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 _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE DANVILLE	620 WARRINGTON AVENUE DANVILLE, IL 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) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey Investigation of Facility Reported Incident of January 27, 2024/IL169600	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)4)5) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an	S9999		

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S9999	Continued From page 1 effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All 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 interview and record review, the facility failed to implement fall prevention interventions according to resident's plans of care. This failure affects one resident (R69) out of five reviewed for accidents and falls on the sample list of 50. This failure resulted in R69 experiencing a femur fracture requiring surgical intervention to repair. Findings include: R69's Nurses Notes dated 1/8/24 document R69 was admitted to the facility on this date, 1/8/24. R69's Medical Diagnoses (undated) list documents R69 was admitted to the facility with medical diagnoses including Anxiety, Dementia, Difficulty in Walking, and Osteoarthritis.	S9999		

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S9999	Continued From page 2 R69's Fall Risk Assessment dated 1/8/24 documents R69 was at risk for falls. R69's Care Plan, initiated 1/8/24, documents R69 experiences mobility performance deficits related to dementia and de-conditioning. This same Care Plan documents R69 is at high risk for falls with fall prevention interventions initiated 1/8/24 including for R69 to wear non-skid footwear when ambulating or in the wheelchair. R69's Nurses Notes dated 1/10/24 document R69 experienced a fall in the doorway of her room while attempting to go to the bathroom. R69's Fall Risk Assessment dated 1/10/24 documents R69 was rated at risk for falls. R69's Minimum Data Set for admission dated 1/11/24 documents R69 experienced at least one fall in the month prior to admission, and at least one fall in the period of two to six months prior to admission. This same Minimum Data Set documents R69 received a score of three out of a possible 15 on a Brief Interview for Mental Status, rating R69 with severe cognitive impairment. This Minimum Data Set documents R69 could not dress her lower body without substantial to maximal assistance from staff and could not put on footwear without at least verbal cues, if not physical touching assistance. R69's Nurses Notes dated 1/27/24 document R69 experienced a fall by sliding out of the wheelchair, landing on her buttocks. R69's Nurses Notes dated 1/28/24 document R69 began to complain of pain in the right trochanter (hip) and was sent to the emergency room for evaluation.	S9999		

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S9999	Continued From page 3 R69's Hospital Reports dated 1/28/24 document R69 received a computed tomography study (CT scan) and was determined to have experienced an acute impact fracture of the right femur neck. These same Hospital Reports include a review of R69's injury resulted from a fall at her wheelchair on 1/27/24, and documented R69 underwent a surgical open reduction internal fixation to repair the right femur fracture. R69's Nurses Notes dated 1/29/24 include an Interdisciplinary Team Investigation Note for R69's fall on 1/27/24, documenting R69 landed on her bottom with her legs straight out in front of her. This same note documents the root cause of R69's fall as "resident was wearing regular socks on carpeted area and slid out of chair." On 2/20/24 at 11:33 AM, V5 (Director of Rehabilitation Services) stated, "(R69's) transfer status has declined since her fall. (R69) is on the skilled therapy caseload, receiving Physical Therapy, Occupational Therapy, and Speech Therapy (ST)." V5 continued, "(R69) is receiving ST for cognitive rehabilitation, she has been a lot more unable to comprehend what she needs to do to maintain her balance since she had a fall a few weeks ago. (R69) was fairly independent only requiring contact with hands on assist with transfers, now she needs a maximum assist with verbal, physical, and tactile cues. (R69) doesn't seem to comprehend standing positions and she tries to stand with her hips protruding forward and her upper body leaning backwards." V5 concluded by stating, "(R69) was already in skilled Physical Therapy and Occupational Therapy prior to fall and her physical recovery as far the healing of the fracture is going well, but her mobility has declined."	S9999		

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S9999	Continued From page 4 R69's Minimum Data Set dated 2/5/24 documents R69 was experiencing a significant change in condition that was not expected to resolve itself. This Minimum Data Set documents R69 had experienced declines in functional status including eating, putting on or taking off footwear, all aspects of bed mobility, transitioning from sitting to standing positions, surface to surface transfers, and her ambulation was limited to ten feet as opposed to fifty feet with two turns. On 2/22/24 at 11:27 AM, V2 (Director of Nursing) stated, "It is a true statement" (R69 was not wearing non-skid socks at the time of her fall on 1/27/24). V2 further stated, "I think (R69) would not have the cognitive ability to know what kind of socks she had on, even if she could put them on herself. I think (R69) was declined when she first got here." V2 continued, "(R69's) care plan did have to put the non-skid socks on her feet before the fall on 1/27/24 and I don't know why they (staff) didn't, but I could only imagine she was already in bed and trying to get up so they (staff) brought her out by the nurses station to keep an eye on her and just didn't put them on." "A"	S9999		