

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 06/25/2025
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure confidentiality/privacy of resident information for one of five residents (R1) reviewed for resident rights in the sample list of five.</p> <p>Findings include:</p> <p>R1's Minimum Data Set, dated [DATE] documents R1 has severe cognitive impairment.</p> <p>On 6/24/25 at 9:18 AM V6 Certified Nursing Assistant (CNA) stated R1 had a history of abusing/molesting R1's children prior to admitting to the facility, and this was reported to V6 by an unidentified hospice nurse. V6 stated R1 was having behaviors that caused V30 (R1's Family) to remember past experiences. V6 stated staff aren't suppose to discuss resident information with other staff in the hallways, this has happened, we all have done it.</p> <p>On 6/24/25 at 9:36 AM V5 CNA stated a few months ago V5 overheard unidentified staff talking about R1 having a history of abuse towards R1's family. V5 stated staff are not suppose to discuss resident information amongst each other or with family/visitors.</p> <p>On 6/24/25 at 10:03 AM V8 Licensed Practical Nurse stated it was going around the whole facility for months that he (R1) had molested his kids. V8 stated V6 and V32 CNAs were talking about this information, and it is not appropriate for staff to be talking about that.</p> <p>On 6/24/25 at 11:34 AM V10 Activity Aide stated V12 Activity Director told V10, the day after R1 fell and broke his hip (6/10/25) , that R1's children didn't want to do any medical treatment and V12 thought it was because R1 had molested his children. V10 stated V12 said this in front of V11 Activity Aide, and V11 said that R1 had urinated on his children. V10 stated this was discussed in V12's office with the doors open, and could easily be overheard by others in the hallway. V10 stated it was unnecessary for the staff to talk about this and V10 wondered what this information had to do with R1's fall. V10 stated this bothered V10 and V10 turned in her resignation that day. V10 stated V1 spoke with V10 about V10's resignation and V10 then reported this same information to V1, who told V10 the staff had violated the Health Insurance Portability and Accountability Act.</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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NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Warrington Avenue Danville, IL 61832	

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 at 12:22 PM V11 Activity Aide stated V12 and V6 informed V11, while in V12's office, that R1 had sexually assaulted R1's children, R1 broke his leg and R1's family declined treatment. V11 stated V12's office doors were open, and information could have been overheard if anyone was standing in the hall or nurse's station near V12's office. V11 stated V11 also overheard V6 make remarks about R1's call light going off and R1 could wait because of what R1 had done to R1's children while V6 was sitting at the nurses station and V12 also witnessed this. V11 stated this happened last month on an unknown date.</p> <p>On 6/24/25 at 12:57 PM V12 Activity Director stated on an unidentified date V12 overheard V6 CNA, while standing near the middle hall nurses station, tell unidentified staff that R1 molested his children and R1 urinated on R1's children when they were younger. V12 stated V6 still provided care for R1, timely answered R1's call light and was pleasant when V6 cared for R1. V12 denied overhearing or witnessing V6 make statements or refusal to answer R1's call light.</p> <p>On 6/24/25 at 2:30 PM V1 Administrator confirmed it would not be appropriate for staff to discuss R1's history of abuse amongst other staff and in common areas.</p> <p>The facility's Resident Rights policy dated 8/23/17 documents the purpose of the policy is to promote the exercise of rights for each resident, and resident rights include privacy and confidentiality.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow their abuse policy for reporting, investigating, and documenting injuries of unknown source for one of four residents (R3) reviewed for injuries in the sample list of five.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Reporting - Illinois policy dated 10/24/22 documents injuries of unknown source are when the source of the injury was not observed or could not be explained by the resident, and the injury is suspicious due to the extent or location of the injury (an area not generally susceptible to injury/trauma) or the number of injuries at one particular point or incidents of injuries over time. This policy documents the same time frames for reporting and investigating abuse will be followed for injuries of unknown source and the resident's physician and representative shall be notified, if necessary. This policy documents at a minimum, attempt to interview the person who reported the incident, anyone who likely has direct knowledge of the incident, and the resident.</p> <p>On 6/24/25 at 9:10 AM R3 was lying in bed. R3 had bruising on the right side of her face along her cheek and jawline. R3 stated R3 didn't have any bruises and was unaware of the bruise on R3's face. R3 was unsure what caused the bruising. On 6/25/25 at 12:00 PM R3 and V26 (R3's Family) were sitting near the front entrance of the facility. R3 had blue bruising on the right side of her face. V26 stated R3's bruising was present on either Friday 6/20/25 or on Monday 6/23/25. V26 stated R3 has a lot of bruising to R3's arms as well and the bruising is health related, R3 was admitted to the hospital about two weeks ago and diagnosed with a blood disorder, possible cancer.</p> <p>R3's MDS dated [DATE] documents R3 has moderate cognitive impairment. There is no documentation in R3's electronic medical record of R3's facial bruising as of 6/25/25.</p> <p>The facility's Incidents by Incident Type log dated 4/24/25-6/24/25 does not document any incidents involving R3.</p> <p>On 6/24/25 at 9:02 AM V4 Licensed Practical Nurse stated R3 has significant bruising to her face and arms, but her platelets are very low. V4 stated V4 notified V26, who was aware and saw it on 6/18/25. V4 stated V4 was unsure of the cause of R3's facial bruising, other than R3's low platelets.</p> <p>On 6/25/25 at 12:44 PM V2 Director of Nursing stated V2 was not aware of R3's facial bruising. V2 stated injuries should be investigated and if unable to determine the cause, then the injury is reported to the Illinois Department of Public Health (IDPH). V2 stated V2 should have been notified of R3's facial bruising in order to investigate the cause of the injury. V2 confirmed there was no investigation of R3's facial bruising. V2 stated R3's bruising should have been documented and R3's physician (V22) notified, which would be noted in a progress note.</p> <p>On 6/25/25 at 1:43 PM V1 stated V1 was not aware of R3's facial bruising. V1 stated R3 was recently hospitalized and admitted to hospice. V1 stated injury of unknown origin is reported to V2, and depending on the injury and the cause, would then be reported to V1 and IDPH. V1 stated V1 should be notified of any unknown bruising or injuries of unknown origin.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report an allegation of neglect and injuries of unknown origin to the administrator and state survey agency for three of five residents (R1, R2, R3) reviewed for resident rights in the sample list of five residents.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Reporting - Illinois policy dated 10/24/22 documents neglect is the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish; this includes withholding of adequate medical care, assistance with activities of daily living, and deprivation of goods/services by staff. This policy documents employees are required to report allegations or suspicions of potential abuse/neglect immediately to the administrator. This policy documents abuse allegations or incidents that result in serious bodily injury will be reported to the Department of Public Health immediately, but no more than two hours after the allegation; or within 24 hours if the incident does not involve abuse or serious bodily injury. This policy documents injuries of unknown source are when the source of the injury was not observed or could not be explained by the resident, and the injury is suspicious due to the extent or location of the injury (an area not generally susceptible to injury/trauma) or the number of injuries at one particular point or incidents of injuries over time. This policy documents the same time frames for reporting and investigating abuse will be followed for injuries of unknown source, including notifying the state survey agency.</p> <p>1.) R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment, is incontinent of bowel and bladder, and requires dependence on staff assistance for toileting and supervision/touching assistance for transfers.</p> <p>On 6/24/25 at 12:22 PM V11 Activity Aide stated V12 Activity Director and V6 Certified Nursing Assistant (CNA) informed V11, while in V12's office, that R1 had sexually assaulted R1's children. V11 stated V11 also overheard V6 make remarks about R1's call light going off and R1 could wait because of what R1 had done to R1's children while V6 was sitting at the nurses station and V12 also witnessed this. V11 stated this happened last month on an unknown date. V11 stated V11 was unsure if this was reported to V1 Administrator, but V12 was aware.</p> <p>On 6/24/25 at 12:57 PM V12 Activity Director stated on an unidentified date V12 overheard V6 CNA telling unidentified staff that R1 molested his children and R1 urinated on R1's children when they were younger. V12 stated V6 still provided care for R1, timely answered R1's call light and was pleasant when V6 cared for R1. V12 denied overhearing or witnessing V6 make statements or refusal to answer R1's call light.</p> <p>On 6/24/25 at 1:30 PM V1 Administrator denied that anyone had reported concerns with V6 not answering R1's call light or providing R1's cares timely. At this time V11's allegation regarding V6 was reported to V1. V1 stated V1 would consider this to be an abuse allegation that should have been reported to V1, investigated and reported to the state survey agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.) On 6/24/25 at 9:27 AM R2 was asleep and sitting in a wheelchair in his room. V25, R2's caregiver was in R2's room. V25 stated V25 visited R2 on 6/11/25 and noticed dried blood to R2's eyebrow that wasn't there the day prior. V25 showed a picture on V25's personal cellular phone that showed bruising and swelling to R2's left eye, and dried blood above R2's left eyebrow. V25 stated V25 did not talk to staff about R2's eye injury that day, V25 assumed the staff were already aware, and four days later the staff contacted V25 to ask about R2's eye injury. V25 stated R2 doesn't speak much and falls all the time.</p> <p>R2's MDS dated [DATE] documents R2 has short and long term memory impairment. R2's active physician's orders do not include blood thinning medication. R2's active care plan documents R2 has behaviors of picking items off of the floor, sleeping on the floor, lowering himself to the floor, ramming into objects, and grabbing at staff during care.</p> <p>R2's Nursing Note dated 6/15/2025 at 8:27 AM documents CNA noted R2's left eye was bruised and purple in color. R2 was assessed and left eye was bruised with slight swelling to the bottom of left eye and a scratch above R2's left eyebrow. R2's Nursing Note dated 6/15/2025 at 9:32 AM documents R2's personal caregiver reported R2's left eye bruising was present yesterday.</p> <p>R2's Bruise of Unknown Origin report dated 6/15/25 at 8:30 AM, provided by V2 on 6/25/25, documents R2 had bruising from inner to outer eye, and above and below the eye. This report documents for resident description, R2 does not talk. This report includes two interviews with unidentified staff, dated 6/15/25, that document R2's eye bruising was found by the CNAs during R2's morning care/transfer. There are no other documented interviews to identify the cause of R2's injury. This report documents a note dated 6/16/25 that the interdisciplinary team (IDT) reviewed R2's eye bruising, R2 has behaviors of rolling off of bed onto a floor mat, and R2 has had no recent falls This report does not document the cause of R2's injury was witnessed.</p> <p>On 6/24/25 at 10:03 AM V8 Licensed Practical Nurse stated R2's eye bruising was reported by V9 and V29 CNAs, who reported the bruising was not there the day prior. V8 stated it looked like someone punched R2's eye, it was bruised and puffy with a laceration above his eyebrow. V8 stated no one knew how R2's injury happened and there was no prior documentation about the injury.</p> <p>On 6/25/25 at 10:55 AM V2 Director of Nursing (DON) confirmed the CNA interviews dated 6/15/25 were the only documented interviews for the investigation of R2's eye injury. At 12:44 PM V2 stated V2 conducted the investigation of R2's eye injury. V2 sated V2 talked to unidentified floor staff, R2 had no recent falls, and R2 has behaviors of crawling on the mat. V2 was asked about the cause of R2's bruise, and V2 stated at times R2 lays his head down on the mat, moving from side to side. V2 stated this was discussed with the IDT. V2 stated V2 did not consider R2's eye injury to be an injury of unknown origin and R2's injury was not reported to the Illinois Department of Public Health (IDPH). V2 confirmed the cause of the injury was not witnessed by staff and R2 is unable to explain the cause of the injury.</p> <p>On 6/25/25 at 1:43 PM V1 Administrator stated V1 was not aware of R2's eye bruising. V1 stated injury of unknown origin is reported to V2, and depending on the injury and the cause, would then be reported to V1 and IDPH. V1 stated V1 should be notified of any unknown bruising or injuries of unknown origin.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.) On 6/24/25 at 9:10 AM R3 was lying in bed. R3 had bruising on the right side of her face along her cheek and jawline. R3 stated R3 didn't have any bruises and was unaware of the bruise on R3's face. R3 was unsure what caused the bruising. On 6/25/25 at 12:00 PM R3 and V26 (R3's Family) were sitting near the front entrance of the facility. R3 had blue bruising on the right side of her face. V26 stated R3's bruising was present on either Friday 6/20/25 or on Monday 6/23/25. V26 stated R3 has a lot of bruising to R3's arms as well and the bruising is health related, R3 was admitted to the hospital about two weeks ago and diagnosed with a blood disorder, possible cancer.</p> <p>R3's MDS dated [DATE] documents R3 has moderate cognitive impairment. There is no documentation in R3's electronic medical record of R3's facial bruising as of 6/25/25.</p> <p>On 6/24/25 at 9:02 AM V4 Licensed Practical Nurse stated R3 has significant bruising to her face and arms, but her platelets are very low. V4 stated V4 notified V26, who was aware and saw it on 6/18/25. V4 stated V4 notified V27 Assistant DON. V4 stated V4 was unsure of the cause of R3's facial bruising, other than R3's low platelets.</p> <p>On 6/25/25 at 12:44 PM V2 DON stated V2 was not aware of R3's facial bruising. V2 stated injuries should be investigated and if unable to determine the cause, then the injury is reported to IDPH. V2 stated V2 should have been notified of R3's facial bruising. V2 confirmed an investigation to determine the cause of R3's bruising was not completed and IDPH was not notified.</p> <p>On 6/25/25 at 1:43 PM V1 stated V1 was not aware of R3's facial bruising. V1 stated R3 was recently hospitalized and admitted to hospice. V1 stated injury of unknown origin is reported to V2, and depending on the injury and the cause, would then be reported to V1 and IDPH. V1 stated V1 should be notified of any unknown bruising or injuries of unknown origin.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to thoroughly investigate injuries of unknown origin for two of four residents (R2, R3) reviewed for injuries in the sample list of five.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Reporting - Illinois policy dated 10/24/22 documents employees are required to report allegations or suspicions of potential abuse/neglect immediately to the administrator and abuse incidents/allegations will be investigated. This policy documents injuries of unknown source are when the source of the injury was not observed or could not be explained by the resident, and the injury is suspicious due to the extent or location of the injury (an area not generally susceptible to injury/trauma) or the number of injuries at one particular point or incidents of injuries over time. This policy documents the same time frames for reporting and investigating abuse will be followed for injuries of unknown source. This policy documents at a minimum, attempt to interview the person who reported the incident, anyone who likely has direct knowledge of the incident, and the resident.</p> <p>1.) On 6/24/25 at 9:27 AM R2 was asleep and sitting in a wheelchair in his room. V25, R2's caregiver was in R2's room. V25 stated V25 visited R2 on 6/11/25 and noticed dried blood to R2's eyebrow that wasn't there the day prior. V25 showed a picture on V25's personal cellular phone that showed bruising and swelling to R2's left eye, and dried blood above R2's left eyebrow. V25 stated V25 did not talk to staff about R2's eye injury that day, V25 assumed the staff were already aware, and four days later the staff contacted V25 to ask about R2's eye injury. V25 stated R2 doesn't speak much and falls all the time.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 has short and long term memory impairment. R2's active physician's orders do not include blood thinning medication. R2's active care plan documents R2 has behaviors of picking items off of the floor, sleeping on the floor, lowering himself to the floor, ramming into objects, and grabbing at staff during care.</p> <p>R2's Nursing Note dated 6/15/2025 at 8:27 AM documents Certified Nursing Assistant (CNA) noted R2's left eye was bruised and purple in color. R2 was assessed and left eye was bruised with slight swelling to the bottom of left eye and a scratch above R2's left eyebrow. R2's Nursing Note dated 6/15/2025 at 9:32 AM documents R2's personal caregiver reported R2's left eye bruising was present yesterday.</p> <p>R2's Bruise of Unknown Origin report dated 6/15/25 at 8:30 AM, provided by V2 on 6/25/25, documents R2 had bruising from inner to outer eye, and above and below the eye. This report documents for resident description, R2 does not talk. This report includes only two interviews with unidentified CNAs dated 6/15/25, that document R2's eye bruising was found by the CNAs during R2's morning care/transfer. There are no other documented interviews to identify the cause of R2's injury. This report documents a note dated 6/16/25 that the interdisciplinary team (IDT) reviewed R2's eye bruising, R2 has behaviors of rolling off of bed onto a floor mat, and R2 has had no recent falls This report does not document the cause of R2's injury was witnessed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 between 9:36 AM and 10:51 AM the following staff were interviewed: V5 CNA stated V5 was unsure what caused R2's eye bruising, and R2 falls a lot. V9 CNA stated V9 reported R2's eye bruising on the weekend of 6/14-6/15/25. V9 stated R2 was lying on the mat on the floor at the time and V9 was unsure what caused the injury. V9 stated R2 hasn't had any recent falls and V9 did not witness any incident to cause the injury. V8 Licensed Practical Nurse stated R2's eye bruising was reported by V9 and V29 CNAs, who reported the bruising was not there the day prior. V8 stated it looked like someone punched R2's eye, it was bruised and puffy with a laceration above his eyebrow. V8 stated no one knew how R2's injury happened and there was no documentation about the injury.</p> <p>On 6/25/25 between 10:35 AM and 10:45 AM the following staff were interviewed: V24 CNA stated R2 crawls around a lot and bumps into things, R2 is always on the floor. V24 stated it is hard to say what caused R2's eye injury, unless it was witnessed. V24 stated V24 did not see R2 bump into anything and R2 hasn't had any recent falls. V28 CNA stated V28 overheard V9 CNA talk about R2's eye bruising the day V9 discovered the injury. V28 stated V28 was not aware of any incidents or falls that would cause that type of injury. V28 stated R2 does crawl around a lot and is frequently found on the floor.</p> <p>On 6/25/25 at 10:55 AM V2 Director of Nursing (DON) confirmed the CNA interviews dated 6/15/25 were the only documented interviews for the investigation of R2's eye injury. At 12:44 PM V2 stated V2 conducted the investigation of R2's eye injury and V9 and V29 were the documented interviews on 6/15/25. V2 stated V2 talked to unidentified floor staff, R2 had no recent falls, and R2 has behaviors of crawling on the mat. V2 was asked about the cause of R2's bruise, and V2 stated at times R2 lays his head down on the mat, moving from side to side. V2 stated this was discussed with the IDT. V2 stated V2 did not consider R2's eye injury to be an injury of unknown origin. V2 confirmed the cause of the injury was not witnessed by staff and R2 is unable to explain the cause of the injury.</p> <p>2.) On 6/24/25 at 9:10 AM R3 was lying in bed. R3 had bruising on the right side of her face along her cheek and jawline. R3 stated R3 didn't have any bruises and was unaware of the bruise on R3's face. R3 was unsure what caused the bruising. On 6/25/25 at 12:00 PM R3 and V26 (R3's Family) were sitting near the front entrance of the facility. R3 had blue bruising on the right side of her face. V26 stated R3's bruising was present on either Friday 6/20/25 or on Monday 6/23/25. V26 stated R3 has a lot of bruising to R3's arms as well and the bruising is health related, R3 was admitted to the hospital about two weeks ago and diagnosed with a blood disorder, possible cancer.</p> <p>R3's MDS dated [DATE] documents R3 has moderate cognitive impairment. There is no documentation in R3's electronic medical record of R3's facial bruising as of 6/25/25.</p> <p>On 6/24/25 at 9:02 AM V4 Licensed Practical Nurse stated R3 has significant bruising to her face and arms, but her platelets are very low. V4 stated V4 notified V26, who was aware and saw it on 6/18/25. V4 stated V4 was unsure of the cause of R3's facial bruising, other than R3's low platelets. On 6/24/25 at 9:36 AM V5 CNA stated R3 had facial bruising noticed today and V5 was unsure what caused it. V5 stated V5 reported it to a nurse, who said it was due to R3's blood being thin.</p> <p>On 6/25/25 at 10:51 AM V9 CNA stated V9 noticed R3's facial bruising yesterday and reported this to the nurse, who said it was related to blood cancer. V9 stated V9 was unsure what caused the bruising, other than the blood cancer, and R3 was unable to state what happened.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 12:44 PM V2 DON stated V2 was not aware of R3's facial bruising. V2 stated injuries should be investigated and if unable to determine the cause, then the injury is reported to IDPH. V2 stated V2 should have been notified of R3's facial bruising in order to investigate the cause of the injury. V2 confirmed there was no investigation of R3's facial bruising.</p> <p>On 6/25/25 at 1:43 PM V1 stated V1 was not aware of R3's facial bruising. V1 stated R3 was recently hospitalized and admitted to hospice. V1 stated injury of unknown origin is reported to V2, and depending on the injury and the cause, would then be reported to V1 and IDPH. V1 stated V1 should be notified of any unknown bruising or injuries of unknown origin.</p>		

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 06/25/2025
NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Warrington Avenue Danville, IL 61832	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement physician's orders and complete neurological assessments for three of four residents (R2, R4, R5) reviewed for injuries in the sample list of five.</p> <p>Findings include:</p> <p>1.) On 6/24/25 at 11:07 AM R4 was sitting on the side of bed and R4 had adhesive strips covering a small scabbed wound on R4's forehead. There was an arm sling on the seat of R4's wheeled walker. R4 stated R4 fell while R4 was walking in her room, moving things from a dresser drawer to R4's closet. R4 stated R4 did not ask for staff assistance, but staff were in the hallway outside of R4's door at that time. R4 hit her head on the floor and received stitches at the emergency room. R4 stated R4's left arm was hurting but is feeling better now, x-rays were completed and showed no fractures. R4 stated R4 is no longer wearing the sling to her left arm.</p> <p>R4's Nursing Note dated 6/16/25 at 5:30 PM documents R4 stated R4 was trying to get dressed, lost balance and fell. R4's Nursing Note dated 6/16/2025 at 11:55 PM documents R4 returned from the hospital around 11:00 PM with stitches to forehead and left arm on a splint. Orders were received to remove stitches in seven days and keep left hand in splint for seven days until x-ray completed. R4's Nursing Note dated 6/17/25 at 6:45 AM documents R4 fell on 6/16/25 and per report R4 returned with stitches to forehead and left arm in splint. This note documents R4's neurological checks were initiated at this time.</p> <p>R4's 72 Hour Neurological Check initiated on 6/16/25 at 6:47 PM documents entries recorded by V2 Director of Nursing (DON), including assessments dated 6/17/25 at 12:15 AM and 4:15 AM.</p> <p>R4's left arm x-ray dated 6/16/25 documents can not definitively rule out fracture or subluxation. R4's Hospital After Visit Summary dated 6/16/25 documents R4 was evaluated for left elbow pain and head injury related to fall; remove sutures in seven days, wear sling for seven days until repeat x-ray in seven days, and follow up with orthopedics. There is no documentation in R4's medical record that R4's repeat x-ray was obtained or that an orthopedic appointment was scheduled as of 6/25/25.</p> <p>On 6/24/25 at 10:03 AM V8 Licensed Practical Nurse stated R4 returned from the hospital at approximately 11:00 PM and the prior shift's nurse did not complete R4's neurological assessments.</p> <p>On 6/24/25 at 2:16 PM V12 Activity Director stated V12 has been scheduling resident appointments. On 6/25/25 at 10:22 AM V12 stated on 6/23/25 she received a note on her desk that said R4, orthopedic, and a phone number. V12 stated V22 Physician or V2 DON will need to complete the referral, which we will do today and send over to the orthopedic office. V12 confirmed R4 does not have an orthopedic consult scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/25/25 at 10:55 AM V2 DON confirmed R4's follow up x-ray had not been ordered and confirmed R4 had no orthopedic appointment scheduled. V2 stated one will be ordered today. At 12:44 PM V2 confirmed V2 did not complete R4's 6/17/25 neurological assessments. V2 stated V2 transcribed R4's neurological assessment data from a paper form that V20 Agency Registered Nurse had completed. V2 stated V2 will have to look for this documentation. On 6/25/25 at 3:13 PM V2 stated V2 did not have any additional documentation for R4's neurological assessments.</p> <p>2.) On 6/24/25 at 11:14 AM R5 was lying in bed and there was a scabbed area to R5's right eyebrow. R5 stated R5 fell out of his wheelchair causing the injury to R5's right eyebrow. R5 stated R5 was admitted to the hospital and diagnosed with a stroke, which is what caused R5 to fall forward out of his wheelchair.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact.</p> <p>R5's active physician orders document R5 receives Aspirin 81 milligrams (mg) and Plavix 75 mg daily (medications that can contribute to bleeding).</p> <p>R5's Nursing Note dated 6/9/2025 at 9:37 AM documents R5 fell from his wheelchair and was lying on his stomach with his head turned on the right side. There was a large amount of bleeding from the right side of his face. R5 was transferred to the local emergency room for evaluation. R5's Nursing Note dated 6/16/2025 at 10:50 AM documents R5 had vomited a large amount and reported feeling kind of woozy since his fall. Orders were received for hourly neurological assessments for the next 12 hours.</p> <p>R5's 72 Hour Neurological Check initiated on 6/16/25 does not document these checks were completed hourly for 12 hours as ordered.</p> <p>On 6/25/25 at 12: 44 PM V2 DON stated neurological assessments should be documented under the assessments section of the resident's electronic medical record. V2 confirmed R5's neurological assessments are not documented as completed hourly as ordered on 6/16/25.</p> <p>3.) R2's MDS dated [DATE] documents R2 has short and long term memory impairment.</p> <p>R2's Nursing Note dated 6/15/2025 at 8:27 AM documents R2's left eye was bruised, purple in color, and swelling to bottom of eye. There was a scratch above R2's left eyebrow. Neurological checks were initiated.</p> <p>R2's 72 Hour Neurological Check initiated on 6/15/25 at 8:15 AM, only documents nine checks were completed on 6/15/25 and 11 of the scheduled checks were incomplete.</p> <p>On 6/25/25 at 12:44 PM V2 confirmed neurological assessments should be completed for unwitnessed falls and head injuries. V2 reviewed R2's neurological assessments and confirmed missing entries. V2 stated neurological assessments should be completed for 72 hours.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's undated Neurological Assessment policy documents neurological assessments will be completed for head injuries, when necessary related to changes in condition, or when ordered by the physician. This policy documents to observe, assess, and document level of consciousness, speech, pupils, hand grasps and vital signs. This policy documents neurological assessments will be completed every 15 minutes for one hour, then every 30 minutes for two hours, then every 4 hours for 24 hours, and then every shift for 48 hours, unless otherwise ordered by the physician.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to thoroughly investigate a fall to identify the root cause and determine appropriate post fall interventions for one of three residents (R4) reviewed for falls in the sample list of five.</p> <p>Findings include:</p> <p>On 6/24/25 at 11:00 AM R4 was in bed and stated R4 needed to use the bathroom. R4 was asked to turn her call light on and R4 demonstrated ability to activate her call light. V21 Human Resources entered R4's room and instructed R4 to wait for nursing staff assistance. R4 did not wait for staff assistance and self ambulated to the bathroom with her wheeled walker. At 11:07 AM R4 was sitting on the side of bed and R4's wheeled walker was at the foot of R4's bed. R4 had adhesive strips covering a small scabbed wound on R4's forehead. R4 stated R4 fell while R4 was walking in her room, moving things from a dresser drawer to R4's closet. R4 stated R4 did not ask for staff assistance, but staff were in the hallway outside of R4's door at that time. R4 hit her head on the floor and received stitches at the emergency room. R4 stated R4's left arm was hurting but is feeling better now, x-rays were completed and showed no fractures.</p> <p>R4's Minimum Data Set, dated [DATE] documents R4 has severe cognitive impairment, R4 uses wheelchair and wheeled walker, and requires supervision/touch assistance from staff while walking.</p> <p>R4's active care plan documents R4 transfers/walks with wheeled walker and assistance of one staff person and gait belt. This care plan was updated on 6/17/25 with an intervention for a dressing and grooming restorative program.</p> <p>R4's Nursing Note dated 6/16/25 at 5:30 PM documents R4 stated R4 was trying to get dressed, lost balance and fell. R4's Nursing Note dated 6/16/2025 at 11:55 PM documents R4 returned from the hospital around 11:00 PM with stitches to forehead and left arm on a splint. Orders were received to remove stitches in seven days and keep left hand in splint for seven days until x-ray completed.</p> <p>R4's 6/16/25 fall investigation folder, provided by V2 Director of Nursing (DON), included an unwitnessed fall incident report for this fall. This report documents R4 stated she was trying to get an outfit from R4's closet, lost her balance and fell hitting her head on the chair. This report does not document R4's footwear or if she was using her wheeled walker at the time. This report documents the interdisciplinary team (IDT) reviewed the fall, R4 requires substantial staff assistance with dressing and supervision with standing/walking, R4 would benefit from a restorative dressing program, and R4's care plan was updated. There is no documentation that a root cause of this fall was determined. The undated interview written by V13 Certified Nursing Assistant (CNA) documents V13 was in R4's room delivering R4's meal tray, R4 was walking on the right side of R4's bed towards her closet, and R4 fell. This interview does not document if R4 was trying to get dressed, R4's footwear at the time, or if R4 was using R4's wheeled walker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 at 2:38 PM V13 CNA stated on 6/16/25 between 5:00 PM and 5:30 PM V13 delivered R4's meal tray to R4's room. V13 stated R4 was between R4's bed and the wall walking towards R4's closet and within five seconds was on the floor, V13 was unable to get to R4 in time to break R4's fall. V13 stated R4's forehead was bleeding since R4's head hit the floor when she fell. V13 stated R4 was not carrying any items, R4 was not using her wheeled walker, and R4 tripped over her own feet. V13 was unsure if R4 was wearing any footwear. V13 stated R4 does a lot of things on her own, walks by herself and takes herself to the bathroom, but we try to help her. V13 stated sometimes R4 is caught walking without using her walker. V13 stated R4 told V13 that R4 was going to her closet to get eye drops.</p> <p>On 6/25/25 at 10:55 AM V2 DON confirmed R4's fall investigation did not identify the root cause of the fall. V2 stated the root cause of R4's fall was R4 was getting into her closet and dresser, self ambulating to get dressed, so a new intervention for a restorative dressing and grooming program was implemented. V2 stated V2 did not interview V13 and just went by V13's written statement. V2 confirmed there was no documentation of R4's footwear or if R4 was using her wheeled walker when she fell, which could change R4's post fall intervention to be more appropriate.</p> <p>The facility's Fall Prevention Program dated 11/21/17 documents care planned interventions are changed with each fall, as appropriate. This policy documents the IDT reviews incident/accident reports to ensure appropriate care and services are provided and determine possible safety interventions, and fall/safety interventions may include reminding the resident to call for assistance before attempting to ambulate and monitoring for appropriate footwear.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an accurate medical record for one of three residents (R4) reviewed for falls in the sample list of five.</p> <p>Findings include:</p> <p>The facility's undated Neurological Assessment policy documents to complete neurological assessments when a resident experiences a head injury or when ordered by a physician for a change in resident's condition. This policy documents to observe, assess and document the resident's level of consciousness, speech, pupils, hand grasps and vital signs as part of this assessment.</p> <p>The facility's undated Medical Record Policy documents the facility will maintain complete and accurate resident medical records, and in accordance with applicable federal and state regulations.</p> <p>R4's Minimum Data Set, dated [DATE] documents R4 has severe cognitive impairment.</p> <p>R4's Nursing Notes document on 6/16/25 at 5:30 PM R4 lost balance and fell, neurological assessments were initiated and R4 was transferred to the hospital. R4 returned to the facility at 11:55 PM with stitches to her forehead. On 6/17/25 Purple bruising was noted to R4's forehead and right eye/cheek.</p> <p>R4's 72 Hour Neurological Check initiated on 6/16/25 at 6:47 PM documents entries recorded by V2 Director of Nursing, including assessments dated 6/17/25 at 12:15 AM and 4:15 AM.</p> <p>On 6/25/25 at 12:44 PM V2 confirmed V2 did not complete R4's 6/17/25 neurological assessments. V2 stated V2 transcribed R4's neurological assessment data from a paper form that V20 Agency Registered Nurse had completed. V2 stated V2 will have to look for this documentation. On 6/25/25 at 3:13 PM V2 stated V2 did not have any additional documentation for R4's neurological assessments.</p>		