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 _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF DANVILLE	3222 INDEPENDENCE DRIVE DANVILLE, IL 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
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation #1661070/IL83669-No deficiencies Validation Survey for Subpart U: Alzheimer Unit Hawthorne Inn of Danville is in substantial compliance with Subpart U:Alzheimer Unit, 77 Illinois Administrative Code Section 300.7000	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to make survey results readily assessable for residents to examine and failed to provide access to complaint survey results. This has the potential to effect all 62 residents residing at the facility. Findings include: On 3/1/2016 at 12:45PM, the facility "Survey Book" was located in the front lobby. The Survey Book contained the annual licensure and	F 167		3/3/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/17/2016

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F 167	Continued From page 1 certification results and plans of correction from 2013, 2014 and 2015. There were no complaint surveys (7/30/2015, 8/31/2015, 9/3/2015, 10/30/2015, 11/12/2015 and 1/27/2016) results or plans of correction available for resident review. On 3/1/2016 at 1:00PM, E3 (Human Relations Director) stated " It requires a code for the door in order for residents residing in the long term care section of the home to access the lobby. The staff have the door code. Residents do not have the door code. The residents do not have access to the front lobby without staff assistance. On 3/1/2016 at 1:15AM, R18 stated " I have no idea where the survey results are kept. I've never seen them." On 3/2/2016 at 9:50AM, E1 (Administrator) stated "I did not know the complaint surveys needed to be in the survey book for review." The Resident census and Condition Report dated 2/29/2016 documents 62 residents reside at the facility.	F 167		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		3/4/16

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F 329	Continued From page 2 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents' psychotropic medication consents included the correct dosage amount, after the psychotropic medication is increased. This applies to one of four residents (R7) reviewed for psychotropic medication, in the sample of 15. The findings include: R7's Physician Order Report, for 2/2/16-3/2/16 states on 2/9/16, Risperidone 0.5 milligrams (mg) oral, twice a day was ordered. R7's Psychotropic Medication Consent, dated 2/4/16 and signed by Z3 (R7's husband), states R7 receives Risperidone 0.25 mg twice a day. On 3/1/16, E2 (Director of Nurses) stated a new Psychotropic Medication Consent was not updated to reflect the increase in dosage of R7's	F 329		

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F 329	Continued From page 3 Risperidone. The facility's Psychopharmacologic Drug Usage Procedure policy, revised 9/08, states consent for use of psychopharmacologic medications must be in writing by the resident and/or resident's representative. The policy fails to identify the inclusion of medication dosage on the consent.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain two ventilation system diffusers and a roll-up type fire door to prevent dust contamination of food items. This failure has the potential to effect eleven residents (R1, R4, R5, R7, R8, R9, R10, R14, R16, R17, and R18) on the sample of fifteen and thirty-three residents on the supplemental sample (R2, R6, R11, R12, R13, R23, R24, R25, R26 through R44, and R46 through R51). Findings include: 1. On 3/1/16 at 11:57 am, the ceiling ventilation	F 371		3/3/16

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F 371	Continued From page 4	F 371		

diffuser in the Manor Dining Room kitchenette was discolored and visibly soiled with dust. This ventilation diffuser was directly overhead to the steam table where the resident's meal was being served.

2. On 3/1/16 at 12:12 pm, the ceiling ventilation diffuser in the Garden Court Dining Room kitchenette was discolored and visibly soiled with dust. This ventilation diffuser was directly overhead to the steam table where the resident's meal was being served.

3. On 3/1/16 at 12:12 pm, the fusible link on the automatic roll-up fire door in the kitchenette service window in the Garden Court Dining Room was covered in dust so that the dust was hanging down from the fusible link like icicles. This fusible link is directly overhead to the counter surface in the kitchenette window through which resident meals are placed for service.

On 3/1/16 at 11:57 am, E17 stated, "Maintenance is responsible for cleaning those (vent diffusers)."

On 3/1/16 at 12:18 pm E18, Dietary Supervisor, acknowledged the diffuser was dusty and stated , "O.K.."

On 3/1/16 at 3:00 pm E5, Maintenance Director stated, "That is dust. I am having one of my guys get to work on cleaning these items right now."

The facility's Resident Listing and Level of Care, labeled by E1, Administrator, to show which dining room each resident dines, documents R1, R5, R8, R10, R14, R16, R18, R24, R25, R26, and R28 through R36 dine in the Manor Dining Room, and R2, R4, R6, R7, R9, R11, R12, R13,

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F 371	Continued From page 5 R17,R23, and R37 through R44 and R46 through R51, dine in the Garden Court Dining Room.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		3/4/16

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F 441	Continued From page 6 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to dispose of a lung tube drainage system in a biohazard container and failed to disinfect hair rollers between usage. This applies to 2 of 3 residents (R2 and R16) reviewed for infection control in a sample of 15 and 2 residents (R21 and R23) in the supplemental sample. Findings include: On 3/1/2016 at 1:45PM, a lung tube drainage bottle with foul smelling green/gray liquid with mold like substance growing in the liquid was on the counter in the soiled utility room on Manor Court. On 3/1/2016 E5 (Environmental Director) stated "I have no idea what that bottle is, but it has a very foul smell. I will get the Director of Nursing (E2). On 3/1/2016 E2 (Director of Nursing) stated "That is a lung drainage bottle. The bottle should have been placed in a biohazard red bag and disposed of immediately after removal. The last resident (R21) who had a lung drain expired on 1/8/2016, therefore the bottle has sat on the counter from 1/8/2016 through 3/1/2016." The Physicians Order Sheet dated 12/31/2016 documents R21 has a lung tube in place and the bottle is to be changed weekly.	F 441		

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F 441	Continued From page 7 R21's Social Services Note dated 1/9/2016 documents " Expired on 1/8/2016." R21's Face Sheet dated 12/31/2015 document a diagnosis of Pneumonia due to Streptococcus Pneumoniae and Lung Cancer." The facility "Biohazard Spill Clean Up" documents #6- dispose of gloves and any contaminated materials in a leak proof red plastic bag or a bag marked with biohazard symbol." On 3/1/2015 at 1:00 PM, R16 was sitting in the beauty shop chair getting hair set on plastic rollers. The rollers were in a tub next to the sink. The rollers had hair and a sticky substance on them. On 3/1/2016 at 1:20PM, Z1 (Beautician) stated " I sanitize the rollers two or three times a week. I do use the rollers on more than one resident before sanitizing them." On 3/1/2016 at 2:45PM, E2 (Director of Nursing) stated " There were three residents (R16, R22 and R23) who had their hair washed and set on rollers today. There is no facility policy for beauty shop equipment cleaning. The beautician cleans the equipment. I would say that rollers should be cleaned between resident use."	F 441		