STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146090	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Inn of Danville	3222 Independence Drive Danville, IL 61832

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed on admission to obtain complete physician orders for medication to meet the immediate needs of a resident. This failure affected one (R1) of eight resident reviewed for medications on the sample list of 12. Findings include: R1's current Continuity of Care sheet documents R1 diagnoses Problem list as follows: Paroxysmal Atrial Fibrillation, Unspecified Atrial Flutter, Cardiac Murmur, Unspecified, Essential (primary) Hypertension, Alzheimer's Disease, Unspecified, Vitamin D deficiency, Unspecified, Ascorbic Acid Deficiency, and Vitamin Deficiency, Unspecified. R1's Local Hospital Discharge - Cardioversion Procedure Note, dated 5/12/25, documents R1 had Atrial Flutter (fast heart rate) with rapid ventricular rate of the heart while in the hospital. The rapid heart rate required Electro-Cardioversion (electric shock treatment to the heart) with sedation to convert R1's heart rate to normal sinus rhythm. R1's Local Hospital Discharge Medication List, dated 5/13/25, documents the following incomplete physician orders, when admitted to the facility on [DATE].: *Metoprolol Succinate (Beta-blocker medication that blocks hormones that target the heart) 100 milligram (MG) tablet (tab) SR (sustained release) - 24 hour. Commonly known as: Toprol XL (extended release). The Metoprolol order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication is to be administered. *Mirtazapine (Antidepressant medication also used for appetite stimulant.) 30 MG Tabs. Commonly known as: Remeron. The Mirtazapine order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication is to be administered. *Fosinopril (Medication treatment for high blood pressure and heart failure) 10 MG Tabs. Commonly known as: Monopril. The Fosinopril order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication was to be administered. On 6/12/25 at 10:00 am, V2, Director of Nursing (DON), stated R1's Fosinopril, Metoprolol, and Mirtazapine medication orders were not clarified when R1 was admitted on the 5/13/25 . V2, DON, also stated, This should have been caught immediately when the nurse confirmed the orders on admission. (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Pharmaceutical Procedures, dated 2010, documents the following: It is the policy of the facility to review residents' medication on a regular basis in order to provide residents with only the necessary medication for their health needs. Purpose: To provide the appropriate control procurement, distribution, administration, and utilization of drugs to the facility. The same policy documents: Physicians' Medication Orders All medications, including non-legend drugs (cathartics, headache remedies, vitamins, etc.) shall be given only upon the written order of a physician. All such orders shall have the signature of the physician and shall be given as prescribed by the physician and at the designated time. When necessary, telephone orders may be taken by a registered nurse or licensed practical nurse. All such orders shall be immediately written and/or entered on the resident's clinical record. Electronic orders shall be authenticated by the physician within ten (10) days via handwritten signature or unique identifier. The same policy documents: The Physician's Order shall be recorded legibly and include the following: date, name of medication, dosage, route, time of administration and, if appropriate, the length of time the resident is to receive the medication. All NEW physicians' orders shall be communicated electronically via (Proper name of electronic system) or by telephone and/or FAX (facsimile) to the pharmacy by the nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility pharmacy repeatedly failed to provide medications in a timely manner. This failure affects one (R1) of eight residents reviewed for medications on the sample list of 12. Findings include: R1's Local Hospital Discharge Medication List, dated 5/13/25, documents the following incomplete physician orders for Fosinopril, Metoprolol Succinate, and Mirtazapine as follows: 1. Fosinopril (Medication for the treatment for high blood pressure and heart failure) for 10 MG Tabs. Commonly known as: Monopril. The Fosinopril order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication was to be administered. R1's current Physician Order Report Sheet (POS) documents R1 was admitted to the facility on [DATE] at 12:40 pm. R1's Physician Order for Fosinopril , was clarified and ordered by V8, Nurse Practitioner, as follows: Fosinopril tablet; 10 mg; amt: 10; oral [DX: Essential (primary) hypertension], Once A Morning; 07:00 AM - 10:00 AM The same Physician Order documents the medication start date as 5/17/25. R1's Medication Administration Record documents R1's Fosinopril medication was not available for administration from the pharmacy until 5/20/25. The facility (Proper Name) Pharmacy Consolidated Delivery Sheet documents the facility staff (unidentified) signed off the delivery of Fosinopril medication on 5/20/25. 2. Metoprolol Succinate (Beta-blocker medication that blocks hormones that target the heart) 100 milligram (MG) tablet (tab) SR (sustained release) - 24 hour. Commonly known as: Toprol XL (extended release). The Metoprolol order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication is to be administered. R1's Physician Order noted above, was clarified and ordered by V7, Physician, as follows: Metoprolol Succinate tablet extended release 24 hr; 100 mg; Amount to Administer: 150 mg oral, once a day; 07:00 AM - 10:00 AM. The same Physician Order documents the medication start date as 5/14/25. The facility (Proper Name) Pharmacy Consolidated Delivery Sheet documents the facility signed off the delivery of Metoprolol medication on 5/15/25. 3. Mirtazapine (Antidepressant medication also used for appetite stimulant.) 30 MG Tabs. Commonly known as: Remeron. The Mirtazapine order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication is to be administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician Order for the Mirtazapine was clarified and ordered by V8, Nurse Practitioner, as follows: Remeron (Mirtazapine) tablet; 15 mg; amt: 7.5 mg; oral,[DX: Vitamin deficiency, unspecified] At Bedtime; 07:00 PM - 10:00 PM. The same Physician Order documents the medication start date as 05/16/25. The facility (Proper Name) Pharmacy Consolidated Delivery Sheet documents the facility signed off the delivery of Mirtazapine medication on 5/18/25. On 6/12/25 at 11:50 am, V18, Corporate Nurse Consultant, provided a Pharmacy Hours of Operations sheet that directs staff to call the off hours phone number to obtain medications when the pharmacy is closed. V18 stated, There are several issues with obtaining the medications. We dropped the ball. The nurses should have clarified (R1's) medication orders on admission [DATE]). The orders must have the doses and times the meds are to be given. 'See instructions' is not appropriate when sending orders from the hospital. (Name of an electronic provider messaging system) documentation 5/13/25 notified, 5/13/25 the provider responded without providing clarification orders, then 5/15/25 an additional delay in response. Our nurses should have been all over this. I get the pharmacy received the orders on Friday night, and out of stock on Saturday. Pharmacy needed to call the after hours number to get (R1s) medication. Our nurses identified it was not delivered, they dropped the ball here too. The facility Pharmacy HOURS OF OPERATION & CUTOFF TIMES HOURS sheet documents the following: REQUESTING MEDICATIONS OUTSIDE OF REGULAR DELIVERIES STAT ORDERS If medication is needed STAT, home staff must call the pharmacy and speak with the technician to request the specific item(s). The pharmacy staff will then arrange to have the item either filled in house or at a local backup pharmacy, and then delivered directly to the home.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent significant medication errors by failing to clarify incomplete hospital physician ordered medications on admission in a timely manner, and failed to obtain medication from the pharmacy in a timely manner. These failures resulted in multiple missed doses of heart and blood pressure medication administration after electro-cardioversion, and missed doses of antidepressant/appetite stimulant medications. This failure affects one (R1) of eight residents reviewed for medications on the sample list of 12. Findings include: R1's Hospital Record CARDIOVERSION PROCEDURE NOTE (NON-OR) documents: Procedure Date: 5/12/2025, Pre-Procedure Diagnosis/Indication for Procedure: Atrial flutter with rapid ventricular rate. Post-Procedure Diagnosis: Sinus rhythm. Procedure: Electro-cardioversion with sedation. R1's current Continuity of Care sheet documents R1 diagnoses Problem list as follows: Paroxysmal Atrial Fibrillation, Unspecified Atrial Flutter, Cardiac Murmur, Unspecified, Essential (primary) Hypertension, Alzheimer's Disease, Unspecified, Vitamin D deficiency, Unspecified, Ascorbic Acid Deficiency and Vitamin Deficiency, Unspecified. R1's Local Hospital Discharge Medication List, dated 5/13/25, was provided to the facility at the time of R1's admission. The local Hospital Discharge Medication List documents the following incomplete physician orders: 1. Fosinopril (medication for the treatment for high blood pressure and heart failure) 10 MG (Milligram)Tabs (tablets). Commonly known as: Monopril. R1's Fosinopril medication order documents See instructions. There are no instructions documented in the discharge orders for the medication dosage, route, or time the medication was to be administered. R1's May 2025 Physician Order Report Sheet (POS) documents R1 was admitted to the facility on [DATE] at 12:40 pm. R1's same POS documents R1's Fosinopril medication order was not clarified until 5/17/25 (four days post admission), by V8, Nurse Practitioner (NP). V8, NP, clarified R1's medication order as follows: Fosinopril tablet; 10 mg; amt (amount): oral [Diagnosis : Essential (primary) hypertension], Once A Morning; 07:00 AM - 10:00 AM. The same POS documents the medication was to be started on 5/17/25 (four days after the above admission, hospital physician ordered medication list was sent to the facility). The facility (Proper name) Pharmacy Consolidated Delivery Sheet documents the facility signed off the delivery of Fosinopril medication on 5/20/25. R1's Medication Administration Record (MAR), dated 5/13/25 - 5/20/25, documents administration or omissions by nurses initials, as follows: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/25, V32, Registered Nurse (RN), initialed V32, RN, administered R1's Fosinopril medication. The medication had not been delivered to the facility, as documented above on the (Proper name) Pharmacy Consolidated Delivery Sheet, and therefore was not administered. R1's same MAR documents V32, RN's, bracketed initials on 5/18/25, which indicates the medication was not administered. V32, RN, further documents the reason the medication was not administered was the medication was not available from the pharmacy. R1's same MAR documents V6, RN, bracketed initials on 5/19/25, which indicates the medication was not administered. V6, RN, further documents the medication was not available from pharmacy. From admission 5/13/25 - 5/20/25, six doses of Fosinopril medication were not administered from the initial medication order list sent from the hospital on admission. 2. Metoprolol Succinate (Beta-blocker medication that blocks hormones that target the heart) 100 milligram (MG) tablet (tab) SR (sustained release) - 24 hour. Commonly known as: Toprol XL (extended release). The Metoprolol order documents See instructions. R1's Physician Order noted above, was not clarified until 5/14/25 and ordered by V7, Physician, as follows: Metoprolol Succinate tablet extended release 24 hr; 100 mg; Amount to Administer: 150 mg oral, once a day; 07:00 AM - 10:00 AM. The same Physician Order documents the medication start date as 5/14/25. The facility (Proper name) Pharmacy Consolidated Delivery Sheet documents the facility signed off the delivery of Metoprolol medication on 5/15/25. R1's MAR, dated 5/13/25 - 5/20/25, documents Metoprolol Succinate was not initialed as administered until 5/15/25, indicating one missed dose. 3. Mirtazapine (Antidepressant medication also used for appetite stimulant.) 30 MG Tabs. Commonly known as: Remeron. The Mirtazapine order documents See instructions. There are no instructions documented in the discharge orders that include dosage, route, or time medication is to be administered. R1's Physician Order for the Mirtazapine medication order was not clarified until 5/16/25, (three nights after hospital orders were sent to the facility on admission) and ordered by V8, Nurse Practitioner, as follows: Remeron (Mirtazapine) tablet; 15 mg; amt: 7.5 mg; oral,[Diagnosis: Vitamin deficiency, unspecified] At Bedtime; 07:00 PM - 10:00 PM. The same Physician Order documents the medication start date as 05/16/25. R1's MAR, dated 5/13/25 - 5/20/25, documents Mirtazapine was not initialed as administered until 5/16/25. Three doses at bedtime were not administered, since the hospital physician order was sent and not clarified on 5/13/25. The facility (Brand Name) electronic communication messenger, to the providers documents the following: On 5/13/25 at 6:06 PM, the facility nurse (unidentified) communication message to consult with V7, Physician, and V8, Nurse Practitioner, documents the first entry as follows: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R1) admitted from (private hospital) after a fall at home, here for PT/OT (Physical Therapy/Occupational Therapy). Has orders for Fosinopril 10 mg tabs, Metoprolol Succinate 100 mg, Mirtazapine 30 mg tabs last given 7.5 mg on 5/12; orders say please see instructions, no instructions given, please advise. V8, NP, responded on the the same electronic provider communication messenger that same evening 5/13/25, at 6:16 pm: The message documents: Why was it ordered. The facility nurse (unidentified) communication message responded to V8, NP, message above did not occur until 5/14/25 at 11:13 pm (28 hours and 57 minutes later) The message documents: No diagnoses given. V8, NP, responded to the unidentified nurse message above did not occur until 5/15/25 at 6:19 am (7 hours and 6 minutes later). The message documents a question: She (R1) does not take at home? The facility nurse (unidentified) communication message responded to V8, NP, message above did not occur until 5/15/25 at 9:48 pm (28 hours and 29 minutes later). The message documents: Yes, she (R1) takes at home. There were no other messages documented on R1. The facility Medication Error Report, dated 6/11/25, signed by V2, Director of Nursing, documents R1's medication errors occurred 5/13/25 through 5/20/25, and was reported to V7, Physician. No negative outcome per (V7, Physician), at this time. The same Medication Error Report documents the medications ordered include: Fosinopril 10 mg daily, Metoprolol 150 mg daily, Remeron 7.5 mg daily. The same report documents A delay in starting medications listed above. and Other (explain): Incomplete discharge orders from (local hospital), delay in (V7, MD) and (V8, NP), response in (Brand Name, electronic communication messenger) to clarify orders. On 6/12/25 at 10:00 am, V2, Director of Nursing (DON), reviewed R1's medical records and provider electronic communication messages. V2, DON, confirmed R1 did not receive her Fosinopril, Metoprolol, or Mirtazapine as ordered. V2, DON, said medications missed were significant errors due to multiple issues as follows: The hospital incomplete discharge orders, a delay in nursing clarifying R1's medication orders on admission, delay in the provider electronic communication responses, delay in pharmacy providing the medication and not utilizing back- up pharmacy services. On 6/11/25 at 12:00 pm, V33, R1's Family Member, stated V33 felt the facility was not taking V33 seriously. V33 said the facility was not addressing R1's medications that were not being administered. On 6/12/25 at 11:50 am, V18, Corporate Nurse Consultant (CNC), reiterated V2, DON, statement noted above. V18, CNC, stated We dropped the ball. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 9:00 am, V8, Nurse Practitioner (NP), stated, There were no adverse effects to her (R1's) missed (omission of medication administration) doses of Fosinopril, nor (R1's) missed doses of Metoprolol and Remeron that I found on her chart review. The hospital (medication orders) should have been clear on the medication, dose, and frequency for starters. Overall, I do feel these missed medications were a significant medication errors. They should not have been missed. V8, NP, acknowledged V8, NP, and the facility nurses delay in message response time in the electronic system for R1's medication order clarification was part of the delay in starting those medication administration. On 6/17/25 at 10:25 am, V27, Physician, stated, The new admission orders from the hospital must be reviewed with a provider. That is the acceptable standard of practice. Medications that are not available from the Pharmacy should be reported to the providers. We would generally consider other medications that are readily available. V27, Physician, also stated, If (R1) was receiving a blood thinner (Eliquis was administered) in the facility after (R1's) cardioversion, I don't believe there would be harm or a threat of harm. Though, a delay in administering her other medication would be a concern that should have been reported, and addressed by (R1's) Primary Care Physician (V7, MD) or (V8) Nurse Practitioner, who know (R1) and could review the total picture.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for one (R1) of twelve resident reviewed medical record accuracy on the sample list of 12. Findings include: 1.) R1's admission Observations, dated [DATE], documents R1's code status was Full Code (attempt resuscitation). R1's Face Sheet, dated [DATE] - [DATE], documents R1's code status was Full Code. R1's IDPH (Illinois Department of Public Health) Practitioner Order For Life-Sustaining Treatment (POLST) Form, also dated [DATE], signed by R1, documents R1's code status was No CPR (Cardio Pulmonary Resuscitation), Do Not Attempt Resuscitation (DNAR). R1's Physician Order Sheet (POS), dated [DATE] - [DATE], documents R1's code status was a Full Code, and incongruent with the above POLST signed by R1 on [DATE]. R1's Progress Notes, dated [DATE] at 11:04 am, documents the following; Patient (R1) did c/o (complain/of) not feeling well, c/o SOB (complained of shortness of breath), weakness, cough. Heard crackling in bilateral upper lobes. (V8, Nurse Practitioner) was here and seen patient, gave order to send out to hospital. (V33, Family Member) in room and heard what was going on. Ambulance called at 9:35 am. Patient left facility via ambulance service around 9:55 am. Report called to ER (Emergency Room) at 10:10 am. On [DATE] at 9:20 am, V4, Resident Service Director (RSD), provided R1's POLST signed by R1 [DATE], on admission. V4, RSD, confirmed R1's POLST form was incomplete. V4, RSD, confirmed R1's POLST form did not document a provider signature until V34, Nurse Practitioner, signed the POLST form on [DATE] (13 days after R1 admitted to the facility). R1's POLST form documents R1 was DNAR status. V4, RSD, reviewed R1's electronic medical records. V4 confirmed R1 was transferred to the hospital on [DATE]. V4, RSD, stated, Usually, the POLST form is sent to the hospital with the residents POS, and bed hold documents. (R1's) POS says she was a full code when she went to the hospital on [DATE]. I think (R1) expired in the hospital [DATE] (hospital records document R1's deceased date as [DATE]). V4, RSD, stated, Obviously, if the POLST was sent to the hospital, it would have been very confusing, since the other resident records don't match the POLST. On [DATE] at 10:00 am, V2, Director of Nursing, stated, The facility considers all residents a full code until the POLST is signed by the provider, usually that is within a week. (R1's POLST form was not signed by V34 NP, until [DATE], 13 days after R1 signed it, and six days after R1 was admitted to the hospital therefor incomplete medical record. The POLST is sent to the hospital, with the bed hold form and the POS (Physician Order Sheet). (V3, Registered Nurse) should have documented these were sent with (R1). V2, acknowledged the POLST form and POS are incongruent and incomplete. 2.) R1's Progress Note, dated [DATE] at 5:28 pm, documents R1 was admitted to the local hospital with bilateral pneumonia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Note, dated [DATE] at 12:49 pm, signed by V25, Social Service Director (SSD) documents the following: (R1) discharged to home yesterday from a hospital stay, [DATE]. R1's Hospital Death Summary documents R1 was admitted to the hospital on [DATE] after transfer to the hospital emergency room from the facility. R1 remained in the hospital seven days. The same Death Summary documents R1 expired in the hospital [DATE] at 3:44 am. On [DATE] at 10:40 am, V25, Social Service Director (SSD), confirmed she wrote a note in R1's medical record on [DATE] that was not accurate. V25, SSD, stated, I wrote (R1) was discharged from the hospital to home. I thought I heard in morning meeting that (V33, R1's Family Member) said (R1) went home from hospital. I did not talk to the family myself. I shouldn't have documented that in (R1's) medical record. 3.) R1's Physician Order Sheet (POS) documents R1's Fosinopril medication order was not clarified until [DATE]. R1's physician ordered medication documents: Fosinopril tablet; 10 milligrams tablet, by mouth, once each morning between 07:00 AM - 10:00 AM. The facility (Proper name) Pharmacy Consolidated Delivery Sheet documents the facility staff (unidentified) signed off the pharmacy delivery sheet for R1's Fosinopril medication on [DATE]. R1's Medication Administration Record (MAR), dated [DATE] - [DATE], documents V32, Registered Nurse (RN), signed off that V32, RN, administered R1's physician ordered Fosinopril medication on [DATE]. The medication had not been delivered to the facility, as documented above on the (Proper name) Pharmacy Consolidated Delivery Sheet. On [DATE] at 10:00 am, V2, Director of Nursing (DON), reviewed R1's medical records. V2 DON confirmed R1 did not receive R1's Fosinopril medication, as it was not delivered until [DATE]. On [DATE] at 1:10 pm, V32, Registered Nurse (RN), stated V32 knew R1's medication was ordered from the pharmacy, but the pharmacy was out of stock. V32's acknowledged she could not have administered R1's Fosinopril on [DATE]. V32 stated, I had just come back after vacation, and I had a lot of new residents that I did not know. I can't recall without looking at my charting. If I charted I gave a medication when I didn't, I don't usually do that.