stated during the entire incident R1 was was struggling to breath, he was diaphoretic, and anxious. V4 denied calling for emergency services or alerting V18 APRN.

On [DATE] at 2:35 PM V3 Registered Nurse stated on [DATE] she was working on another unit when she got a phone call from V4 LPN stated R1 is in respiratory distress and they needed help with the suction machine. V3 stated she ran to R1's room and the staff (V24 DON at the time, V22 and V23 MDS coordinators, and V4 LPN) were having issues with the tubing and how to place it onto the suction equipment correctly. V3 RN stated she hooked up the suctioning tubing correctly and it worked. V3 stated she did the initial oral suctioning but couldn't get much out, then V18 APRN came in and did a deep nasotracheal suctioning then asked for a non-rebreather mask and high flow oxygen and V3 left the room to get it. V3 RN stated staff should know how to use the suctioning equipment.

On [DATE] at 3:32 PM V23 Minimum Data Set Nurse confirmed on [DATE] she attempted to assist in providing emergency care to R1 when he was in respiratory distress. V23 stated R1 was in his wheelchair and was diaphoretic, had labored breathing, audible gurgling, and was in severe distress. R1 oxygen saturation was very low and he was not getting enough air in and out. I was attempting to assist in getting the suctioning equipment working but the kit was missing pieces and we could not get it to work. V22 MDS Nurse was making trips in and out of R1's room to get what we were missing and we still could not get it working. V3 RN was called over and she was able to finally get the suctioning working and she began to suction R1. V23 stated she was never trained on the suctioning unit that was being used and did not know how to use it. V23 stated V18 APRN came in the room and performed nasotracheal suctioning however R1 was not responding to her efforts and had no eye contact, was not verbal or talking and continued with labored breathing post suctioning and oxygen administration. V23 stated as far as she knows 911 was never called.

On [DATE] at 2:00 PM V22 Minimum Data Set Nurse confirmed on [DATE] he attempted to assist in providing emergency care to R1 when he was in respiratory distress. V22 stated entered R1's room and he could not breath- it appeared as though he had aspirated. R1 was gasping for air and trying to clear stuff from his throat but was unsuccessful. V22 stated the suctioning equipment was brought to the room however it was not complete and he had to run in and out of the room ,d+[DATE] times to retrieve the necessary pieces for the suctioning. V22 confirmed that they still could not get the machine to work until V3 RN came over from another unit and was able to get it working. V3 then started suctioning R1. V18 APRN also came into the room and started suctioning R1. After V18 APRN suctioned R1, I moved him to his bed. R1 did not recover and passed away later that evening.

(continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 9:18 AM V24 Registered Nurse (Previous Director of Nurses DON) confirmed on [DATE] she was called into R1's room to assist in caring for him. V24 stated R1 had aspirated and was struggling to breath. V24 stated when she arrived in R1's room V22 and V23 Minimum Data Set Nurses were attempting to put together the machine and get it working however pieces were missing and V22 had to leave the room a few times to get different things. Even after V22 retrieved the missing pieces they could not get the machine working and ended up calling for V3 Registered Nurse who was working on another unit to come and assist. V3 RN arrived and was able to get the suctioning machine to start working and began to suction R1. V24 stated soon after that V18 APRN came into the room and requested a different suctioning catheter, which had to be retrieved, and V18 then suctioned R1 herself. V24 confirmed many errors occurred during the incident and R1 was not able to get the suctioning/care he needed timely because of the missing suctioning pieces and that they could not get the machine working right away. V24 stated R1's primary nurse V4 Licensed Practical Nurse should have called 911, R1's Power of Attorney, and V18 APRN. On [DATE] at 10:11 AM V18 Advance Practice Registered Nurse (APRN) stated on [DATE] R1 had a massive aspiration episode. V18 stated she was in the building and was notified V24 DON at the time would be late or the meeting because she was assisting in an emergency with R1. V18 stated she jumped up and ran to R1's room to see what was going on. V18 stated when she entered R1's room, V3 RN was performing oral suctioning but it was not doing any good. R1 was hypoxic and in severe distress. V18 stated she asked for a different suctioning catheter and performed nasotracheal suctioning on R1 retrieving copious amounts of thick secretions. V18 stated despite her efforts R1's status was not improving and the suctioning was not going to relieve his distress. V18 stated she spoke with R1's POA (V6) who requested at that point they keep R1 comfortable. V18 stated R1 was provided with comfort measures and medications to keep him comfortable until he expired later that evening. V18 stated the facility nursing staff knew she was in the building and should have notified her immediately when it was first noticed that R1 was in respiratory distress. V18 stated she was not aware that initially the nursing staff had issues finding the suctioning equipment or issues with getting it working. V18 confirmed nursing staff should know where to locate suctioning equipment and how to use it. On [DATE] at 2:16 PM V6 (R1's) Health Care Power of Attorney/Niece stated even through R1 had a DNR order in place she would have wanted the facility to call EMS when R1 began having trouble breathing. V6 stated she feels the facility was negligent. V6 stated she was only called concerning the situation by V7 (R1's Personal Care Taker) a little before 1:00 PM. V6 stated she could hear all the commotion in the background and V7 told R1 V6 was coming. V6 stated she got there about ten minutes later. V6 stated when she arrived in R1's room, R1 was still struggling to breath but he was no longer able to speak, he was not making eye contact, or acknowledging her presence. V6 stated she knew he was not going to make it at that point. V6 stated she made a comment in the past (when he seemed to be declining naturally) that if R1 was comfortable and calm, they did not need to send him to the hospital but V6 stated- that does not mean that if there was an emergency situation, and R1 was gasping for air and needed emergent care that they should not get him the help he needed. V6 stated R1 deserved better than this and the facility should have done better. The undated Oropharyngeal Suctioning policy documents the purpose is to maintain an unobstructed airway and prevent aspiration of mucus secretions. Staff are to place a resident in semi-Fowlers or side lying position and proceed with suctioning procedure. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Facility Assessment, last reviewed on February 2024 documents the facility will ensure staff are educated and have competencies in the areas that are necessary to provide the level and type of support and care needed for their resident population. This includes specialized care such as oxygen administration and suctioning. The same assessment documents the facility on average within an typical month has eight residents requiring oxygen respiratory services and one resident requiring suctioning. (This is a typical month, not taking into an account emergency medical situations.) The facility resident roster dated [DATE] documents 77 residents reside in the facility. The facility presented an abatement plan to remove the immediacy on [DATE] at 11:34 AM. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on [DATE] at 2:32 PM, and the survey team accepted the abatement plan on [DATE] at 3:22 PM. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: 1. On [DATE] V1 [NAME] President of Operations initiated education of all licensed nursing staff regarding Physician-Family Notification - Change of Condition Policy and policy on when to transfer or discharge the resident from the facility. 2. On [DATE] all facility nursing staff were in-serviced by V1 [NAME] President of Operations and V3/V24 Nurse Managers regarding the suctioning manufacturer's guidelines for suction machine maintenance including but not limited to machine inspection before each use to ensure there are not cracks, breaks, etc. before using the machine. 3. On [DATE] all facility nursing staff were in-serviced by V1 [NAME] President of Operations and V3/V24 Nurse Managers regarding where emergency medical equipment is stored, checking all items for medical emergency are in place weekly per checklist and a nurse is responsible to complete the audit and sign off on the checklist weekly. 4. On [DATE] all facility nursing staff were in-serviced by V1 [NAME] President of Operations and V3/V24 Nurse Managers regarding the facility's guidelines for Oropharyngeal Suctioning including but not limited to resident positioning, suctioning process, canister exchange, and documentation. 5. On [DATE] all facility nursing staff and Direct Care Staff were in-serviced by the V1 [NAME] President of Operations and V3/V24 Nurse Managers regarding the facility's Code Blue Procedure Policy, including but not limited to CPR for choking event. 6. On [DATE] all facility nursing staff and Direct Care Staff were in-serviced by the V1 [NAME] President of Operations and V3/V24 Nurse Managers regarding the facility's Equipment Replacement - Disposable - Nursing Policy including but not limited to suctioning equipment replacement including canister, connection tubing, oral suctioning tool, and sterile suction catheters. 7. On [DATE] an impromptu Quality Assurance Performance Improvement meeting was held with V12 Medical Director and staff Interdisciplinary Team to discuss facility deficiencies and an action plan. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observation, record review and interview the facility failed to ensure facility nursing staff had the appropriate competencies and skills required to provide residents with potentially life saving nursing services. This failure affected one of three residents (R1) reviewed for Dysphagia and aspiration risk on the sample list of three. Findings Include: The Facility Assessment, last reviewed on February 2024 documents the facility will ensure staff are educated and have competencies in the areas that are necessary to provide the level and type of support and care needed for their resident population. This includes specialized care such as oxygen administration and suctioning. The same assessment documents the facility on average within an typical month has eight residents requiring oxygen respiratory services and one resident requiring suctioning. (This is a typical month, not taking into an account emergency medical situations.) R1's Progress Note dated 9/19/24 documents R1 was diagnosed with Esophageal Cancer, Dysphagia, Choking in Adult, and History of Esophageal Stricture. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is severely cognitively impaired, requires partial/moderate assistance with eating, holds food in his mouth, and coughs or chokes during meals. R1's Physician Order Sheet dated September 2024 documents R1 is prescribed a regular diet, pureed texture, and thin liquids. R1's Care Plan dated 10/17/23 documents R1 is at risk for aspiration due to difficulty eating and coughing noted with meals. Staff are to monitor for choking or coughing with meals or liquids. The same Care Plan documents on 9/11/24 R1 was placed on a Regular diet, Pureed texture, Thin Liquid consistency. Resident placed on a puree diet temporarily related to mucus, choking, and Barrettes Esophagus. R1's Progress Note dated 9/19/24 documents R1 was observed in the dining room during the noon meal, unable to cough up phlegm or verbalize words. R1's Progress Note: Skilled Nursing Facility Acute Note dated 9/19/24 documents at 12:30 PM that day, R1 was found coughing and choking on secretions. V7 Family Caregiver was with R1 at the start of the incident. V18 Advanced Practice Registered Nurse went into R1's room to find staff attempting oral suction for R1. R1 was in his wheelchair and hypoxic with oxygen at 50%, heart rate at 120, respiratory rate at 40. R1 was pale and diaphoretic with grossly congested lungs. V18 APRN took over suctioning, switched to nasotracheal suctioning and retrieved copious amounts of dark tan secretions. R1 however did not improve. R1 was placed on oxygen support at 10 liters via non-rebreather mask. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Warrington Avenue Danville, IL 61832	

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 11/21/24 at 3:50 PM V4 Licensed Practical Nurse (LPN) stated V7 (R1's Caregiver) came up to her with R1 in the wheelchair and told her R1 had aspirated and was having trouble breathing. V7 took R1 back to his room. V4 stated she did not know where the suctioning machine was located and V13 Certified Nurses Assistant located the suctioning machine for her and brought it to R1's room. V4 stated multiple staff (V24 DON at the time, V22 and V23 MDS coordinators) were attempting to use the suction machine but had to stop multiple times to get parts and the machine still did not work. V4 called V3 who came and knew how to work the machine. V4 stated she had never been trained on the facility's suctioning machine and did not know where it was.

On 11/20/24 at 2:35 PM V3 Registered Nurse stated on 9/19/24 she was working on another unit when she got a phone call from V4 LPN stated R1 is in respiratory distress and they needed help with the suction machine. V3 stated she ran to his room and the staff (V24 DON at the time, V22 and V23 MDS coordinators, and V4 LPN) were having issues with the tubing and how to place it onto the suction equipment correctly. V3 RN stated staff should know how to use the suctioning equipment. V3 stated she has not been trained anytime recently on the suctioning equipment and any newer staff would probably not know how to use the equipment because the machines the facility has are pretty old.

On 11/20/24 at 3:32 PM V23 Minimum Data Set Nurse confirmed on 9/19/24 she attempted to assist in providing emergency care to R1 when he was in respiratory distress. V22 MDS Nurse was making trips in and out of R1's room to get the necessary pieces for suctioning and they still could not get it working. V3 RN was called over and she was able to finally get the suctioning working and she began to suction R1. V23 stated she was never trained on the suctioning unit that was being used and did not know how to use it.

On 11/21/24 at 2:00 PM V22 Minimum Data Set Nurse confirmed on 9/19/24 he attempted to assist in providing emergency care to R1 when he was in respiratory distress. V22 stated the suctioning equipment was brought to the room however it was not complete and he had to run in and out of the room [ROOM NUMBER]-4 times to retrieve the necessary pieces for the suctioning. V22 confirmed that they still could not get the machine to work until V3 RN came over from another unit and was able to get it working.

On 11/22/24 at 9:18 AM V24 Registered Nurse (Previous Director of Nurses DON) confirmed on 9/19/24 she was called into R1's room to assist in caring for him. V24 stated R1 had aspirated and was struggling to breath. V24 stated when she arrived in R1's room V22 and V23 Minimum Data Set Nurses were attempting to put together the machine and get it working however pieces were missing and V22 had to leave the room a few times to get different things. Even after V22 retrieved the missing pieces they could not get the machine working and ended up calling for V3 Registered Nurse who was working on another unit to come and assist. V3 RN arrived and was able to get the suctioning machine to start working. V24 confirmed many errors occurred during the incident and R1 was not able to get the suctioning/care he needed timely because of the missing suctioning pieces and that they could not get the machine working right away. V24 confirmed it had been quite some time since the facility had completed any skills training and she does not think most of the current nurses had been training on the facility's suctioning equipment.

On 11/20/24 at 9:45 AM when asked where the suctioning equipment is kept, V10 Licensed Practical Nurse goes into the medication room and looks all around in cabinets and on top of the cabinets to look for a suction machine and states she cannot find it. V10 stated if there was a resident who needed to be suctioned, she would have to run down to the Mid Hall and get their suction machine.

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	145183	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 10:11 AM V18 Advance Practice Registered Nurse (APRN) stated she was not aware that initially the nursing staff had issues finding the suctioning equipment or issues with getting it working. V18 confirmed nursing staff should know where to locate suctioning equipment and how to use it.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to provide a full time director of nurses to oversee and coordinate nursing services provided within the facility. This failure has the potential to affect all 77 residents residing in the facility. Findings Include: On 11/20/24 and 11/22/24 there was no staff member in the facility designated as the Director of Nursing (DON) or DON present at the facility. On 11/20/24 at 9:00 AM, V1, [NAME] President of Operations, stated, There is no DON (Director of Nursing) right now. The former DON (V24) resigned as of 11/9/24. We did hire a new DON to replace the former one but then the new one decided not to come work at this facility. On 11/22/24 at 12:40 PM, V1 further stated, We do have a Regional Nurse covering this building but she is sick, and we have a second Regional Nurse, so between the two of them, I would say they are here more than part time but not full time. On 11/20/24 at 9:30 AM, V8, Registered Nurse, stated, We have no DON right now and there is no one to facilitate, like what are we doing. On 11/22/24 at 10:15 AM, V18, Nurse Practitioner, stated there has been a general decline in resident care, especially in regards to wound care, at the facility without a DON. V18 further stated she had reported this decline in resident care to her superiors and set a meeting with the facility regional staff to discuss this decline in care. V18 then stated she was at the facility often and had not seen any of the regional nursing staff in the building. The Facility assessment dated [DATE] (revised by V1 on 11/22/24 during survey) documents the facility requires nursing services provided by a DON to provide competent support and care for the resident population on a daily basis and during emergencies. The facility Illinois Department of Public Health facility License dated 7/1/24 (expires 6/30/25) documents this facility is licensed as a skilled nursing facility with 90 bed capacity. The facility resident roster dated 11/20/24 documents 77 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to provide the services of a full time administrator to oversee and ensure applicable regulations are met in facility and ensure for operations and provision of resident services. This failure has the potential to affect all 77 residents residing in the facility. Findings Include: On 11/20/24 at 9:20 AM, V1, [NAME] President of Operations, stated, The administrator (V25) was in a motorcycle accident back in September and we are not sure if she will be coming back to work. We have considered hiring (V2, Human Resources Manager) as the administrator in training. On 11/20/24 and 11/22/24, there was no full time staff member present in the facility Licensed as a Nursing Home Administrator. The Illinois Administrative Code Title 77 Department of Public Health Long Term Care Facilities Skilled Nursing Code documents Section 300.510 Administrator, a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act full-time for each licensed facility. The facility Illinois Department of Public Health facility License dated 7/1/24 (expires 6/30/25) documents this facility is licensed as a skilled nursing facility with 90 bed capacity. On 11/22/24 at 10:15 AM, V18, Nurse Practitioner, stated there has been a general decline in resident care at the facility without an administrator. V18 then stated there had not been an administrator of the facility since (V25) has been off of work. V18 further stated she had reported this decline in resident care to her superiors and set a meeting with the facility regional staff to discuss this decline in care. On 11/22/24 at 12:16 PM, V2 stated she had not yet submitted her application nor associated fees for the Administrator in Training License (Non-Examination Temporary License). On 11/22/24 at 12:40 PM, V1 confirmed that V2 was currently in the process of completing her application for the Administrator in Training License and would be starting the process of being oriented to the Administrator duties this coming Monday (11/25/24). V1 further stated that there had been some discussion about V2 assuming the position of Administrator as an Administrator in Training that began last Thursday (11/14/24) but there had been no official announcement to the facility staff, but now that there were surveyors that came in to the building, she had to make it known that V2 would begin the training to assume the Administrator position. The Facility assessment dated ,d+[DATE] (revised by V1 on 11/22/24 during survey) documents the facility requires services provided by an Administrator to provide competent support and care for the resident population on a daily basis and during emergencies. The facility's resident roster dated 11/20/24 documents 77 residents reside in the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34058 Based on interview and record review, the facility failed to implement a quality improvement review for an adverse event resulting in a resident's (R1) death. This failure has the potential to affect all 77 residents residing in the facility. Findings Include: On 11/22/24 at 10:45 AM, V1, [NAME] President of Operations, stated, This incident was never reported to any of us (corporate staff), or the regional nurses. The first I heard of it was when you (surveyors) came in 2 days ago. V1 further stated, We would have done staff education and all the things we needed to do at that time (9/19/24). On 11/22/24 at 12:45 PM, V1 stated there had been no QAPI/ QA (Quality Assurance Performance Improvement/ Quality Assurance) reviews or risk management reviews conducted as a result of the aspiration incident involving R1. On 11/22/24 at 9:18 AM, V24, Registered Nurse/ former Director of Nursing, stated that there had been no reviews or staff education conducted after the incident involving R1 and stated, We all just kind of moved on. On 11/26/24 at 3:20 PM, V2, Human Resources Manager, stated that V24 should have been the one who should have initiated the QAPI reviews and corrective actions for clinical issues for R1's incident. The facility resident roster dated 11/20/24 documents 77 residents reside in the facility. The facility's Quality Assurance and Performance Improvement plan dated 9/15/24, and modified to document a review on 11/22/24 during the survey, documents the facility governance team will be responsible for evaluating systems and processes, gathering data from experiences of caregivers including adverse events, identifying problems, and implementing corrective actions and performance improvement projects in an effort to have a high quality of service delivery and resident quality of life.