STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLDWATER CARE DANVILLE	620 WARRINGTON AVENUE DANVILLE, IL 61832

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S 000	Initial Comments Investigation of Facility Reported Incident of July 30, 2023/IL162822	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All	S9999		

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S9999	Continued From page 2 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to re-evaluate a resident's transfer status (R1) and utilize a gait belt to safely transfer a resident (R2). This resulted in R1 sustaining a laceration that required 10 sutures to close the wound and R2 sustaining a fall that resulted in fractures of the right medial and lateral malleolus (ankle). The facility also failed to accurately assess fall history and fall risk, develop, and implement fall interventions, and thoroughly investigate falls for R2 and R3. R1, R2, and R3 are three residents reviewed for falls in the sample list of three. Findings include: 1.) The facility's Report to Illinois Department of Public Health documents on 7/30/23 at 9:45 AM R1 sustained a laceration of the right leg during a transfer. R1 was sent to the emergency room and received 10 sutures. This report documents the cause of R1's laceration was R1 bumped R1's right leg on the bracket of R1's wheelchair during a transfer. R1's Emergency Room Provider Note dated 7/30/23 at 11:38 AM documents R1 presented with a 4-centimeter laceration of the right lower leg that required 10 sutures to close. R1 reported the laceration occurred when staff transferred R1 from the	S9999		

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S9999	Continued From page 3 wheelchair. R1's Minimum Data Set (MDS) 6/24/23 documents R1 transfers and walks in the room and corridor with extensive assistance of one staff person. R1's Care Plan dated 4/5/23 documents R1 transfers with assistance of one staff person. R1's Care Plan with revised dated 8/14/23 documents R1 is at risk for impaired skin integrity and R1 received a skin tear to the lower extremity during a transfer. R1's Order Summary Report Dated 8/14/23 documents an order dated 3/17/23 for stand/pivot transfers with one assist and use of sit to stand mechanical lift as needed, Apixaban (anticoagulant) give 2.5 milligrams twice daily, and an order dated 7/20/23 for physical and occupation therapy. R1's Response History Report for R1's transfers from chair/bed dated 8/14/23 documents R1 required dependence on two staff six days between 7/16/23 and 7/29/23. R1's Nursing Notes document the following: On 6/29/23 at 7:17 PM documents R1 continues to work with physical therapy for left shoulder pain and range of motion, and R1 needs moderate assistance for sit to stand transfers. On 07/20/2023 at 7:00 PM documents an interdisciplinary team meeting summary note that R1 continues to receive therapy for shoulder pain, nursing staff notes R1 has not been stand/pivot transferring as well as R1 had previously, and an agreement for Physical Therapy to evaluate transfer status and Occupational Therapy to evaluate for wheelchair seating. On 07/30/2023 at 9:45 AM a Certified Nursing Assistant (CNA) reported that during R1's transfer R1's right leg hit the wheelchair, R1 sustained a bleeding laceration below R1's right knee that measured 6 centimeters (cm) by 1 cm. A pressure dressing was applied and R1 was	S9999		

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S9999	Continued From page 4 transferred to the emergency room. R1 received 10 stitches and returned to the facility. R1's Physical Therapy Treatment Encounter Notes dated 7/27/23 documents "Patient (R1) is mod (moderate) A (assist) for sit<>stand and max (maximum) A with transfers. Patient movement is slow, and patient requires extra time. Patient has decreased co-contraction in BLE (Bilateral Lower Extremities) resulting in segmented movements." R1's Occupational Therapy Evaluation & Plan of Treatment with a start date of 7/21/23 documents R1 requires substantial/maximum assistance with transfers. There is no documentation in R1's medical record that R1's transfer status was changed after 4/5/23. On 8/14/23 at 2:54 PM R1 was sitting in R1's wheelchair in R1's room. There was a full mechanical lift sling positioned underneath of R1. V2 (Director of Nursing/DON) pulled up R1's right pant leg and there was a healing, closed, pink wound to the right outer calf and dark pinpoint areas where sutures were previously. V2 stated R1 had R1's stitches removed today. On 8/14/23 at 8:58 AM V4 (CNA) stated R1 had been walking well when R1 first admitted to the facility, but R1 started walking slower and having more difficulty with transfers. V4 stated before R1's injury R1 had difficulty with transfers, R1 transferred with one staff person and use of gait belt, and staff had to use more weight bearing extensive assistance. V4 stated after R1's injury therapy evaluated R1 and R1 now uses a full mechanical lift for transfers. V4 stated V4 had reported R1's difficulty with transfers to V2, prior to R1's injury.	S9999		

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S9999	Continued From page 5 On 8/14/23 at 9:40 AM V5 (CNA) stated V5 was the CNA who transferred R1 at the time R1's injury occurred. V5 stated V5 transferred R1 from the bed to the wheelchair and no other staff assisted with R1's transfer. V5 stated R1 stood and pivoted for the transfer but was weak and slow. During the transfer R1 bumped R1's right lower leg into the bracket on the wheelchair where foot pedals attach. V5 stated R1 sliced open an area to R1's right lower leg where a previous bruise was. V5 stated R1 was transferred to the hospital and received stitches. Therapy informed us that R1 is a strict full mechanical lift now for all transfers. On 8/14/23 at 11:06 AM V9 (Physical Therapist) stated R1 was requiring 50-75% assistance, moderate/maximum assistance, for transfers prior to R1's right leg injury. V9 stated the facility is a "no lift" facility so residents requiring maximum assistance use a sit to stand or full mechanical lift. V9 stated V9 would not have recommended the use of a sit to stand lift for R1 due to R1's shoulder pain, so would have recommended a full mechanical lift for transfers. V9 stated R1 is now a full mechanical lift for all transfers. On 8/14/23 at 11:19 AM V10 (Certified Occupational Therapy Assistant) stated V10 did not recommend R1's transfer status to change to full mechanical lift until after R1's right leg injury. V10 stated staff can always downgrade a resident's transfer status if they are having difficulty with transfers, and since this is a no lift facility staff would downgrade to the use of mechanical lifts for transfers. On 8/14/23 at 12:54 PM V13 (Nurse Practitioner) stated on 7/30/23 V13 received a call from the	S9999		

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nurse reporting R1's laceration and during a transfer R1's leg had caught on the hardware of the wheelchair where the foot pedals attach. V13 stated V13 has seen that type of injury before caused by bumping into the wheelchair hardware. V13 stated it was a big laceration and R1 is on Eliquis (anticoagulant) and bleeds. Due to R1's fragile skin, any kind of protruding edge could have caused it. V13 was not aware that R1 had a decline in transfers prior to the injury.

On 8/14/23 at 2:07 PM V2 (Director of Nursing/DON) stated resident transfer status is reviewed during the Medicare meetings and morning meetings, and the facility doesn't make changes in transfer status unless recommended by therapy. V2 stated R1 was a stand pivot one assist transfer, CNAs reported R1 was weaker for transfers, and we did not downgrade R1's transfer status prior to R1's injury. V2 stated R1 required staff assist/performance of 50-75% of R1's transfers, then therapy should have given us a recommendation for R1's transfer status. V2 stated we do not have access to therapy notes and V2 was not aware that R1 was requiring that much assistance from staff for transfers. V2 stated if V2 was aware V2 would have asked therapy if they felt R1 should be a full mechanical lift for transfers. At 3:00 PM V2 confirmed if R1 was transferred with a full mechanical lift, R1 would have been lifted from above the chair, potentially avoiding contact with the wheelchair hardware.

On 8/14/23 at 3:40 PM V1 (Administrator) stated V1 conducted the investigation for R1's injury. V1 stated V1 had V5 re-intact R1's transfer and during the transfer R1 bumped R1's right leg on the bracket of the wheelchair causing the laceration. After the injury we padded the

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brackets on R1's wheelchair. V1 stated CNAs can report difficulty with transfers to the nurses, nurses and therapy can direct the CNAs on resident transfer status. V1 stated therapy attends the morning interdisciplinary team meetings and never mentioned changing R1's transfer status.

2.) On 8/14/23 at 10:10 AM R2 was lying in bed and had an elastic bandage wrapped around R2's right lower leg, from R2's toes to R2's knee. R2 stated a CNA was assisted R2 to a standing position from the bed so that R2 could pull up R2's pants which were around R2's knees. R2 stated the CNA instructed R2 to take a step forward and when R2 took a step R2's right knee buckled causing R2 to twist R2's right foot and ankle and fall to the floor. R2 stated R2 has a triple fracture, all three bones in R2's ankle are fractured. R2 stated R2 has a history of R2's right knee buckling and had fallen at home prior to R2's admission to the facility. R2 stated a gait belt was only used by therapy during R2's transfers, and a gait belt was not used during R2's transfer that resulted in the fall.

R2's Admission MDS dated 8/4/23 documents R2 admitted to the facility on 7/31/23, is cognitively intact, weighs 218 pounds, requires assistance of one staff for transfers (occurred only 1-2 times during the 7-day period), and R2 had no falls within the last six months prior to R2's admission.

R2's Hospital Admission History & Physical dated 7/1/23 documents R2 presented to the emergency room after falling twice at home. R2's Fall Risk Assessment dated 7/31/23 completed by V2 (Director of Nursing documents R2 has not had any falls within the prior 3 months, and a fall risk score of 9 indicating R2 is not at risk for falls.

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S9999	Continued From page 8 R2's Admission Assessment/Baseline Care Plan dated 7/31/23 documents the section for fall risk is incomplete and does not document R2's fall risk or interventions. There is no documentation that R2 had a fall risk care plan prior until 8/9/23 when R2 fell. R2's Physical Therapy Evaluation & Plan of Treatment with start date of 8/1/23 documents R2 requires partial/moderate assistance when moving from sitting to standing position and with transfers, and R2 has poor standing balance. R2's Nursing Note dated 8/9/2023 at 2:15 PM documents R2 fell at 9:35 AM in R2's room while staff was assisting R2 with dressing. R2 was standing next to the bed, took a step with R2's walker, R2's right leg buckled and R2 fell twisting R2's right leg. R2 complained of right ankle pain. R2's X-rays dated 8/9/23 at 2:17 PM documents the indication for the x-ray was a fall with right knee and ankle pain, R2 has a minimally displaced oblique intratracheal fracture of the medial malleolus with associated soft tissue swelling, a minimally displaced intra-articular fracture of the medial malleolus with associated soft tissue swelling, and a minimally displaced comminuted fracture of the lateral malleolus with associated soft tissue swelling. R2's Hospital After Visit Summary dated 8/9/23 documents R2 was evaluated in the emergency room for a fall, R2 had pain/swelling of right ankle and a diagnoses of right ankle bimalleolar fracture. The facility's Report to Illinois Department of Public Health Regional Office dated 8/11/23 documents on 8/9/23 at 9:35 AM R2 was standing while a CNA (V7) assisted R2 with dressing. R2 took a step forward, R2's right knee	S9999		

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buckled, R2 fell to the floor and as R2 complained of right ankle pain while falling. R2 was transferred to the hospital, diagnosed with right ankle bimalleolar fracture, R2 is non-weight bearing to the right lower leg, and a soft cast was applied. The facility's investigation of R2's fall documents V7 and R2 were interviewed but does not document if a gait belt was utilized during this transfer/fall.

On 8/14/23 at 11:06 AM V9 (Physical Therapist) stated on R2 required moderate assistance with 50% effort from staff for transfers prior to R2's fall. V15 stated R2 wore a knee brace and had a history of R2's knee buckling. V9 stated a gait belt should be used with hands on assistance during R2's transfer.

On 8/14/23 at 10:59 AM V7 (CNA) confirmed V7 transferred R2 during the fall on 8/9/23. V7 stated V7 had R2 stand up from the bed. V7 asked R2 to take a step forward and R2 fell. V7 stated R2 was using R2's walker and a gait belt was on R2. V7 stated V7 was standing beside R2 but did not have hold of R2's gait belt when R2 fell.

On 8/14/23 at 12:51 PM V8 (Nurse Practitioner) stated R2's right knee buckled and R2 fell during staff assist. V8 confirmed R2's right ankle fractures are consistent with a fall injury. V8 confirmed if the CNA had utilized a gait belt and had a hold on the belt it could have prevented R2's fall.

On 8/14/23 at 2:07 PM V2 (DON) stated gait belts should be used each time staff assist with transfers or walking with a resident who is not able to self-ambulate. V2 stated staff should have a hold on the gait belt if the resident is

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S9999	Continued From page 10 unsteady or requires one assist. V2 confirmed with R2's history V7 (CNA) should have held onto R2's gait belt. V2 stated V7 had turned her back to R2 during the transfer and V2 would have had R2 sit down to assist with dressing. V2 stated R2 was educated not to take a step without staff assistance for the fall intervention. V2 stated R2 is alert and oriented to person, place, time, and situation and V2 did not ask R2 about R2's fall history upon admission. V2 stated the referral and hospital records are reviewed to determine fall history. V2 confirmed R2's 7/31/23 fall risk assessment does not document R2's history of falls and confirmed this would change R2's fall risk score placing R2 at a higher risk for falls. At 4:00 PM V2 stated the nurses are supposed to initiate/document the baseline care plan and fall interventions as part of the admission assessment. V2 confirmed R2's baseline admission care plan was incomplete and did not document R2's fall risk and interventions. On 8/14/23 at 3:04 PM V14 (MDS Coordinator) stated V14 reviews hospital documentation and talks to the resident to determine fall history upon admission. V14 confirmed R2's MDS does not identify R2's falls prior to admission. On 8/14/23 at 3:40 PM V1 (Administrator) stated V1 conducted R2's fall investigation. V1 stated R2 told V1 that R2 was standing with the walker and V7 was helping R2 dress. R2 took a step forward, R2's knee buckled, R2 felt R2's right ankle "turn funny" during the fall and R2 had right ankle pain. V1 stated V1 interviewed V7 and R2 regarding the fall and V1 did not see documentation that a gait belt was used during R2's transfer/fall. 3.) R3's MDS dated 6/26/23 documents R3	S9999		

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admitted to the facility on 6/23/23, has moderate impaired cognition, and requires extensive assistance of one staff person for toileting and two staff for transfers. R3's Fall Risk Assessment dated 7/30/23 documents R3 has had four or more falls within the last three months and is at risk for falls with a fall risk score of 16. There are no prior documented Fall Risk Assessments in R3's medical record. R3's Care Plan revised on 7/14/23 documents R3 is at risk for falls but does document R3's falls since admission or the use of chair and bed alarms. This care plan includes interventions the use of a fall mat and bed in low position initiated on 6/1/23. There are no documented interventions after 7/14/23.

R3's Nursing Notes document the following: On 7/1/23, 7/3/23, 7/4/23, 7/6/23, and 7/9/23 R3 was using bed and chair pressure sensor alarms. On 7/28/2023 at 6:00 AM R3 was found lying on R3's bottom next to the right side of R3's bed. R3 did not have any injuries. There is no documentation to indicate the positioning of R3's bed or if a fall mat and pressure sensor alarms were in place. On 7/29/23 at 9:40 AM R3 had an unwitnessed fall in R3's room and was found by housekeeping staff on hands and knees on the fall matt beside the bed in low position. R3 had no injuries and there is no documentation that a sensor alarm was in place or sounding at the time of R3's fall. On 7/30/2023 at 8:15 PM R3 was heard yelling help. Staff went to R3's room and found R3 lying face down on the fall mat covered in urine. R3 had no injuries and R3's urostomy bag was leaking and changed. There is no documentation to indicate a fall mat or sensor alarms were in place.

R3's Fall Investigation dated 7/28/23 provided by V2 (DON) documents R3 was last checked

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around 5:00 AM. R3 was confused thinking R3 was at home and the back door was open and was re-oriented by the nurse. The root cause of the fall was "confusing/possibly dreaming" and the intervention was to reorient R3 to location. There is no documentation to indicate what R3 was doing when last observed at 5:00 AM, when R3's urostomy was last emptied/checked, the positioning of R3's bed, or the use of sensor alarms and a fall mat. R3's Fall Investigation dated 7/30/23 provided by V2 documents R3's bed sensor alarm was off. The root cause of the fall was R3 climbed out of bed and the urostomy bag was off, and R3 was disoriented. The intervention was to check the urostomy bag more frequently and staff were educated on bed alarm activation when R3 is in bed. There is no documentation that R3's fall on 7/29/23 was investigated.

On 8/14/23 at 12:27 PM R3 was sitting in a wheelchair in R3's room. There was a pressure sensor alarm on the back of R3's wheelchair and on R3's bed.

On 8/14/23 at 2:07 PM V2 stated R3 fell on 7/28/23 and 7/30/23. V2 confirmed R3's 7/28/23 fall investigation does not document fall interventions that were in place at the time of R3's fall. V2 stated we recently transitioned to a different style of incident reports, we used to use investigation forms filled out by the nurse. V2 was unable to locate this form for R3's 7/28/23 fall. V2 stated R3's fall interventions include a fall matt, low bed, bed alarm, chair alarm, and gripper socks. V2 stated R3's bed alarm did not sound when R3 fell on 7/30/23, and the alarm had not been activated. V2 stated staff were educated on bed alarm activation after R3's fall. V2 stated fall interventions should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001952	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE DANVILLE	620 WARRINGTON AVENUE DANVILLE, IL 61832

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S9999	Continued From page 13 documented on the care plan. V2 confirmed R3's care plan does not include any fall interventions after 7/14/23 or the use of bed/chair alarms. V2 stated V2 was unaware that R3 had fallen on 7/29/23 and confirmed there is no fall investigation to identify a root cause and post fall interventions. On 8/17/23 at 9:45 AM V2 stated fall risk assessments are completed upon admission and quarterly. At 10:18 AM V2 stated R3 did not have any fall risk assessments completed prior to 7/30/23 and that will have to be an educational piece for the staff since they were not used to doing all the extra charting/assessments. The facility's undated User Defined Assessment protocol documents to complete Fall Risk Assessments upon admission, quarterly, and after each fall. The facility's Fall Prevention Program dated 11/21/17 documents the following: The program includes determining the resident's needs by assessing fall risk, appropriate interventions will be implemented, and assistive devices will be utilized, as necessary. Care plans will include risk, interventions, preventative measures, and address each fall. The Fall Risk Assessment will be completed upon admission. The use of transfer conveyances will be used during transfers in accordance with the resident's care plan. The facility's Transfers-Manual Gait Belt and Mechanical Lifts dated as revised 1/19/18 documents the resident's transfer status will be assessed on an ongoing basis and will include the resident's mobility, weight bearing status, and cognition. Transfer status is categorized as independent, one person with 25% or less	S9999		

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S9999	Continued From page 14 assistance from staff with use of gait belt, two-person (only when use of mechanical lift is not possible), sit to stand lift with two staff, and full mechanical lift with two staff. The care plan will include the resident's transfer and lifting needs. This policy documents the use of a gait belt is mandatory when performing physical assist transfers. "A"	S9999		