

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 01/29/2025
NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34058</p> <p>Based on interview and record review, the facility failed to acquire and administer medications to meet the needs of residents. This failure affects one resident (R1) out of seven reviewed for medications.</p> <p>Findings include:</p> <p>On 1/28/25 at 12:12 PM, V11, Family of R1, stated the facility did not have available R1's Ativan (anti-anxiety) for two days. V11 further stated she had found 2 pills in R1's bed and did not believe the nurses at the facility were making sure R1 took her medicine. V11 stated one of the pills she found in R1's bed was Zoloft (anti-depressant).</p> <p>R1's current Physician Order Sheet (POS) dated 1/28/25 documents R1 had physician orders for Lorazepam (Ativan) 0.5 milligrams (mg) twice daily scheduled at 8:00 AM and 8:00 PM. This same POS documents R1 had physician orders for Zoloft 75 mg every bed time at 8:00 PM, and Docusate (Colace) 100 mg every morning at 8:00 AM. This same POS documents R1 had a physician order to receive a Cyanocobalamin (B-12) injection of 1,000 micrograms monthly which was scheduled for the 17th of January 2025.</p> <p>On 1/28/25 at 10:31 AM, V4, Registered Nurse, stated that V11 had brought a couple of pills to her on 1/22/25, and V11 had told V4 that she had found the pills in R1's bed. V4 stated one of the pills was Colace (laxative) and then remembered the other pill was Zoloft. V4 stated she could not pinpoint when the pills ended up in R1's bed so she threw them away. V4 confirmed the Colace was scheduled to be given daily at 8:00 AM, and the Zoloft was scheduled to be given daily at bed time.</p> <p>R1's current Medication Administration Record (MAR) dated for January 2025 documents on 1/17/25 for the morning dose of Ativan, 1/18/25 for both the morning and evening doses of Ativan, and 1/20/25 for the morning dose of Ativan were coded with a reference number 9. The reference legend for this MAR documents the number 9 is a reference to see the nursing progress notes. R1's Nursing Progress Notes did not contain any notes whatsoever between 1/16/25 at 4:18 PM and 1/20/25 at 1:43 AM, and this latter note from 1/20/25 at 1:43 AM did not make any reference to R1's medications.</p> <p>R1's MAR for January 2025 documents the B-12 monthly injection was not documented as administered to R1 as scheduled on 1/17/25.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/29/25 at 11:20 AM, V2, Director of Nursing, stated she could not confirm that R1's B-12 injection was administered because there was no nurses initial in the blank square where the nurse should have documented the injection was given. V2 further stated she had knowledge of the situation about R1's Ativan not being available. V2 clarified that at least one of the missed doses of Ativan was due to an agency nurse being on duty and agency nurses do not have access to the facility's onsite back-up medications in the pharmacy system. V2 stated another time, a facility nurse called the pharmacy to obtain an access code for the onsite back-up system but the pharmacy never returned the call to provide an access code for the back-up system. V2 continued that R1's Ativan prescription required a renewal from R1's Primary Physician and that was why the pharmacy had not returned the call to provide an access code to obtain the Ativan from the onsite back-up system. V2 stated she did know about the pills being found in R1's bed and confirmed that when the facility nurses administer medications to residents they are supposed to watch to make sure the resident swallows the medication. V2, likewise, stated she could not pinpoint when the medications came to be in R1's bed.</p> <p>On 1/29/25 at 11:35 AM, V6, Registered Nurse/ Assistant Director of Nursing, confirmed the place on R1's MAR where a nurse should have documented the administration of R1's B-12 injection on 1/17/25 was blank. V6 indicated there was not a way to confirm the injection was administered.</p> <p>The facility policy Medication Administration General Guidelines (undated) documents the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication administration. This same policy documents that residents may cheek or pocket medications as an intentional refusal or from other causes such as dry mouth causing pills to stick inside the mouth. Nurses should observe residents take and swallow medications. To check, the nurse may offer more water or inspect the mouth. This policy further documents if a medication with a current active order can not be located, the pharmacy is contacted or the medication is removed from the emergency kit (onsite back-up pharmacy system).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34058</p> <p>Based on observation, interview, and record review, the facility failed to use sanitary practice to handle and administer medications to residents. This failure has the potential to affect all 81 residents in the facility.</p> <p>Findings include:</p> <p>On 1/29/24 at 9:45 AM, V10, Registered Nurse, was actively engaged in medication administration duties preparing residents' medications. V10 was manually opening drawers of the medication storage cart, removing and replacing medications cards in the drawers, and manipulating the computer mouse, all with bare hands. V10 was removing residents pills from the cards and placing them into her same bare hands then placing the pills into a small plastic cup to administer to residents. V10 stated she knew she wasn't supposed to be putting pills into her bare hands before placing the pills into the cup. V10 stated the resident she was preparing medications for at that time was R7</p> <p>On 1/29/25 at 11:12 AM, V2, Director of Nursing, was actively engaged in medication administration duties preparing residents' medications. V2 was manually opening drawers of the medication storage cart, removing and replacing medication cards and house stock bottles from the drawers, and manipulating the computer mouse, all with bare hands. V2 was removing medications from the cards and bottles and placing the pills into her same bare hands then placing the pills into a small plastic cup. When questioned about the practice of placing pills into bare hands, V2 stated, Yep, that's how we do it if our hands are clean. When it was brought to V2's attention that her hands could not be considered clean because she was handling the drawers, handled by all other nurses on different shifts, grabbing the medication cards and bottles, handled by all other nurses on different shifts, and handling the computer mouse, also handled by all other nurses on different shifts, V2 responded, This has been an education.</p> <p>On 1/29/24 at 3:35 PM, V1, Administrator, acknowledged placing pills in bare hands is an infection control concern.</p> <p>The facility policy Medication Administration General Guidelines (undated) documents the person administering medications adheres to good hand hygiene including thorough handwashing and hand sanitization after coming in contact with any potentially contaminated surface.</p> <p>The facility's Resident Roster dated 1/28/25 documents there were 81 residents residing in the facility.</p>		