

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058214		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville				STREET ADDRESS, CITY, STATE, ZIP CODE 620 WARRINGTON AVENUE , DANVILLE, Illinois, 61832			
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S0000	Initial Comments Complaint Investigations:2661933/2743544 Facility Reported Incident of 2/12/26/2794343 Facility Reported Incident of 2/14/26/2795496		S0000			03/23/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2) 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 resident's comprehensive assessment, which allow		S9999			03/23/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician These regulations were not met as evidenced by: 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			S9999			

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S9999	Continued from page 2 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 1/25/26 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		S9999				

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S9999	Continued from page 3 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 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		S9999				

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S9999	Continued from page 4 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		S9999				

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S9999	Continued from page 5 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 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		S9999				

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S9999	Continued from page 6 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 2/20/26 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 12/25/25 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.		S9999				

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S9999	Continued from page 7 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 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 shift 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		S9999				

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S9999	Continued from page 8 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.		S9999				

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S9999	Continued from page 9 On 3/12/26 at 9:03 AM V2 Director of Nursing reviewed R1's February MAR/TAR and confirmed Ibuprofen administration and 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 2/18/26 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.			S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058214		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Goldwater Care Danville				STREET ADDRESS, CITY, STATE, ZIP CODE 620 WARRINGTON AVENUE , DANVILLE, Illinois, 61832			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 10 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. (A)		S9999				