(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		A. BUILDING:		С					
		IL6001952	B. WING		02/20/2025				
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOLDW	ATER CARE DANVILL	F	RINGTON AV E, IL 61832	ENUE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
S 000	Initial Comments		S 000						
	Complaint Investiga	ation: 2560986/IL186000							
S9999	Final Observations		S9999						
	Statement of Licensure Violations:								
	300.610a) 300.1210b) 300.1210d)1)2)								
	Section 300.610 R	esident Care Policies							
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conformer of nursing and othe policies shall compositive facility and shall by this committee, and dated minutes	divisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting.							
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care							
	care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident.							

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

03/04/25 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 5 RXZT11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6001952		B. WING		C 02/20/2025		
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 42/2	0.2020
GOLDW	ATER CARE DANVILL	F	RINGTON AV E, IL 61832	'ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page 1		S9999			
	nursing care shall in following and shall seven-day-a-week 1) Medications hypodermic, intrave be properly adminis 2) All treatmer administered as ord These regulations was a seed on interview failed to provide particular to one reviewed for signific sample list of eight.	s, including oral, rectal, enous and intramuscular, shall				
	Findings include:					
	diagnoses as: afte Replacement surge	oses sheet, documents R1's reare following Joint ery, presence of Left Artificial sis, unspecified, and unilateral itis, left hip.				
	2025, documents H Oral Tablet 5-325 m mouth one time onl Joint Replacement tablets Hydrocodon	er Sheet (POS) dated January dydrocodone/Acetaminophen nilligrams (mg), give 5 mg by y for pain related to following surgery, for 1 day, give 2 le/Acetaminophen 5/325 mg; start date 1/30/2025, 31/2025.				

Illinois Department of Public Health STATE FORM

RXZT11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ` CON			ATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
IL6001952		B. WING		1	C 02/20/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDW	ATER CARE DANVILL	F	RINGTON AV E, IL 61832	'ENUE		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page 2		S9999			
	R1's January 2025, Medication Administration Record (MAR) has no documentation that Hydrocodone/Acetaminophen Oral Tablet 5-325 milligrams (mg), medication was given on 1/30/25.					
	R1's MAR dated January 2025, documents an order for Clotrimazole Vaginal Cream 2%, insert one applicator vaginally at bedtime for yeast infection, start date 1/30/2025. R1's Treatment Administration Record (TAR) dated January 30, 2025, has no documentation of Clotrimazole Vaginal Cream 2% being administered on 1/30/25 at bedtime. R1's TAR dated February 2025, has no documentation of Clotrimazole Vaginal Cream 2% being administered on 2/4/25, 2/7/25, 2/8/25, and 2/13/25. R1's Orthopedic Discharge Summary dated 1/22/25-1/30/25, documents an order for Lidocaine 4% one patch transdermal on 12 hours, off 12 hours.					
	Lidocaine External topically every morr	nuary 2025, documents Patch 4% apply to left hip ning and at bedtime for pain e at night, start date				
		oruary 2025, has no Lidocaine patch being put on 25.				
	got here, they did not she did not get her in a lot of pain. R1	S AM, R1 stated when she first of have her medications so pain medications and she was stated they have forgotten her R1 stated she is not getting				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED	
	С	
IL6001952 B. WING	02/20/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COD MARRINGTON AVENUE		
GOLDWATER CARE DANVILLE 620 WARRINGTON AVENUE DANVILLE, IL 61832		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY TAG DEFICIENCY)		
Continued From page 3 her vaginal cream at night and still has symptoms of an infection On 2/14/25 at 12:54 PM, V2 (Director of Nursing) DON stated when R1 was admitted the pharmacy did not get R1's orders in time so they did not have the medications. V2 stated the script that was sent to the facility first was for Oxycodone and the facility does not have that in the convenience box and had to get another order for something else that the facility does have which took a while so R1 did not get the pain medication until the middle of the night. V2 stated if a medication is not checked off as being given then it was not administered. V2 verified R1's Clortrimazole has not be given to R1 on several days according to the TAR. V2 verified R1 did not get the one time dose of Hydrocodone on 1/30/25 and that R1 did not get the Lidocaine patch on 2/1/25. On 2/20/25 at 11:35 AM, V6 Medical Doctor (MD) stated R1's hospital discharge orders should have been followed and R1 should have gotten pain medications that were ordered. V6 stated by not getting pain medications when ordered, it can lead to an increase in pain after a hip replacement and R1 should have received the Lidocaine patch as ordered. V6 also stated R1's orders for medication for a yeast infection should have been followed and given as ordered. V6 stated with a delay in treatment, the infection can continue to get worse. The facility's Medication Administration General Guidelines Policy, undated, documents medications are administered in accordance with written orders of the prescriber.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S		SURVEY _ETED			
					С			
IL6001952		B. WING		02/20/2025				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDWATER CARE DANVILLE 620 WARRINGTON AVENUE DANVILLE, IL 61832								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		

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STATE FORM 6899 RXZT11 If continuation sheet 5 of 5