STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046367	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF DANVILLE	3222 INDEPENDENCE DRIVE , 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
S0000	Initial Comments Complaint Investigation #2567511/2585352 - 300.1510a)1)2)e)1) cited Complaint Investigation #2567418/2585631- 300.1510a)1)2)e)1) cited	S0000		08/25/2025
S9999	Final Observations Statement of Licensure Violations: 330.710 a) 330.1510 a)1 330.1510 a)2) 330.1510 e)1) 330.710. 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. 1) Medication policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written	S9999		08/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 program of care and services. 2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy. e) Medication Records 1) All medications used by residents shall be recorded by facility staff at time of use. (See Section 330.1710. This requirement is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to administer pain medications timely for one of three residents (R2) reviewed for abuse in the sample list of eight. Findings include: The facility's Supportive Living Resident Medication Policy, dated December 2016, documents medications are ordered by a licensed prescriber and changes in orders will be documented in the resident's medication record. This policy documents Medication administration/oversight shall be documented according to the needs of each resident, and Certified Nursing Assistant (CNAs) staff may provide oversight which includes reminders and removal of medication that is set up by the pharmacy or licensed nurses from the locked storage area, CNAs may also open medication packages or containers, but may not remove the medication from the package. Documentation will include that the resident has taken or refused to take the medication. R2's Emergency Room note, dated 8/10/25 at 2:30 AM, documents R2 was evaluated for lower back pain, and R2 rated his pain an "8" on a 1-10 scale. R2's Hospital After Visit Summary, dated 8/10/25, documents R2 was evaluated for back pain and diagnosed with back contusion. This summary includes an order for Norco 5-325 milligrams (mg) take one to two tablets by mouth twice daily. R2's Medication Administration Record, dated 8/1/25-8/11/25, documents to give Norco 5-325 mg one tablet by mouth twice daily initiated as of 8/10/25 for 7:00-10:00 AM administration. This record documents as of 8/11/25, R2 had not received this medication due to	S9999		

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S9999	Continued from page 2 the medication not being available and waiting on the pharmacy to deliver the medication. R2's Nursing Notes do not document R2's pain or any follow up regarding this medication. The facility's current backup medication inventory list includes five tablets of Norco 5-325 mg. On 8/11/25 at 9:50 AM, R2 was sitting in his wheelchair. R2 yelled out "ow" with facial grimacing when he moved. At this time, V20, Personal Assistant, came to R2's room. V20 stated R2 has been complaining of back pain and was prescribed Hydrocodone (Norco), but the facility is waiting on the prescription to come in. On 8/13/25 at 9:55 AM, R2 stated R2's pain is on the left side of his lower back. R2 stated R2's back started hurting the night before after staff assisted R2 to bed and placed R2's legs in bed. R2 stated R2 initially went to bed and awoke with back pain later during the night. R2 stated the hospital did x-rays and ordered a "strong pain pill", which R2 has not yet received. On 8/11/25 at 1:02 PM, R2 stated R2 still has not received his pain medication. R2 rated his pain at rest as a "1" and a "10" with movement, on a 1-10 scale. V20 stated R2's Norco is still not available. V20 stated V20 offered R2 Tramadol this morning, but R2 refused saying it would make R2 sleepy. At this time, R2 was asked about taking Tramadol; R2 stated R2 wanted to wait for "the good stuff" to come in. On 8/11/25 at 1:24 PM, V6, Social Services Director and manager for R2's unit, stated controlled medications for R2's unit are obtained from the facility's skilled unit's backup medication kit if there is a signed script on file. V6 stated V6 was not aware of R2's Norco order until today. On 8/11/25 at 1:31 PM, V7, Licensed Practical Nurse, stated V7 received R2's signed script for Norco and faxed it to the after hours pharmacy yesterday. V7 provided R2's signed script dated 8/10/25, that documents to administer Norco 5-325 mg one to two tablets by mouth twice daily. V7 stated there is a supply of this medication in the facility's backup medication kit, which can be removed for R2. On 8/11/25 at 1:43 PM, V8, Registered Nurse, stated V8 had not offered R2 Norco today. V8 stated V8 just pulled Norco from the skilled unit's backup medication kit and brought it over to R2's unit. (B)	S9999		

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