

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Avenues at Royal Oak		STREET ADDRESS, CITY, STATE, ZIP CODE  605 East Church Street Kewanee, IL 61443	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32061</p> <p>Based on interview and record review, the facility failed to protect one of three residents (R2) from physical abuse by another resident, in a sample of seven.</p> <p><b>FINDINGS INCLUDE:</b></p> <p>The facility policy, Abuse Prevention and Reporting, dated (approved) 09/2024 directs staff, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.</p> <p>The facility Report to State Office, dated 3/8/2025 at 6:00 A.M. and signed by V1/Administrator documents, (R3) alleges (he) was struck by another resident (R2). Injuries: 2 CM (Centimeter) laceration to left forearm. Residents were immediately separated. Laceration assessed and treated by nurse. Responsible party, MD (Medical Doctor), Police and Ombudsman notified.</p> <p>The facility form dated 3/10/2025 and signed by R3 documents, (R3) states that he was sitting in his wheelchair and (R2) threw something across the room then went over and hit (R3) with his crutches.</p> <p>The facility form dated 3/10/2025 and signed by R2 documents, (R2) stated that he got into his chair and went over to (R3) and hit him three times with his crutch. (R2) stated he did it because (R3) was making snoring noises the night before when (R2) was trying to play his game.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Original Allegation: Peer to Peer form, dated (final) 3/11/2025 documents, Review of facility investigation documents, (R2) is a [AGE] year old resident with diagnosis to include Chronic Diastolic Heart Failure, COPD (Chronic Obstructive Pulmonary Disease), Nonrheumatic Aortic Valve Insufficiency, Alcohol Abuse, Essential Hypertension, Acquired Absence of Right Leg Above Knee, Rheumatic Tricuspid Insufficiency, Chronic Kidney Failure Stage 3 and Major Depressive Disorder. (R3) is a [AGE] year old resident with diagnosis to include Paranoid Schizophrenia, COPD, Depression, Intellectual Disabilities and Anxiety Disorder. It was reported to (V2/Administrator) an altercation between (R2) and (R3) while in their room. (R2 and R3) were immediately separated and assessed. Responsible parties, Physician, Law Enforcement and Ombudsman notified. (R3) noted to have a 5 CM (Centimeter) X .5 CM abrasion to left forearm. Area cleansed and dressed per MD (Medical Doctor) orders. No psychological changes noted to either (R2 or R3). Investigation initiated. Resident interviews were obtained. There were no witnesses to altercation. Summary and Analysis of the Evidence: Staff and residents both reported residents were in room with no witnesses's present when altercation occurred. (R2) became agitated related to (R3) making noises and struck (R3) in left forearm and shoulder. Conclusion and Action Taken: (R2) was moved to another room. No psychological changes were noted to either (R2 or R3). SSD (Social Services Director) or designee will follow up with (R2 and R3) for any psychological needs that arise. Care Plans are reviewed and updated as necessary for both (R2 and R3). Both (R2 and R3) relate that they feel safe in their environment on 3/10/25.</p> <p>On 3/24/2025 at 9:58 A.M., R2 states (R3) was always bugging me. (R3) would make this loud moaning sounds on purpose. (R3) knew it bugged me. I had told (R3) to knock it off and (R3) wouldn't listen. I took my crutches and hit (R3) in the head with it. (R3) still wouldn't stop and I went to hit him again and he put his arm up to block me and I cut his arm with it. I would do it again if (R3) kept bugging me. They came in and moved me to another room. I was by myself for awhile, but they moved some guy in with me. I haven't had any problems with him yet.</p> <p>On 3/27/2025 at 2:30 P.M., V1/Administrator verified the resident to resident abuse between R2 and R3.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32061</p> <p>Based on interview and record review, the facility failed to perform a PASARR (Pre-Admission Screening and Resident Review) rescreen after the emergence of a newly diagnosed severe mental illness for one of three residents (R2) reviewed for PASARR screening, in the sample of 7.</p> <p><b>FINDINGS INCLUDE:</b></p> <p>The facility policy, Preadmission Screening and Annual Resident Review, dated (reviewed) 3/2024 directs staff, Annually and with any significant change of status, the facility will complete the PASARR Level 1 screen for those individuals identified per the Level 11 screen requiring specialized services. The facility will report any changes identified via the screen to the state mental health authority or the state intellectual disability authority promptly. The facility will refer all level 11 residents and all residents with newly evident or possible serious mental disorder for a level 11 review upon a significant change in status assessment to the State PASARR representative.</p> <p>R2's most current PASARR screen, dated 5/4/2024 documents, The Level 1 screen indicates that a PASARR disability is not present present because of the following reasons: There is no evidence of a PASARR condition of an intellectual/development disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted.</p> <p>R2's facility Face Sheet documents that R2 was admitted to the facility on [DATE] with the following diagnoses: Right Above the Knee Amputation, Chronic Diastolic Heart Failure; Chronic Obstructive Pulmonary Disease and Alcohol Abuse.</p> <p>R2's Psychiatric Note, dated 3/10/25 documents, Since last visit, an empty bottle of tequila was found in patient's room and he has tried to attack another resident with a stick. History Of Present Illness: (R2) is a [AGE] years old male patient with a recorded history of Major depressive disorder and Alcohol abuse. Per social work, (R2) has been responding to internal stimuli for the past two months. Last month, this escalated to verbal outbursts. Also since last visit, an empty bottle of tequila was found in his room and (R2) has tried to attack another resident with a stick. Interviewed in his room, sitting in a chair. (R2) is oriented to person, place, time and situation. His mood is anxious, irritable and is cooperative. Minimizes symptoms, his insight and judgment are poor. States he is only reacting to</p> <p>people trying to test him. Denies drinking alcohol over the past year. Patient is an unreliable historian. Sleep patterns remain unaffected, and there have been no significant changes in appetite. No other manic symptoms are observed or reported. No reports of Auditory Hallucinations, Visual Hallucinations, Suicidal Ideation's or Homicidal Ideation's, no paranoid thought were observed or noted on this visit. No other side effects from medication reported. Plan to decrease Duloxetine (Anti depressant) to 60 MG (Milligrams) daily due to behavior change since adjustment. Will start Quetiapine (Anti psychotic) 50 mg twice daily due to increasing psychotic symptoms. Diagnosis: Severe recurrent major depression with psychotic features.</p> <p>(continued on next page)</p>		

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F 0644  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 3/27/2025 at 10:35 A.M., V1/Administrator confirmed no updated PASARR screen had been performed for R2 after the emergence of a documented serious mental illness diagnosis on 3/10/2025.		