

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Investigation of Facility Reported Incident of 5/24/24/IL173934	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3210t) 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	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
07/01/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 1</p> <p>meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the 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)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.3210 General</p> <p>t) The facility shall ensure that residents are not</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 2</p> <p>subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to protect the resident's right (R1) to be free from sexual abuse by another resident (R2) by failing to supervise R2, a resident with a known history of behaviors of inappropriate touching towards other residents (R3, R4, R5, R6, R7, R8, R10, R14). R1-R8, R10, and R14 are nine of 14 residents reviewed for abuse in the sample list of 16. These failures resulted in R2 sexually abusing R1 when R2 was left unsupervised.</p> <p>Findings include:</p> <p>The facility was previously cited F600D on Facility Reported Incident of April 7, 2024/IL171905, survey exit 4/23/24 for resident to resident sexual abuse by R2.</p> <p>The facility's Abuse Prevention and Reporting-Illinois policy dated 10/24/22 documents residents have the right to be free from abuse and the facility prohibits abuse. This policy documents the facility will identify occurrences and patterns of potential mistreatment, investigate abuse allegations and make changes to prevent future occurrences. This policy documents sexual abuse is non-consensual contact with a resident and includes unwanted intimate touching of any kind, including breasts and perineal area.</p> <p>The facility's investigation for R2's/R3's incident on 4/7/24 at 2:58 PM documents V1 was notified</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 3</p> <p>that R3 reported that R2 touched R3's breast. This investigation documents V11 Activity Aide was interviewed and V11 stated R3 was brought to activities by V20 Visitor who reported R3 said R3 was afraid of R2, because R2 follows R3 around and won't leave R3 alone. This interview documents V20 told V11 that V20 witnessed R2 grab R3's hand and R3 told V11 that R3 was afraid of R2 because "He's (R2) following me around and rubbing my chest on top of my clothes." V11's statement dated 4/8/24 documents after lunch on the same day as R2's/R3's incident, R2 was sitting next to R5 with R2's hand on R5's upper left thigh, R5 pushed R2's wheelchair away, and V11 separated R2 and R5. V41 Certified Nursing Assistant (CNA) interview dated 4/8/24 documents R2 and R14 were sitting at the nurse's desk and R2 rubbed R14's stomach.</p> <p>The facility's investigation for R1's/R2's incident of 5/24/24 at 3:18 PM, documents the following: A Registered Nurse (RN V3) reported R2's hand was underneath of R1's shirt. Prior to the incident, V5 CNA brought R2 to the East lounge. Approximately five to ten minutes later, V4 Registered Nurse (RN) looked up to see R2 had wheeled his wheelchair in front of R1, and R2's right hand was underneath the left front side of R1's shirt. V4 asked V3 RN (who had her back to R1/R2) to separate R1 and R2. R1 had no reaction to R2, and neither R1 or R2 remembered the incident. R2 was placed on one to one monitoring during waking hours and has a bed alarm at night. R2 has a history of wandering into other resident rooms looking for R2's spouse, who previously resided in the facility. This investigation documents that during staff and resident interviews, R6 reported R2 wandered into R6's room and asked to hold R6's hand and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 4</p> <p>staff promptly removed R2 from R6's room. V21's (CNA) statement dated 5/24/24 documents prior to today V21 had not witnessed R2 touch other residents, but at supper R2 was sitting with R2's eyes closed and his hand was underneath of the table on R10's leg. This statement documents V21 asked R2 if R2 knew that R2's hand was on a man's leg, and R2 immediately removed R2's hand. V10's (CNA) statement dated 5/28/24 documents two or three weeks ago V10 came from the main dining room, R5 was sitting in a wheelchair in the middle hall and R2 came from the west area and reached towards R5's chest. This statement documents R2 barely touched R5 as V10 separated R2 from R5 and took R2 back to the East wing (where R2 resides).</p> <p>R1's Minimum Data Set (MDS) dated 4/11/24 documents R1 has severe cognitive impairment. R1's Care Plan revised 5/29/24 documents R1 is at risk for abuse/neglect related to dementia, depression, and behaviors, and there was an incident with another resident on 5/24/24 where R1 was touched inappropriately.</p> <p>R2's MDS dated 4/15/24 documents R2 has severe cognitive impairment. R2's Care Plan dated 4/8/24 documents R2 has behaviors of physical inappropriate touching towards female residents due to R2's dementia and poor impulse control. The Care Plan includes interventions to analyze the time of day, places, circumstances, triggers, and what de-escalates the behavior (5/24/24), encourage acceptable behaviors (4/8/24), involve physicians and counseling services to detour inappropriate behaviors (4/8/24), maintain communication with R2's family and potentially suggest memory care placement (4/8/24), monitor/document/report inappropriate behaviors (5/24/24), staff should monitor R2</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 5</p> <p>when around female residents and remove R2 if R2 moves too close to female residents or displays inappropriate behaviors (4/8/24), and R2 will be offered one to one monitoring (5/24/24). There is no documentation in R2's medical record of one to one monitoring implementation, besides nursing notes that do not document consistent one to one monitoring daily for each shift.</p> <p>The Daily Nurse Assignment Sheets dated 5/25/25-6/10/24 documents a sitter is assigned for one to one monitoring on days and evening shifts, but does not document one to one monitoring was assigned on evening shift on 6/7/24 and 6/8/24 or any night shifts.</p> <p>On 6/10/24 at 8:45 AM and 1:56 PM, and on 6/11/24 at 8:50 AM R2 was lying in bed with bed alarm in place, and no staff were in or directly outside of R2's room. On 6/10/24 at 8:45 AM R2 was confused and did not recall incidents involving female residents. On 6/10/24 at 9:16 AM R2 self propelled R2's wheelchair up the East hall towards the nurses' station. There was no staff directly with R2. V1 Administrator came up behind R2 and mentioned R2 was done with therapy, and then V13 Housekeeper pushed R2 to the dining room and sat with R2. On 6/10/24 at 3:27 PM R2 was sitting in the dining room at the end of a table participating in a large group BINGO activity. R7 and R13 (female residents) were on each side of and within R2's reach. There was no staff directly with R2 besides V14 Activity Director who was standing near R2 and leading the activity, occasionally turning V14's back to R2 as V14 called out BINGO numbers.</p> <p>On 6/10/24 at 8:48 AM R1 was lying in bed. R1 was confused and not interviewable. On 6/10/24 at 9:38 AM R3 stated there was only one time</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 6</p> <p>that a male resident (identified as R2) touched her inappropriately. R3 stated (R2) put his hand on R3's thigh and went up underneath of R3's shirt, which made R3 feel uneasy. R3 stated when R3 sees (R2) now R3 thinks "danger" and stays aware from R2. On 6/10/24 at 10:00 AM R6 stated several weeks ago a male resident (identified as R2) came into R6's room while R6 was in bed, and attempted to hold R6's hand. R6 stated R6 pulled her hand away and called for staff who immediately removed R2 from R6's room. At this time R5 (R6's roommate) was confused and not interviewable.</p> <p>On 6/10/24 at 8:55 AM V9 CNA stated V9 heard that R2 has inappropriately touched R1, R3, R5 and R7.</p> <p>On 6/10/24 at 9:00 AM V3 RN stated (in reference to R1's/R2's 5/24/24 incident) at 3:20 PM V3 was talking to an unidentified resident in the East lounge and V4 RN asked V3 to get R2. V3 stated V3 turned around to see R1 and R2 sitting near the patio doors and R2's hand was up underneath of R1's sweatshirt near R1's breast. V3 stated R1 had no expression or response to R2 touching R1. V3 stated R2 was moved to an area away from R1. V3 described R1 as having limited cognition and V3 confirmed R2 had prior similar incidents involving other unidentified female residents. V3 stated staff had been trying to keep R2 in a visual observed area and there was no one specifically assigned to monitor the East lounge at the time of R1's/R2's incident.</p> <p>On 6/10/24 at 9:22 AM V12 Housekeeping Supervisor stated V12 heard that R2 tried to touch R3 again and R4 a couple of weeks ago, and R2 had tried to touch R10. V12 stated R2 gets "touchy feely" with staff as well and a couple</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 7</p> <p>weeks ago R2 rubbed V12's arm and tried to move up V12's arm.</p> <p>On 6/10/24 at 10:17 AM V8 CNA stated a couple months ago R8 was yelling "get out of here" and V18 receptionist found R2 in R8's room. V8 stated V8 heard R8 yell out "he (R2) was rubbing my (R8's) leg", but V8 did not witness R2 touch R8. V8 stated a couple months ago R2 was found on the floor of R7's room after R2 tried to get into bed with R7. V8 stated V8 was not sure what was done at that time to address R2's behaviors other than staff would redirect R2 when R2 wandered to the middle hall. V8 stated R2 has a sitter now, but if there isn't an assigned sitter then R2 sits in an area where staff can watch R2. V8 stated after R2 is gotten up V8 takes R2 to activities where staff are present, since the CNAs are busy giving showers. V8 stated today someone is assigned to be with R2 from 9:00 AM until 3:00 PM, but there isn't always someone assigned for R2's one to one monitoring.</p> <p>On 6/10/24 at 10:30 AM V4 RN stated (in reference to R1's/R2's incident) V4 had just started V4's shift and was working the East hall. V4 stated R2 had tried to get out of bed and V4 told V5 to bring R2 to the East Lounge where a lot of residents were seated due to a severe thunderstorm. V4 stated V4 was not aware at that time that R2 was not to be by other residents and supervised. V4 stated R2 was sitting between R10 and an unidentified female resident. V4 stated V4 was counting narcotic medications with the oncoming shift nurse and about five to ten minutes after R2 was brought to the lounge, V4 looked up to see R2 in front of R1 with R2's hand underneath of R1's shirt near R1's breast. V4 stated V4 told V3 RN, who had her back to the lounge, to separate R2 from R1. V4 stated R2</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 8</p> <p>was not aware of what was going on, R2 is confused and tries to find R2's wife, which V4 believes to be the root cause of R2's behavior. V4 stated R1 had no response to R2, R1 is confused and does not have the cognitive ability to consent to being touched like that. V4 stated there was no staff directly supervising the lounge at the time of the incident, and if R2 had a sitter or direct supervision it likely would have prevented the incident. V4 stated "The hard thing is, he moves very fast. You can be watching him one minute and then the next thing you know he's on the other side of the building. He is very fast when he gets his feet moving. It's very hard to do your stuff (work) and keep an eye on him." V4 stated since the incident R2 has been on one to one monitoring during the day until 8:00 PM, but not at night since R2 has a bed alarm.</p> <p>On 6/10/24 at 11:16 AM V10 CNA stated V10 has only heard of incidents approximately one month ago including R2 touching R8 while R8 was in bed, R2 touching R5's thigh, and R2 falling in R7's room while attempting to get into bed with R7. V10 stated within the last couple weeks, V10 caught R2 "just in time" as V10 came from the dining room and witnessed R2 reach out towards R7's breast while sitting near the middle hallway. V10 stated R2's fingertip barely brushed across R7's breast as V10 separated R2 from R7. V10 stated R2 now has someone assigned to be with R2, and if we don't due to short staffing then we just keep our eyes on R2.</p> <p>On 6/10/24 at 3:22 PM V5 CNA confirmed V5 was the CNA who brought R2 to the lounge on 5/24/24. V5 stated prior to that day, V5 was not aware that R2 had behaviors of inappropriately touching other residents.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 9</p> <p>On 6/10/24 at 3:46 PM V22 CNA stated V22 worked evening shift on the East wing on 6/7/24 and 6/8/24. V22 confirmed R2 requires one to one monitoring and there was no staff assigned for R2's one to one monitoring on evening shift on 6/8/24.</p> <p>On 6/10/24 at 1:18 PM V1 Administrator confirmed R2's history of inappropriate touching and attempts to touch other residents. V1 stated we implemented closer monitoring, which was not one to one supervision, for 72 hours after R2's first incident with R3 on 4/7/24, and after the 72 hours staff were just aware to keep an eye out for R2's location and keep R2 away from female residents. V1 stated that same day (4/7/24), R2 had R2's hand on R5's leg. V1 stated R2 returned from the hospital on 5/24/24 and R2's wife had visited at the hospital, which we believe may have been a trigger for R2's behavior causing R2 to think R1 was R2's wife who previously resided in the facility. V1 stated after R2's incident on 5/24/24, we implemented one to one monitoring of R2 while awake since R2 has a bed alarm. V1 stated therapy staff do not always notify the staff when R2 is finished with therapy. V1 stated with staffing we try to assign someone to be with R2 or the department heads/office staff take turns sitting with R2, and the Daily Staffing Sheets document the assigned one to one sitter. V1 stated R2 likes to wander about the facility and talk to residents, R2 is confused and not aware of what R2 is doing. V1 stated V1 did not think R1 has the ability to consent to sexual contact, and V1 interviewed R1 who had no recollection of the incident with R2. On 6/10/24 at 2:24 PM the Daily Staffing Sheets were reviewed and verified with V1, confirming no documented assigned staff to provide R2's one to one monitoring on evening shift on 6/7/24 and 6/8/24. V1 stated the East</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2024
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDWATER CARE DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 10</p> <p>CNAs would have shared the monitoring on 6/8/24 and V1 did R2's monitoring from 5:00 PM until 7-7:30 PM on 6/7/24. On 6/11/24 at 8:55 AM V1 confirmed there is no documentation of one to one monitoring in R2's medical record, besides the nursing notes.</p> <p>On 6/10/24 at 2:18 PM V6 (R1's Family) stated the facility notified V6 that a male resident put his hand up underneath of R1's shirt. V6 was asked how R1 would have felt or responded if R1 did not have cognitive impairment. V6 stated R1 would have been shocked and would have yelled/screamed. (B)</p>	S9999		