

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/26/2025
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)		
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the security and proper accounting of a controlled substance (Ativan) for R1. This failure affected one of three residents (R1) reviewed for abuse in the sample of three. This past non-compliance occurred from 8/30/25 to 11/24/25. Findings Include: R1's Facility census documents R1 was admitted to the facility on [DATE] and has the following medical diagnoses; Hospice, Hemiplegia and Hemiparesis, Type 2 Diabetes, COPD, Chronic Respiratory Failure with Hypoxia, Cerebrovascular Disease, Major Depressive Disorder, Obstructive and Reflux Uropathy, Retention of Urine, Obesity, Presence of Urogenital Implants, Delusional Disorders, Presence of Cardiac Pacemaker, Mood [Affective] Disorder, Vascular Dementia, HTN, GERD, Heart Disease, Chronic Kidney Disease Stage 3 and Anxiety Disorder. R1 Minimum Data Set (MDS) dated [DATE] documents R1 Brief Interview for Mental Status (BIMS) score 10, moderate cognitive impairment and received antianxiety medications the last 7 days. R1's Physician Order Sheet dated 8/6/25 documents Lorazepam Oral Concentrate 2 milligram/milliliter, give 0.25 milliliters by mouth every 3 hours as needed for restlessness or anxiety. R1's Physician Order Sheet dated 8/6/25 documents Lorazepam Oral Concentrate 2 milligram/milliliter, give 0.25 milliliters by mouth every 3 hours as needed for restlessness or anxiety. Pharmacy Deliver Form dated 8/8/25 documents manifest ID# 5449229/001-R1-Lorazepam concentrate 2 milligram/milliliter x 30 doses. Delivered. Pharmacy Deliver Form dated 8/19/25 documents manifest ID# 5456952/001-R1-Lorazepam concentrate 2 milligram/milliliter x 30 doses. Delivered. V5 Licensed Practical Nurse Witness Statement dated 9/4/25 documents on 8/30/25 that V5 conducted a narcotic medication count on the 2 East medication cart with V3 Registered Nurse the oncoming nurse V3 asked V5 about the other Ativan in the refrigerator and V5 told V3 there was never anything in the refrigerator. There was nothing to count and only one controlled substance form for R1's Ativan that in in the medication cart. The Facilities Narcotic/ Controlled Substances-Counting Policy 11/26/27 documents: Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log. 2. Knowledge of correct response should an error be discovered in the controlled substance count. General Guidelines: Always participate in the counting of the controlled substances at the beginning and ending of your shift. Never say, go ahead without me and I'll sign later. Never leave it at someone else's discretion when you are the one on duty. If you do not observe the medications that you sign as being present, you may be implicated if the medications are missing later. On 11/25/25 at 11:42 AM V3 Registered Nurse stated that on 8/29/25 V3 worked the 6:00 AM - 6:30 PM shift. V3 stated when coming on V3 conducted a narcotic count with the nurse whose shift was ending and that R1 had one bottle (30 milliliters) of Ativan in the medication cart and one bottle in the refrigerator. V3 stated that there were 2 controlled substance forms in the narcotic book for R1's Ativan, one was started and the other blank for the bottle in the refrigerator. V3 stated that V3 passed the morning medications on the 2 East Hall, and was an extra nurse and had other duties, and gave the keys the medication cart to V6 Agency Registered Nurse who was down the east hall passing medication. V3 stated that V3 asked to conduct a narcotic count with V6 and V6 told V3 that V3 is busy. V3 stated that V3 got off of work at 6:30 PM and returned to work on 8/30/25 at 6:00 AM for (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V3's next shift. V3 stated that V3 conducted a narcotic count with V5 who's shift was ending. V3 stated that V3 asked V5 if R1's is the other bottle of Ativan was in the refrigerator and V5 became defensive and said, what don't do that to me. V3 stated that V5 said there was never another bottle of Ativan in the refrigerator and only one controlled substance form in the narcotic book. V3 stated there was not a second controlled substance form in the narcotic book, like there was yesterday morning, and there was no bottle of Ativan in the refrigerator in the locked medication room. On 11/25/25 at 2:00 PM V2 Director of Nursing Stated that on 9/1/25 V3 Registered Nurse notified V2 of a missing 30 milliliter bottle of Ativan. V2 stated that V3 informed V2 that V3 had worked on 8/29/25 from 6:00 AM to 6:30 PM and when V3 came onto work that morning V3 conducted a narcotic count with the nurse whose shift was ending. V2 stated that V3 informed V2 R1 had a bottle of Ativan open in the medication cart, and an unopened bottle in the refrigerator in the locked medication room. V2 stated that V3 informed V2 that there were 2 sheets in the narcotic book, 1 for the opened and 1 for the unopened bottle. V2 stated that V3 informed V2 that V3 passed morning medications on the East Hall and when finished gave keys to V6 Agency Registered Nurse who told V3 that V6 was busy and didn't perform a narcotic count. V2 stated that V3 further informed V2 that when V3 returned to work on 8/31/25 at 6:00 AM and conducted a narcotic count with V5 Licensed Practical Nurse that the bottle of Ativan that was in the refrigerator was gone and also the controlled substance form for the second bottle was gone. Prior to the survey date of 11/26/25, the facility took the following actions to correct the non-compliance: On 9/1/25, R1's Ativan 30 milliliter bottle was replaced by the facility. On 9/1/25, the Quality Assurance Committee developed a Plan of Correction for the 8/30/25 incident and a Performance Improvement Plan. On 9/1/25, the Director of Nursing and Administrator provided in-service education to nursing staff on Controlled Substance Policy/Count and Narcotic Destruction Policy. On 9/1/25, the facility standardized communication pathways with pharmacy on dropping off and picking up controlled medications. Starting on 9/1/25, the Director of Nursing and/or designee began auditing medication carts/medication rooms daily x 7 days a week x 6 weeks to ensure controlled substances (pills, patches and liquids) matched count sheet. The facility QAPI Committee will continue to monitor performance to ensure corrective actions related to the 9/1/25 incident are effective. Completion date of substantial compliance: 11/24/25.		