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	03/12/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement.A. Based on interview and record review the facility failed to implement diabetic care and follow physician's orders for two of three residents (R1, R3) reviewed for diabetic care in the sample list of four. This failure resulted in R3 being admitted to the intensive care unit for treatment of Diabetic Ketoacidosis. B. Based on observation, interview, and record review the facility failed to timely notify family and physician of a change in condition for one of three residents (R1) reviewed for falls in the sample list of four. This failure resulted in R1 experiencing a delay in treatment of compression fracture following a fall causing R1 increased pain and tearfulness. C. Based on observation, interview, and record review the facility failed to complete neurological assessments and assess blood glucose following falls for two of three residents (R1, R2) reviewed for falls in the sample list of 4. Findings include:The facility's Transcription of Physician's Orders policy dated 11/3/22 documents to review the hospital discharge summary, notify the physician to review and clarify orders, and enter each order in the Physician Order section of the resident's medical record. The facility's undated Hyperglycemia guideline documents to report all changes in a diabetic resident's condition immediately to the physician including loss of appetite and nausea/vomiting.The facility's Glucose Testing policy dated 11/28/12 documents to review the physician's order prior to checking blood glucose and document results on the electronic Medication Administration Record (MAR.) The facility's Physician-Family Notification-Change in Condition policy dated 10/1/25 documents to notify the family and physician timely of significant changes in a resident's physical, mental or psychosocial status, including clinical complications or a need to alter treatment significantly. A.1) On 3/9/26 at 9:33 AM V20 (R3's Family) stated R3 was hospitalized for dehydration and blood glucose prior to admitting to the facility. V20 stated R3 readmitted to the hospital on [DATE] after the facility was unable to get a blood glucose reading and R3's blood glucose was 1199 milligrams per deciliter upon arrival to the emergency room. V20 stated R3 has been a diabetic requiring insulin for 35 years and had a continuous glucose monitor to her left arm. V20 stated the monitor quit reading after R3 admitted to the facility, believed to be due to staff obtaining blood pressures on R3's left arm which damaged the sensor on the machine. V20 stated V20 did not think the facility was monitoring R3's blood glucose per R3's hospital discharge instructions. R3's Hospital Discharge Orders dated 1/22/26 documents an order for Novolog insulin subcutaneous per sliding scale three times daily, Insulin Glargine (long-acting insulin) 12 units subcutaneous every evening and to monitor R3's blood glucose often. R3's Progress Note dated 1/22/26, recorded by V18 Physician, documents R1 has history of hyperglycemia related to type 1 diabetes mellitus. This note documents R3's insulin glargine 12 units every evening, to monitor blood glucose regularly and adjust insulin dosage if necessary. R3's electronic medical record does not contain a baseline care plan to address R3's diabetes mellitus or that R3 uses a continuous glucose monitoring device.R3's physician orders dated 1/22/26-1/29/26 do not document orders for Novolog per sliding scale or to avoid obtaining blood pressure in left arm where R3's glucose monitoring device was located. R3's blood pressure log documents R3's blood pressure was obtained in left arm by V5, V21 Registered Nurses (RNs) and V23 Certified Nursing Assistant (CNA). There is no documentation (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 0684 Level of Harm - Actual harm Residents Affected - Few	as to whether the upper arm or wrist was used. R3's January 2026 MAR does not document the order for Novolog per sliding scale. This MAR does not document blood glucose was monitored three times daily prior to meals until 1/24/26. This MAR and R3's blood glucose log do not document R3's blood glucose levels on 1/24/26 at 11:30 AM and 4:30 PM. This MAR documents R3 refused scheduled bolus tube feedings on 1/23/26 at 8:00 AM and noon. R3's Nursing Note dated 1/22/26 at 5:51 PM R3 admitted to the facility after being hospitalized for dehydration and diarrhea. R3 receives bolus tube feedings and R3 vomited a moderate amount of undigested feeding upon arrival. R3's Nursing Note dated 1/22/2026 at 7:00 PM documents R3's blood glucose was 149 milligrams per deciliter and Insulin Glargine 12 units was not given due to R3's vomiting. There is no documentation a provider was notified that insulin was held. R3's Nursing Note dated 1/23/2026 at 8:41 AM documents attempted to administer bolus feedings and R3 refused. There is no documentation that R3's feeding refusals was reported to a provider. R3's Nursing Notes dated 1/23/26 at 3:27 PM and 3:31 PM document R3's blood glucose was over high/over 400 per continuous glucose monitor. Insulin Glargine 20 units and Novolog 8 units were administered per immediate orders. R3's Nursing Note dated 1/24/26 at 4:47 PM documents R3's continuous glucose monitor was not working and R3 refused to have finger poked for blood glucose check. There is no documentation a provider was notified of R3's continuous glucose meter not working and R3's refusal to have blood glucose checked. R3's Nursing Note dated 1/24/26 at 8:10 PM documents R3's blood glucose was high, physician notified, and to recheck blood glucose in one hour. R3's Nursing Note dated 1/24/26 at 11:38 PM R3's continuous blood glucose monitor was not reading, R3's blood glucose was checked and read high, physician was notified and gave orders to give Humalog 5 units. R3's blood glucose log documents R3's blood glucose on 1/25/26 was 365 at 2:26 AM and 375 at 5:45 AM. There is no documentation in R3's medical record that blood glucose was checked again until 12:00 PM. R3's Nursing Note dated 1/25/2026 at 12:00 PM documents R3's blood glucose was high, R3 was lethargic and had labored breathing. Physician notified and R3 was sent to the local emergency room.R3's Hospital emergency room Notes dated 1/25/26 document at 1:09 PM R3's bedside blood glucose was over 500 and at 2:07 PM laboratory glucose was 1194, critically high. R3 was admitted to the intensive care unit with diagnosis of Diabetic Ketoacidosis and placed on an insulin drip. On 3/9/26 at 12:44 PM V4 RN stated blood glucose checks are documented in the vitals section and MAR in the resident's electronic medical record. V4 stated V4 held R3's insulin glargine on evening of 1/22/26 due to vomiting and not having food until the next morning; V4 did not want R3's blood glucose to bottom out. V4 stated V4 doesn't give insulin if blood glucose is less than 100 and did not notify the provider to report holding R3's insulin. V4 stated the next day V4 notified V24 Nurse Practitioner of elevated blood glucose and administered additional doses of insulin. V4 stated R3 refused bolus feedings and did not report this to R3's providers. V4 and V14 RN reviewed R3's blood glucose documentation and orders and verified R3 did not have routine blood glucose checks prior to meals before 1/24/26 or orders for Novolog per sliding scale three times daily. V4 confirmed R3's hospital discharge orders included Novolog per sliding scale three times daily. On 3/9/26 at 2:59 PM V5 RN stated V5 was R3's nurse on 1/24/26 and R3 was more alert/coherent and talking. V5 stated V5 sent R3 to the hospital on 1/25/26 for lethargy, confusion, and inability to obtain blood glucose reading other than high. V5 stated R3's continuous glucose meter wasn't working on 1/24/26 and R3 refused blood glucose finger sticks. V5 stated V5 thought she reported this to R3's physician which would be documented in R3's nursing note. On 3/9/26 at 3:05 PM V6 RN stated R3 had elevated blood glucose reading high around midnight on 1/24/26, V6 notified the physician and gave an additional one-time dose of insulin. V6 stated V6 was concerned with R3's elevated blood glucose and passed on in shift report to follow up to see if R3 was getting enough insulin. V6 stated V6 checked R3's blood glucose with manual meter and was not aware that R3 had a continuous glucose monitor. On 3/11/26 between 9:39 AM and 11:17 AM the following staff were interviewed: V5 RN stated V5 did not recall which arm had R3's continuous glucose meter and this should be documented as a physician's order to avoid obtaining blood pressure (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	in that arm. V21 RN stated V21 did not recall R3 and was unsure which arm had R3's continuous glucose monitor or which armed was used for blood pressures. V22 CNA stated V22 took care of R3 and did not recall if there were any restrictions for obtaining R3's blood pressures. V22 stated typically there is a sign above the bed stating to avoid obtaining blood pressures in a certain arm, but V22 did not think there was a sign for R3. V23 CNA stated V23 did not recall R3, if R3 used a continuous glucose meter, or if R3 had any restrictions for obtaining vital signs. On 3/11/26 at 10:19 AM V3 Minimum Data Set/Care Plan Coordinator stated baseline care plans are completed by the admitting nurse. V3 reviewed R3's medical record and confirmed R3 did not have a baseline care plan that addressed R3's diabetes mellitus. V3 stated typically if a blood pressure should be avoided for one arm it is documented as a physician order and in the care plan. V3 verified there was no documentation to avoid obtaining blood pressures in R3's left arm. V3 confirmed R3's blood pressure log documents left arm but does not identify if this was upper arm or wrist. On 3/11/26 at 1:37 PM V18 Physician stated V18 has no prior knowledge of resident history, V18 relies on the hospitals to have accurate medication lists, and V18 tells the nurses to continue the hospital orders. V18 stated staff should have reported R3's continuous glucose meter was not working and R3's refusals of blood glucose checks. V18 stated R3's hospital orders for Novolog per sliding scale three times daily should have continued as ordered and elevated blood glucose can lead to Diabetic Ketoacidosis. V18 confirmed this contributed to R3's rehospitalization. V18 stated it might have changed things if R3's blood glucose was monitored with Novolog sliding scale ordered three times daily.The continuous glucose monitoring device User Manual dated January 2025 documents pressure on the sensor can affect blood glucose readings. 2.) R1's January 2026 MAR documents to administer Insulin Glargine 6 units every evening with 12 doses not administered. This MAR documents blood glucose checks three times daily and insulin aspart 5 units given three times daily, hold for blood glucose less than 110. This MAR documents 28 doses of insulin aspart weren't given when blood glucose was greater than 110. There is no documentation in R1's medical record that V18 was notified that R1's insulin was held on these dates. R1's February 2026 MAR documents Insulin Glargine held three times and Insulin Aspart 5 units held 19 times with no documentation that V18 was notified. There is no active order after R1 readmitted to the facility on [DATE] to hold Insulin Aspart 5 units for blood glucose less than 110. R1's March 2026 MAR document Insulin Glargine held on 3/1/26 and Novolog 5 units scheduled three times daily, held for nine doses. There is no documentation that V18 was notified of R1's insulin being held on these dates. On 3/11/26 at 1:37 PM V18 stated this is the first V18 heard that staff are holding long-acting insulin. V18 stated V18 does not order parameters to hold long-acting insulin since it has a longer onset time. V18 stated V18 gives orders to hold short acting insulin if blood glucose below 110. V18 stated staff should report any time they hold insulin outside of the ordered parameters.On 3/11/26 at 10:04 AM V2 Director of Nursing confirmed there was no documentation to provider notification for R1's held insulin for the dates listed. At 10:50 AM V2 confirmed R1 does not have an active order to hold short acting insulin. V2 stated staff implemented R1's hospital discharge orders and V2 will need to clarify the prior hold order with V18. B.) On 3/9/26 at 8:45 AM R1 stated R1 stated R1 recently fell and broke her collar bone/neck and has to wear a brace when out of bed. R1 stated R1's pain was initially tolerable but then got worse and R1 was sent to the hospital a couple days after the fall. On 3/9/26 at 10:13 AM V9 Certified Nursing Assistant (CNA) applied a brace to R1's torso and stood pivot transferred R1 from the bed to the wheelchair. R1's Minimum Data Set, dated [DATE] documents R1 has severe cognitive impairment and requires substantial/maximal staff assistance for chair/bed/toilet transfers. This assessment documents R1 did not receive any scheduled or as needed (PRN) pain medications or have indicators of pain within the last five days. R1's Unwitnessed Fall Report dated 2/14/26 at 4:30 PM, recorded by V14 Registered Nurse (RN), documents R1 was found sitting on the floor of the bathroom on the Middle Hall. R1 was assessed with no injuries noted and R1 was transferred back into her wheelchair. This report includes an untimed note dated 2/16/26, recorded by V12 Licensed Practical Nurse (LPN), documenting R1 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	complained of lower back pain and was in tears crying after scheduled Tylenol was given. V24 Nurse Practitioner was notified and gave orders for lumbosacral x-ray and Ibuprofen 600 milligrams (mg) every 8 hours as needed for 7 days. There is no documentation R1's pain and new orders were reported to V17, R1's Family. This report includes an untimed note dated 2/17/26 by V12, which documents x-ray results received, and findings showed L1 compression deformity, V24 and V17 were notified, and R1 was transferred to the hospital. R1's February 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) document R1's twice daily pain rating as 0 on 1-10 scale 2/1/26-2/14/26. R1's pain was rated a 2 on night shift on 2/14/26 and 8 on day shit on 2/15/26. This MAR/TAR documents R1 did not receive any scheduled pain medication prior to readmitting from the hospital on 2/20/26 and only received PRN Tylenol 600 mg once on 2/15/26 at 8:56 AM for pain rated 8. This MAR does not document doses of Ibuprofen were given or follow up pain ratings after this medication was given. R1's Nursing Notes do not document R1's back pain and new orders for x-ray and Ibuprofen were reported to V17 prior to hospital transfer on 2/17/26. R1's Nursing Notes do not document R1's new onset of back pain following R1's fall was reported to a provider prior to 2/16/26. R1's lumbosacral x-ray dated as obtained 2/16/26 at 12:00 PM and resulted 2/17/26 at 7:52 AM, documents an L1 compression deformity. R1's Computed Tomography of Lumbar Spine dated 2/17/26 documents R1 has back pain following a fall and findings showed acute fractures of the right inferior and lateral L3 vertebral body, worsening compression deformity of L1, and chronic compression deformity at L5. R1's Hospital Neurosurgery Progress Note dated 2/19/26 documents medical and pain management per primary team and to wear thoracic-lumbar-sacral orthosis brace for comfort as needed. On 3/9/26 at 11:57 AM V14 RN stated V14 kept asking R1 about her pain the night of R1's fall and R1 later reported her lower back started to hurt, but R1 was still able to twist and turn without hurting. V14 stated V14 notified V18 Physician of R1's fall and initial pain and told V18 that V14 would follow up if an x-ray was needed. V14 stated V14 was going to wait and see how R1's pain was the next day, but the next day V14 was reassigned to a different hallway. On 3/9/26 at 2:53PM V7 LPN stated V7 is an agency nurse and R1's fall was passed on in report. V7 stated when the CNAs got R1 up on the morning of 2/15/26 R1 complained of back pain. R1 was resting her head while leaning forward, her body language signaled pain. V7 confirmed V7 documented R1's pain rated 8 and Tylenol administration that morning. V7 stated the CNAs reported R1 had been complaining of back pain frequently, but was unsure if that was R1's norm or following R1's fall. V7 confirmed V7 did not report R1's pain to R1's family or physician. On 3/11/26 at 12:39 PM V17 stated the facility notified her when R1 fell but then there was no follow up until staff told her that R1 was going to the hospital. V17 stated V17 was not aware R1 had pain or x-ray orders. On 3/11/26 at 1:28 PM V12 LPN stated R1 complained of back pain on 2/16/26 after R1 was gotten up. V12 stated R1 has occasional complaints of back pain prior, but this pain was different. V12 stated R1 was gotten up for lunch and was tearful and crying, complaining of back pain, V12 had staff transfer R1 back to bed, and V12 contacted V24 to obtain orders for x-ray and Ibuprofen PRN. V12 stated V12 gave Ibuprofen at 1:00 PM and all of this should be documented in the risk management report. V12 stated the next day R1 was also tearful the next day and V12 had to contact the x-ray company to obtain R1's results which were received at 8:00 AM and showed a compression fracture. V12 stated V12 had not given R1 any pain medication on 2/17/26 and night shift had passed on in report that R1 was fine during the night, pain was only noted with movement. \On 3/11/26 at 1:37 PM V18 Physician stated V18 was notified of R1's fall. V18 confirmed staff should have reported R1's new onset and increased pain when identified and since the onset of pain was within 24 hours of the fall the compression fracture is believed to be caused from the fall. V18 stated V18 would have ordered x-rays sooner, Lidocaine patch and Norco for pain relief if V18 was notified. V18 stated with compression fractures the focus is on pain relief and kyphoplasty helps with that but R1 was not a surgical candidate. V18 stated compression fractures need time to heal to improve pain management.On 3/12/26 at 9:03 AM V2 Director of Nursing reviewed R1's February MAR/TAR and confirmed Ibuprofen administration and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	post pain assessments were not documented. C.1) R1's Unwitnessed Fall Report dated 2/14/26 at 4:30 PM, recorded by V14 Registered Nurse (RN), documents R1 was found sitting on the floor of the bathroom on the Middle Hall. R1's February 2026 Medication Administration Record (MAR) documents R1 received Aspirin 81 milligrams daily 2/1/26-2/16/26. R1's post fall neurological assessments dated 2/14/26 at 4:30 PM, 4:45 PM, 5:00 PM, 5:15 PM, 5:45 PM, 6:15 PM, 6:45 PM, 7:15 PM, 11:15 PM and 2/15/26 at 3:15 AM all document the same set of vital signs and indicate these vitals were obtained on 2/14/26 at 4:30 PM. On 3/11/26 at 11:37 AM V14 stated neurological assessments are documented electronically in the resident's record and completed every 15 minutes x4, then every 30 minutes x4, then every 4 hours x8 with vital signs taken each time and documented on the assessment form. V14 reviewed R1's neurological assessments dated 2/14/26 and confirmed all have the same recorded vital signs dated as taken at 4:30 PM. V14 stated V14 did not document the vital signs anywhere else other than possibly on a scratch piece of paper which V14 no longer has. The facility's undated Neurological Assessment policy documents to observe, assess and document vital signs with neurological checks as ordered, with changes in condition, and after head injury every 15 minutes for one hour, every 30 minutes for two hours, then every four hours for 24 hours and then every shift for 48 hours. 2) R2's care plan dated 10/23/25 documents R2 has Diabetes Mellitus and includes an intervention to monitor/document/report any signs of hypoglycemia including staggering gait and lack of coordination. This care plan documents R2 is at risk for bleeding complications related to anticoagulant use and to monitor for signs of bleeding. R2's Hospital Discharge summary dated [DATE] documents R2 was treated for a Subdural hematoma and Subarachnoid hemorrhage (brain bleed) following a prior fall. R2's February 2026 MAR documents R2 received Eliquis (blood thinner) twice daily from 2/18/26 until 2/26/26. R2's March 2026 MAR documents R2 receives short acting insulin three times daily per sliding scale at 6:30 AM, 12:00 PM, and 5:00 PM. R2's blood glucose was 124 at 5:00 PM on 3/4/26. R2's Witnessed Fall Report dated 3/4/26 at 5:30 PM, recorded by V15 Licensed Practical Nurse, documents a certified nursing assistant (V8 CNA) heard R2 yell from across the hall and witnessed R2 attempt to self-transfer into bed and fall. There is no documentation that R2's blood glucose was evaluated at the time of the fall or that neurological assessments were initiated. On 3/9/26 at 3:19 PM V8 stated R2 had a recent fall where R2 slid out of bed. V8 was next door and heard a crash. V8 found R2 on the floor. On 3/11/26 at 11:20 AM V15 stated V15 did not check R2's blood glucose when R2 fell since R2 was alert and skin wasn't cool and clammy. V15 stated that is a good idea when asked if blood glucose is assessed as part of post fall assessments for diabetics. V15 stated post fall neurological assessments weren't implemented for R2's fall since V15 thought V8 witnessed R2's fall. On 3/11/26 at 2:54 PM V2 Director of Nursing stated neurological assessments should be initiated for any unwitnessed falls.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement and care plan fall interventions, accurately complete fall risk assessments, and thoroughly investigate falls for three of three residents (R1, R2, R4) reviewed for falls in the sample list of four. Findings include: The facility's Fall Prevention Program dated 11/28/12 documents a fall risk assessment will be completed quarterly and for any falls, safety interventions will be implemented for at risk residents and fall interventions will be identified on the care plan. This policy documents fall reports will be reviewed to ensure appropriate care and services were provided and to determine possible safety interventions. This policy documents interventions may include prompt call light response, residents who require staff assistance will not be left alone for toileting/showering, and toileting assistance as care planned. This policy documents residents will be checked approximately every two hours or according to their care plan to assure they are in a safe position. 1.) R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact and requires supervision/touch assistance from staff for transfers. R2's active care plan documents risk for falls and use of bed and chair alarms as of 3/5/26. R2's Fall Risk Assessments dated 2/12/26 and 3/4/26 document R2 is not at risk for falls and R2 is ambulatory. These assessments incorrectly document R2 uses 1-2 of the following medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, and Sedative/Hypnotics. R2's February and March 2026 Medication Administration Records (MARs) document R2 received Cetirizine Hydrochloride, Flonase allergy relief, Gabapentin, Lasix, Lexapro, Lisinopril, Melatonin, Seroquel, Carvedilol, Glipizide, Metformin, and Humalog insulin, all medications in the drug classifications listed in the fall risk assessment. R2's Fall Report dated 2/12/26 at 3:00 AM documents R2 was found lying on her stomach on the floor. There was blood on the floor and tray table leg from R2 hitting her head on the tray table. R2 said R2 was trying to go to the bathroom and tripped over her wheelchair. The fall investigation for this fall does not include staff statements or interviews that identify when R2 was last observed by staff or toileted prior to the fall. R2's Fall Report dated 3/4/26 at 5:30 PM documents R2 was heard yelling help and slid off the bed onto her buttocks after attempting to self-transfer. R2 reported R2 was trying to transfer into bed. The fall investigation for this fall does not document staff interviews or statements that identify when R2 was last observed or toileted prior to the fall. The interdisciplinary team note dated 3/5/26 documents bed and chair alarms as the new intervention. On 3/9/26 at 11:20 AM R2 was sitting in her room in a recliner that did not have an alarm. At 11:38 AM R2 was still in the recliner with no alarm in place. V10 Certified Nursing Assistant (CNA) entered room and confirmed there was no alarm in R2's recliner. and V10 had assisted R2 into the recliner. V10 stated V10 was unsure if R2 needed the alarm in her recliner or only need the alarm in her wheelchair, and V10 will need to clarify this with the nurse. At 11:41 V26 Licensed Practical Nurse (LPN) stated R2 should have an alarm in the recliner and the CNAs have access to the Kardex which documents fall interventions. On 3/11/26 at 2:54 PM V2 Director of Nursing confirmed all the documentation was provided for R2's fall investigations and it does not identify when R2 was last observed or toileted prior to the falls. On 3/12/26 at 9:03 AM V2 stated R2 only walks short distances and prefers to use the wheelchair. V2 reviewed R2's fall risk assessments and MARs and confirmed the assessments do not accurately reflect R2's ambulation status and medications. 2.) On 3/9/26 at 10:13 AM V9 CNA applied R1's torso brace and transferred R1 from bed to wheelchair. There was a chair alarm in R1's wheelchair. R1's MDS dated [DATE] R1 has severe cognitive impairment, is always incontinent of bowel and bladder, and requires substantial/maximal staff assistance for chair/bed/toilet transfers. R1's Fall Report dated 2/14/26 at 4:30 PM documents R1 was found on the floor of the Middle Hall bathroom. R1 reported that R1 was trying to go to the bathroom. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interdisciplinary team note dated 2/16/26 documents R1 has increased wandering and self-transferred to the toilet and was found on the floor in front of the toilet. R1's hospital computed tomography showed a fracture of L1 vertebrae. The fall investigation for this fall includes three staff statements, V27 Registered Nurse (RN), V14 RN and V13 CNA. V13's statement documents V13 toileted R1 after lunch between 1:30-2:00 PM and brought R1 to the dining room for coffee and activities. There is no documentation if R1 was observed after this prior to the fall, or if staff were asked if anyone had transferred R1 onto the toilet to determine if R1 was possibly left unattended in the bathroom. The facility's daily staffing sheet dated 2/14/26 documents eight CNAs and three nurses were working in the facility at the time of R1's fall. R1's Nursing Note dated 2/16/26 documents R1 had a chair alarm. R1's active care plan documents R1's incontinence with interventions to toilet before/after meals, upon rising, and before bed; check and change frequently. R1's Care Plan does not include the use of a chair alarm. On 3/9/26 at 10:05 AM V11 CNA stated V11 was not aware of any details regarding R1's fall. V11 stated R1 has poor cognition, is dependent on staff for transfers and does not attempt to self-transfer.On 3/9/26 at 11:57 AM V14 RN stated V25 Laundry Aide found R1 on the floor of the middle hallway bathroom across from the nurse's station. V14 stated R1 does not attempt to self-transfer or take herself to the bathroom, so this was odd. There were no CNAs around and V27 RN was passing medications on that hall. V14 stated V13 was R1's assigned CNA that day. None of the staff on the middle hall were aware that R1 was there. V14 stated V14 had last seen R1 in the dining room approximately 15 minutes prior. V14 stated V14 had not asked any staff if they had transferred R1 onto the middle hall toilet. On 3/9/26 at 12:18 PM V28 CNA stated prior to R1's fall V28 had last seen R1 that day in the dining room sometime after lunch. V28 stated V28 was working the middle hallway and had not seen R1 on the hall. V28 stated R1 does not attempt to self-transfer. On 3/9/26 at 3:19 PM V8 CNA stated R1 was found on the floor of the bathroom on the middle hall and V8 was working that hallway the day R1 fell. V8 stated V8 wanders to the middle hallway, but V8 had not seen R1 on that hall or in the bathroom prior to her fall. On 3/11/26 at 12:15 PM V5 RN stated R1 has used a chair alarm for a long time, even prior to R1's recent fall. On 3/11/26 at 2:54 PM V2 confirmed all documentation was provided for R1's fall investigation, including staff interviews/statements. V2 stated R1 wandered to the middle hall bathroom and attempted to self-transfer and that bathroom is unlocked for resident use and the door does not have to be kept closed. V2 stated the new intervention was increased bathroom breaks. On 3/12/26 at 10:04 AM V2 stated V2 looked in R1's medical record back to 2024 admission and can't find any documentation that R1 has used bed or chair alarms prior to recent fall. V2 confirmed R1's chair alarm should have been added to R1's care plan prior to 3/9/26 since staff documented chair alarm was used as a post fall intervention. 3.) R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, is dependent on staff for toileting and transfers, and is always incontinent of bowel and bladder. R4's Care Plan dated 10/3/25 documents R4's incontinence with intervention to check and change frequently. R4's Fall Risk Assessments dated 2/1/26 and 2/23/26 incorrectly documents R4 receives one or two of the following medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, and Sedative/Hypnotics. R4's February 2026 MAR documents R4 received Norvasc, Lasix, Mirtazapine, Seroquel, and Effexor; all medications that fall into the drug classifications listed on the fall risk assessment. R4's Unwitnessed Fall Report dated 2/1/26 at 6:30 PM documents R4 was found on the floor in her room on the fall mat and R4 had somehow dragged her body near the closet. R4 reported seeing children as the reason she attempted to get out of bed. The fall investigation for this fall does not document staff interviews or statements identifying the last time R4 was checked on or toileted prior to the fall. R4's Witnessed Fall Report dated 2/23/26 at 5:00 PM documents R4 slipped out of bed to the floor while CNA was in the room. V28's (CNA) Statement dated 2/23/26 documents V28 was with R4's roommate and saw R4 slipping out of bed. V28 went to R4 and braced R4 as she slid to the floor on the mat. The fall investigation for this fall does not document when R4 was last checked (continued on next page)

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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	620 Warrington Avenue Danville, IL 61832

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on or toileted prior to the fall. On 3/11/26 at 2:54 PM V2 confirmed all documentation for R4's fall investigations were provided. V2 confirmed no documentation on when R4 was last checked on or toileted prior to the falls. On 3/12/26 at 10:04 AM V2 reviewed R4's fall risk assessments and MARs, and confirmed the assessments do not accurately reflect medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician's orders which resulted in repeated significant medication errors for one of three residents (R2) reviewed for medication errors in the sample list of four. Findings include:The facility's Transcription of Physician's Orders policy dated 11/3/22 documents to review the hospital discharge summary and review/clarify the orders with the physician. This policy documents to discontinue previous orders when medication orders change. On 3/9/26 at 8:55 AM R2 stated she had two recent falls. R2 stated during the first fall R2 hit her and on the table and had to go to the hospital where they had to remove the blood; and R2 pointed to her left temple that had dark bruising and scab. R2's care plan dated 10/23/25 documents R2 is at risk for bleeding complications related to anticoagulant use and includes interventions to administer medications as ordered and monitor for signs of bleeding. R2's Hospital Discharge summary dated [DATE] documents R2 was treated for a Subdural hematoma and Subarachnoid hemorrhage (brain bleed) following a prior fall. This summary documents neurosurgery would like to hold aspirin and any antiplatelet/anticoagulant medications until seen again in two weeks with repeat imaging scans. Eliquis (blood thinner) is not listed as part of R2's active hospital discharge orders.R2's February 2026 Medication Administration Record (MAR) documents R2 received Eliquis 5 milligrams (mg) twice daily 2/3/26- 2/11/26 and evening of 2/18/26 through morning of 2/26/26. R2's March 2026 MAR documents R2 received one dose of Eliquis 5 mg on 3/8/26 and 3/9/26, with the medication being on hold 3/1/26-3/7/26 and after 3/9/26. R2's Progress Note dated 2/26/26, recorded by V18 Physician, documents to continue to hold Eliquis until re-evaluated by neurosurgery. R2's Neurosurgery Progress note dated 3/4/26 documents R2's brain bleed was resolved and recommends V18 discusses prescribing Eliquis when reaching a point where there are higher fall risks and events and the risks and benefits of being on a blood thinner should be discussed. This is an individual discussion with each person who comes to their own decision based on the individual's risks, benefits, philosophies, and quality of life. On 3/11/26 at 1:37 PM V18 stated R2's Eliquis should have been held when R2 readmitted to the facility. V18 stated this was already identified and V18 addressed this with V2 Director of Nursing. At 2:21 PM V18 stated R2 followed up with neurosurgery and V18 needs to talk extensively with R2's family to determine if Eliquis should be resumed, V18 is hesitant to resume this medication due to R2's fall risk and increased falls. On 3/11/26 at 2:54 PM V2 Director of Nursing stated R2's Eliquis order was initially missed when cross referencing prior orders with hospital discharge orders. V2 stated R2's Eliquis was resumed for two doses in March due to the hold order being entered with a five-day duration. V2 stated V2 identified this when she ran the report the following morning, V2 notified V18 who said to continue to hold the medication until V18 speaks with R2's family.