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	10/02/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A partial extended survey was conducted. Failures at this level require two separate deficient practice statements. A. Based on observation, interview and record review the facility failed to reposition a resident timely, prevent cross contamination during wound care, provide the correct wound treatment, complete skin assessments timely, update a resident's care plan with pressure sore interventions, provide wound supplements, obtain ordered laboratory tests timely, and implement care plan interventions for pressure sore care and prevention for one (R4) resident of five residents reviewed for pressure sores. These failures resulted in R4 obtaining 18 separate facility acquired Pressure Sores from January 2025 through September 2025. R4 currently has five facility acquired Stage 4 Pressure Sores and two facility acquired Stage 2 Pressure Sores. The immediate jeopardy began on 8/19/25. V1, Administrator was notified of the Immediate Jeopardy on 9/26/25 at 3:23PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 9/26/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. B. Based on observation, interview and record review the facility failed to provide a timely initial assessment of R2's Left Ischium Stage 4 Pressure Ulcer, failed to identify R2's Coccyx Stage 2 Pressure Ulcer, failed to transcribe and provide physician ordered wound supplements and dressing changes and failed to prevent cross contamination during pressure ulcer care. The facility failed to update resident care plans with wound interventions and failed to prevent infections for R2 and R4. R2 obtained a Left Ischium Stage 4 Pressure Ulcer and a Coccyx Stage 2 Pressure ulcer at the facility. R2's Left Ischium Stage 4 facility acquired infected Pressure Ulcer and R13's Right Great Toe Stage 4 facility acquired Pressure Ulcer requires Antibiotic treatment and Contact Isolation. These failures affect two of five residents reviewed for Pressure Ulcers in a sample list of 14 residents. Findings include:A. R4's Electronic Medical Record (EMR) documents R4's medical diagnoses as fusion of the spine-lumbar region, spondylolisthesis, Parkinson's disease without dyskinesia, hypokalemia, anemia, vascular dementia, Escherichia coli, methicillin-susceptible Staphylococcus aureus infection, disorders of muscle, dysphagia- oropharyngeal phase, difficulty in walking, abnormal posture, reduced mobility, and pressure ulcers of the right buttock, left hip, sacrum, and left ankle.R4's Minimum Data Set (MDS), dated [DATE], documents R4 as severely cognitively impaired. This same MDS notes R4 as being completely dependent on staff for assistance with eating, oral hygiene, toileting, dressing, personal hygiene, and bed mobility.R4's Care Plan intervention, dated 11/23/2024, instructs staff to complete weekly treatment documentation including measurements of each area of skin breakdown's width, length, depth, type of tissue, exudate, and any other notable changes or observations. This same Care Plan, initiated 11/19/2024, does not include a focus area, goal, nor interventions due to R4 being placed on contact isolation for his wound infection. It also does not include R4's Stage 4 sacral pressure ulcer; Stage 4 left lateral ankle pressure ulcer; Stage 4 right upper shin pressure ulcer; Stage 4 left lower medial knee pressure ulcer; or Stage 2 left inner buttock and right hip pressure ulcers. R4's Care Plan intervention dated 2/27/25 instructs staff to follow facility policies and protocols for the prevention and treatment of skin breakdown.R4's Pressure Ulcer Risk Assessment, dated 8/28/25, documents R4 as being at high risk for developing a pressure ulcer. R4's tasks do not include a turning schedule.R4's Pressure Report, dated 7/25/25, documents a facility-acquired left inner buttock Stage 2 pressure ulcer measuring 1.5 centimeters (cm) long by 0.8 cm wide with non-measurable depth.R4's Skin Condition Report, dated 8/19/25, documents a newly acquired coccyx pressure ulcer. This same report does not document the size, drainage, redness, signs of infection, and/or odor of R4's coccyx pressure ulcer.R4's Skin Condition Report, dated 8/27/25, documents a Stage 2 left inner buttock pressure ulcer. This same report does not document the size, drainage, redness, signs of infection, and/or odor of R4's left inner buttock pressure ulcer.R4's Physician Order Sheet (POS), dated September 2025, documents physician orders as follows:7/25/25: For R4's left inner buttock Stage 2 facility-acquired pressure ulcer-cleanse the wound, apply skin protectant, and cover with hydrocolloid dressing daily and as needed.9/12/25: Reposition R4 frequently while in bed.9/12/25: Meropenem intravenous solution reconstituted 1 GM every eight hours for twelve days, related to an unstageable sacral pressure ulcer. The same POS also documents an order to administer sulfamethoxazole-trimethoprim oral tablet 800-160 mg twice daily, related to Escherichia coli as the cause of methicillin-susceptible Staphylococcus aureus (MSSA) infection, for 11 days 9/13/25: Right hip Stage 2 pressure ulcer-cleanse with

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review the facility failed to sufficiently staff Certified Nursing Assistants (CNAs). This failure affects all 83 residents in the facility. Findings include:On 10/1/25 between 10:30AM and 11:04AM there were a total of 7 CNAs working in the facility; 3 on the East wing, 2 on the Middle wing, and 2 on the [NAME] wing.The facility's Resident Council Meeting Minutes dated 6/30/25, 7/29/25, 8/26/25, and 9/29/25 document concerns regarding call light response times, water not being passed in the evenings, and showers not being given on scheduled shower days. The facility's Facility Assessment Tool dated 2/26/25 documents the facility has 90 licensed beds but does not identify their average daily census. This assessment documents the facility has an average of 10-15 residents with stage three or stage four pressure ulcers. This assessment documents the facility's staffing plan includes eight CNAs on dayshift and six CNAs on nights. The facility's Daily Staffing Sheets dated 9/14/25-10/1/25 document 16 day shifts had less than 8 CNAs and 11 night shifts had less than 6 CNAs. On 10/1/25 between 10:37 AM and 10:57 AM the following staff were interviewed: V38 CNA confirmed there were 7 CNAs currently working in the facility, 3 CNAs on East, 2 on Middle, and 2 on West. V14 Registered Nurse stated the facility needs 4 CNAs on East, 2 on Middle and 2 on West. V14 stated at times they have to pull a CNA from the East wing to make 2 CNAs on each hall, and the resident rooms have to be divided up between the CNAs, which doesn't seem to be enough staff. V36 CNA stated there is suppose to be 4 CNAs on East, 2 on Middle and 2 on West, but about 35% of the time we work with less than that with only 2 on each unit. V36 stated we have to help each other with the mechanical lifts and call light response is also affected. V37 CNA stated sometimes we work with 6 CNAs on day shift, which is considered short staffed, we are suppose to have 8. V37 stated when that happens we are assigned to 15 residents, showers get missed, and it affects our ability to reposition residents every two hours. V37 stated V37 doesn't feel like one CNA for middle wing is enough for night shift, sometimes the heavy wetters are soaked in the morning when V37 reports to work. V28 CNA stated there are suppose to be 4 CNAs on East, 2 on Middle and 2 on West; sometimes that is not what we are staffed with due to call offs and two employees recently quitting. V28 stated management tries to get people to come in when there are call offs and V28 often gets calls on her days off asking if she is able to come in to work. V28 stated when there are less than 8 CNAs on day shift, it is harder to get to call lights quickly and residents have to wait while we find help to assist with transferring them out of bed. V28 stated we try to stay on top of repositioning residents, but it depends on the day and sometimes it is closer to 3 hours between repositioning. On 10/1/25 at 12:04 PM V2 Director of Nursing stated currently we staff 8 CNAs on day shift, 4 on East, 2 on Middle and 2 on West. V2 stated night shift is staffed with 6 CNAs, 2 on each unit. V2 stated we recently changed night shift staff to have four CNAs for 12 hours and two that work 6-10PM. V2 stated recently the CNAs said that wasn't working so now we are doing five for 12 hour shifts. V2 stated the facility's average census is 70-80. V2 reviewed the 9/14/25-10/1/25 staffing sheets and confirmed they accurately reflect the CNA staffing, which does not match the staffing plan as outlined in the facility assessment. On 10/1/25 at 12:58 PM V2 provided a resident list report dated 10/1/25 with a total of 41 resident names highlighted residents. V2 confirmed the highlighted residents are those that require two person staff assist for transfers/cares. This list documents the facility's census of 83 residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to ensure a medication error rate of less than 5%. A full medication administration observation was completed with three errors out of 28 opportunities resulting in a 10.7% medication error rate. This failure affects one (R11) resident out of seven residents reviewed for medication administration in a sample list of 14 residents. Findings include:R11's Physician Order Sheet (POS) dated September 2025 documents physician orders starting 4/15/25 with no end date to administer Sertraline 175 mg daily, 3/22/25 with no end date to administer Calcium 600 milligrams (mg) + Vitamin D3 20 micrograms (mcg) daily and 7/28/25 with no end date to administer 175 micrograms (mcg) Levothyroxine. This same POS also has a physician order to administer Levothyroxine 225 mcg from 9/11/25-9/18/25 and Levothyroxine 175 mcg from 9/19/25-9/29/25. R11's Medication Administration Record (MAR), dated September 2025, documents that R11 was administered Levothyroxine 225 mcg at 8:00 AM and another dose of Levothyroxine at 8:00 AM (totaling 450 mcg) from 9/11/25 to 9/18/25. The same MAR shows that R11 was administered Levothyroxine 175 mcg at 6:00 AM and another 175 mcg at 8:00 AM (totaling 400 mcg) from 9/19/25 to 9/21/25.R11's Laboratory (Lab) Results Report, dated 9/11/25, documents R11's Thyroid Stimulating Hormone (TSH) level as abnormal, with a result of 0.26 micro-international units per milliliter (uIU/mL). The report states the normal range for TSH is 0.34-4.82 uIU/mL.R11's Nurse Progress Notes, dated 9/21/25 at 4:46 PM, document that R11 had two Levothyroxine (Synthroid) orders: 175 mcg and 225 mcg. The same note confirms the facility consulted V19, the Medical Director, who issued a new order to discontinue the 225 mcg Levothyroxine and continue R11's 175 mcg daily dose.On 9/21/25 at 8:55 AM, V10, Registered Nurse (RN), administered R11's scheduled medications. V10 administered R11's Sertraline 150 mg, Levothyroxine 225 mcg, and Calcium 600 mg + Vitamin D3 50 mcg.On 9/21/25 at 11:00 AM, V10, Registered Nurse (RN), confirmed she had administered incorrect doses of Sertraline, Levothyroxine, and Calcium + Vitamin D3 to R11. V10 stated she thought she had everything but made a few errors. V10 also stated she would be more careful in the future.On 9/22/25 at 3:00 PM, V2, Director of Nurses (DON), stated that residents are expected to receive all of their prescribed medications as ordered. V2 further stated that any medication not administered-whether due to error or omission-must be reported to the physician and the resident's family.The undated facility policy titled Medication Administration General Guidelines documents the five rights-right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: 1. When the medication is selected, 2. When the dose is removed from the container and finally 3. Just after the dose is prepared and the medication is put away. Check #1 select the medication-label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the five rights. Check #2 Prepare the dose-the dose is removed from the container and verified against the label and the MAR by reviewing the five rights. Check #3 Complete the preparation of the dose and re-verify the label against the MAR by reviewed the five rights. Medications are administered in accordance with written orders of the prescriber.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain Contact Isolation Precautions for one (R4) resident out of four residents reviewed for Infection Control in a sample list of 14 residents.Findings include:R4's Electronic Medical Record (EMR) documents the following medical diagnoses: fusion of the spine (lumbar region), spondylolisthesis, Parkinson's disease without dyskinesia, hypokalemia, anemia, vascular dementia, Escherichia coli, methicillin-susceptible Staphylococcus aureus infection, disorders of muscle, dysphagia (oropharyngeal phase), difficulty in walking, abnormal posture, reduced mobility, and pressure ulcers on the right buttock, left hip, sacrum, and left ankle.R4's Minimum Data Set (MDS), dated [DATE], documents R4 as severely cognitively impaired. The same MDS notes that R4 is completely dependent on staff for assistance with eating, oral hygiene, toileting, dressing, personal hygiene, and bed mobility.R4's Physician Order Sheet (POS), dated September 2025, includes a physician order starting on 9/18/25 to place R4 on contact isolation precautions due to a wound infection.On 9/20/25 at 2:45 PM, a sign reading Contact Isolation was posted on R4's room door. Personal protective equipment (PPE) supplies-including masks, gowns, and gloves-were hanging on the door.On 9/20/25 at 2:50 PM, V9 (Licensed Practical Nurse, LPN) and V10 (Registered Nurse, RN) completed pressure ulcer care for R4's sacrum, right ischium, right buttock, left inner buttock, and right hip. Prior to entering R4's room, V9 stated she was entering without PPE to sanitize the bedside table. She entered the room without donning a gown or gloves and used her bare hands to turn the bedside table around twice to clean the top surface. V9 then exited the room without washing her hands or performing hand hygiene and arranged R4's dressing supplies on top of the treatment cart outside the door.On 9/21/25 at 1:15 PM, V2 (Director of Nurses, DON) stated that staff must ensure contact isolation precautions are maintained. V2 confirmed that staff should wear appropriate PPE-specifically a gown and gloves-when entering the room of any resident on contact isolation. V2 also confirmed that V9 contaminated the wound supplies, which were later used on R4's multiple infected pressure ulcers.The facility policy titled Infection Precaution Guidelines, revised May 15, 2023, states that contact precautions are to be used for residents known or suspected to be infected with microorganisms that can be easily transmitted through direct or indirect contact, such as handling environmental surfaces or resident care items.