STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510192	A. BUILDING: _____ B. WING _____	C 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF PEORIA	6906 N STALWORTH DR PEORIA, IL 61615

(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 Original investigation of Complaint 2626380 / IL 202017. Violation : 295.2000 c) 1)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Section 295.2000 Residency Requirements c) A person shall not be accepted for residency if: 1) The person poses a serious threat to himself or herself or to others; TYPE 1 VIOLATION Based on record review and interviews, the establishment accepted one of three sampled residents that posed a serious risk to himself due to his cognitive decline. (R1) This failure creates a substantial probability of severe harm (or death) to a resident. Findings include: R1's Service Plan dated 11/11/25 notes that R1 is oriented to only person and exhibits intentional wandering. R1's Physician's "Comprehensive Observation" dated 1/26/26 notes that R1's Diagnosis include, "Other symptoms and signs involving cognitive functions and awareness. Comprehensive Observation also notes that R1 is alert to only person and walks without any difficulty.	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510192	A. BUILDING: _____ B. WING _____	C 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF PEORIA	6906 N STALWORTH DR PEORIA, IL 61615

(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
A2000	Continued From page 1 On 6/4/26 at 10:02 A.M., Z1 (R1's Son) stated that R1 had been residing in the independent living part of the establishment until November of 2025. R1 moved over to the Assisted Living part of the establishment at that time due to R1 becoming more confused and becoming unsafe to be walking outside on his own. Z1 stated that R1 is not safe at this time to go outside unsupervised. Z1 was under the impression that the assisted living part of the establishment is a locked area, which would keep R1 from getting out unsupervised. Z1 stated that R1 is on a waiting list for a local Memory Care facility. On 6/4/26 at 2:35 P.M., E4 (CNA) stated that R1 is not safe to go outside unsupervised due to his poor safety awareness. E4 stated that she works with R1 most evenings and R1 will attempt to leave the facility but will get scared when the door alarm goes off. E4 stated that the door alarm seems to keep R1 from leaving. On 6/4/26 at 11:10 A.M., Z2 (R1's Private Caregiver) stated that she comes to see R1 a couple hours a day, 5 days a week. Z2 stated she takes R1 on walks and will drive him to go shopping and to have coffee. Z2 stated that R1 is not safe to go outside unsupervised any longer due to his increased confusion.	A2000		