

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2024
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NAME OF PROVIDER OR SUPPLIER HAWTHORNE INN OF GALESBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2245 N SEMINARY ST GALESBURG, IL 61401
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(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
A 000	Initial Comment Annual License Survey	A 000		
A4060	<p>Seciton 295.4060 Alzheimer's and Demential Programs</p> <p>This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs</p> <p>C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include:</p> <ul style="list-style-type: none"> i) assessing resident capabilities and developing and implementing service plans; ii) promoting resident dignity, independence, individuality, privacy and choice; iii) planning and facilitating activities appropriate for the dementia resident; iv) communicating with families and other persons interested in the resident; v) resident rights and principles of self-determination; vi) care of elderly persons with physical, cognitive, behavioral and social disabilities; vii) medical and social needs of the resident; viii) common psychotropics and side effects; ix) local community resources; and x) other related issues. <p>Type 3 Violation</p> <p>Based on interview and record review, the facility failed to ensure all staff received yearly required training for E4, one of five employees reviewed for training in a sample of five. This could affect all 42 residents residing in the facility.</p>	A4060		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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A4060	<p>Continued From page 1</p> <p>Findings include:</p> <p>E4's (LPN/Licensed Practical Nurse) personnel file documents E4 started at the facility on 6-19-2018. E4's Individual Employee Training Record for 2023 and 2024 documents only one inservice being completed. On 1-5-24 a Covid precautions inservice lasting 15 minutes was completed. .</p> <p>On 11-15-24 at 10:45 am, E1 (Manager) stated E4 works only one day a month so she misses inservices. This would be her only facility provided training. E1 stated they will need to come up with a plan for E4 to get her required training completed.</p>	A4060		