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	08/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent cross contamination during wound care and implement pressure ulcer treatments for one of four residents (R4) reviewed for wounds in the sample list of eight. Findings Include: The facility's Wound Care policy, dated 10/16/24, documents wounds are subject to infection, and to wash your hands and wear gloves as part of wound care. This policy documents follow physician's orders for wound care and enter physician's orders into the resident's electronic medical record (EMR). R4's Hospital Discharge Transfer Orders, dated 7/31/25, document R4 has an unstageable pressure ulcer of the coccyx and a deep tissue injury to the right heel. R4's active care plan documents R4 admitted to the facility on [DATE], and includes an intervention for wound treatments and dressing changes per physician's order. R4's Initial Wound Evaluation & Management Summary, dated 8/5/25, recorded by V30, Wound Physician, documents R4's stage two pressure ulcer of right heel measured 2 centimeters (cm) long by 0.8 cm wide, and depth is unmeasurable due to presence of tissue overgrowth. The treatment ordered for this wound is skin protectant daily and as needed. This summary documents R4's stage four sacral pressure ulcer measured 6.5 cm by 5.5 cm, and depth is unmeasurable due to the presence of nonviable tissue and necrosis (dead tissue). This wound was initially unstageable and debrided by V30 to remove the dead tissue, which revealed the wound to be a stage four pressure ulcer, and not a deterioration of the wound. R4's physician's order history, dated 7/13/25-8/13/25, includes an order, dated 8/6/25, for stage four sacral pressure ulcer treatment, cleanse with wound cleanser/normal saline, apply Dakin's (bleach solution) soaked gauze to wound bed, cover with abdominal pad, and secure with tape twice daily and as needed. This order history includes an order, dated 8/1/25-8/13/25, to apply bordered antimicrobial foam dressing to bilateral heels, change every five days. This order history does not document V30's order for skin protectant to R4's heels prior to 8/13/25. On 8/11/25 at 11:21 AM, R4 stated R4 admitted to the facility with a sore on R4's bottom, and V30 removed dead tissue from the wound. R4 stated R4 also had a sore on his heel that he admitted with, but believes it is healed now. On 8/11/25 at 11:26 AM, V17, Certified Nursing Assistant, stated R4 used to have a sore on his heel, but it is now healed. V17 removed R4's socks and there were no dressings covering R4's heels. R4's skin to the left heel was intact, and the right heel had a red,, intact wound. On 8/13/25 at 10:23 AM V10 Registered Nurse (RN), with V17 present, provided R4's sacral wound treatment. V10 removed R4's soiled sacral dressing, washed hands, and changed gloves. R4 was lying in bed and had a golf ball sized open, deep wound to the left buttock/sacral area. The wound bed was pink with a minimal amount of yellow tissue. V10 cleansed the wound with wound cleanser and gauze, and did not perform hand hygiene or change gloves, prior to applying the Dakin's soaked gauze and bordered foam dressing. V10 removed R4's shoes and socks and there were no dressings on R4's heels. There was a small red, intact wound to the right heel. V10 stated the right heel wound was present on admission and was never open. On 8/13/25 at 10:35 AM, V10 confirmed V10 did not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	08/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform hand hygiene or glove changes after cleansing R4's wound, prior to applying the clean dressing. V10 stated V10 thought this was only needed after removing the soiled dressing. On 8/13/25 at 11:00 AM, V8, RN, stated V8 has been filling in as the wound nurse. V8 confirmed V30 ordered skin protectant treatment for R4's heels on 8/5/25, and confirmed this order was not entered into R4's EMR. V8 confirmed bordered foam dressings changed every five days is R4's current/active treatment order. V8 stated the treatment is for protection of R4's heels. V8 stated V30's orders and notes are given to V8 or V2, Director of Nursing, to enter into the resident's EMR. V8 stated the nurses should perform hand hygiene and glove changes after each step of the wound treatment, including after cleaning the wound.

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	08/13/2025

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 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 ensure medical records are complete and accurate for one of four residents (R1) reviewed for injuries in the sample list of eight. Findings Include:R1's Nursing Notes document R1 admitted to the facility from the hospital on 7/10/25. R1's Nursing Notes, dated 7/10/25, do not document an assessment of R1's skin or if R1 had any skin issues or bruising. R1's Nursing Note, dated 7/13/25 at 3:39 PM, documents R1's incisions to left thigh, right groin, and chest are closed. There is no documentation in R1's nursing notes between 7/10/25 and 7/16/25 that R1 had any bruising. R1's admission Observation, dated 7/10/25, documents there were no alterations in R1's skin. R1's Skin Assessment, dated 7/16/25, documents, Incisions & bruising. No new areas of concern. This assessment does not document the location of R1's bruising. On 8/13/25 at 8:31 AM, V10, Registered Nurse, stated R1 admitted to the facility five weeks post Coronary Artery Bypass Grafting (CABG). V10 stated R1 had closed incisions to the groin, leg, and chest that were left open to air and no treatment needed. V10 stated R1 also had bruising to her hip or rib area. V10 stated nurses document weekly skin assessments and admission skin assessments under the observations section of the resident's electronic medical record, and this may also be noted in a nursing note. At 9:26 AM, V10 stated the bruising V10 documented in R1's skin assessment note 7/16/25 was the bruising V10 previously mentioned. V10 stated V10 did not consider the bruising to be a new issue since it was previously reported on R1's admission. V10 stated V10 had received report from the hospital the day R1 admitted and was told R1 had hip bruising. On 8/13/25 at 9:11 AM, V2, Director of Nursing, stated R1 admitted with bruising following CABG. V2 confirmed R1's admission assessments, skin assessments, and notes do not document R1 admitted with incisions or bruising. V2 stated V2 has requested R1's provider progress notes and is waiting on V29, Nurse Practitioner, to send R1's notes to the facility and obtain documentation that R1 had hip bruising on admission. R1's Progress Note, dated 7/11/25, recorded by V29 documents R1 was hospitalized on [DATE] and underwent left heart catheterization; R1 underwent two vessel CABG on 6/5/25 and developed a right femoral arterial sheath hematoma. This note documents R1 had a midsternal incision that was dry and open to air, with no drainage or inflammation noted. This note documents R1's left medial thigh incision from vein graft site was open to air, healed, and dry. This note was included in R1's provider progress notes, provided by V2, with a facsimile cover sheet documents R1's notes were sent to the facility from V29 on 8/13/25 at 8:56 AM. The facility's Job Description Medical Records, dated May 2013, documents responsibilities includes tracking and monitoring physician visits/notes, uploading documentation into the resident's electronic medical record, conducting audits of resident medical records and reporting discrepancies to the Director of Nursing.