STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on interviews and record review, the facility failed to protect two vulnerable residents by not preventing resident to resident physical abuse. This failure applied to two of four residents (R2, R4) reviewed for abuse in a sample of 6 that resulted in R2 being hit on the top of the head by R1 and R4 being slapped on the hand by R5. Findings include: 1. Final investigation report dated 04/25/2025 documented that R1 and R2 were both in the main hallway when alleged incident occurred. R2 was in wheelchair and cut in line in front of R1, who was standing. R2 touched R1's back as she was trying to get around her in the wheelchair. R1 instinctively turned and made contact to the top of R2's head. R1's face sheet indicated the resident admitted to the facility on [DATE] with a past medical history not limited to bipolar II disorder, anxiety disorder, post-traumatic stress disorder, and attention-deficit hyperactivity disorder. Brief Interview for Mental Status (BIMS) dated 05/20/2025 showed R1 has no cognitive impairment. Abuse/neglect screen dated 05/15/2025 (after incident date) indicated R1 is at high risk for abuse/neglect. No aggression screening was noted in R1's electronic medical record. R1's care plan indicated the resident is known to have hallucinations and/or delusions (09/26/2024); uses psychotropic medication to manage mood and/or behavior issues (11/27/2024); and has displayed verbal/physical aggression (11/27/2024). Social Service Note dated 04/22/2025 at 3:29 PM indicated that staff discussed with R1 her behaviors from incident with peer, discussed coping skills and not touching others. R1 stated she was aware. Social Service Note dated 04/23/2025 at 12:35 PM indicated that staff discussed recent behaviors with R1, discussed keeping hands to herself, along with triggers and coping skills. R1 verbalized understanding. On 05/16/2025 at 10:55 AM, R1 said she was standing in line for banking when she (R2) cut in front of her in line. R1 then said R2 had punched her in the back twice so R1 slapped R2 in the face. R1 added that no staff were present during the incident but came afterward and separated them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's face sheet indicated the resident last admitted to the facility on [DATE] with a past medical history not limited to altered mental status, schizoaffective disorder, bipolar disorder, phobic anxiety disorder, depression, paranoid personality disorder, strange and inexplicable behavior. Brief Interview for Mental Status (BIMS) dated 03/19/2025 showed R2 has no cognitive impairment. Abuse screening dated 04/24/2025 indicated R2 is at high risk for abuse/neglect. R2's care plan indicated the resident has impaired cognitive function (rev 03/27/2025); verbal/physical aggression toward residents and has been involved in open conflict with peers, hit another peer related to poor impulse control (rev 02/05/2025); uses anti-psychotic medications related to behavior management (rev 10/16/2024); behaviors can be seen as is disruptive and socially inappropriate (rev 05/01/2024). Social Service Note dated 04/22/2025 at 3:43 PM documented staff discussed with R2 her recent behaviors and alternative ways to handle feeling frustrated. Social Service Note dated 04/23/2025 at 12:25 PM documented staff discussed with R2 her recent behaviors, discussed keeping her hands to herself and using kind words with others. R2 was educated on triggers and coping skills. Nursing Note dated 04/23/2025 at 2:25 PM indicated the interdisciplinary team met with R2 regarding resident to resident altercation. Residents were immediately separated, and each placed on 15 minute checks to avoid further incident. Resident was counseled on being aware of surroundings and to avoid bumping into others, and on using appropriate and respectful language when speaking to and/or about other residents. On 05/16/2025 at 11:03 AM, R2 said she did not recall the incident with R1. On 05/20/2025 at 11:35 AM, V5 (Licensed Practical Nurse) said she was informed by staff that R1 and R2 were standing in line for banking when R1 said R2 either hit her purse or had tried to grab it, so R1 proceeded to turn around and hit R2 on the top of her head. V5 added that she assessed both residents with no findings. V5 then said the aides are supposed to monitor the banking and shopping lines from the unit dining room but no staff had observed the incident to her knowledge. 2. Final investigation report dated 03/31/2025 documented on 03/24/2025, R4 had reached for R5's drink while at the dining table then R5 instinctively reacted and swatted at R4's hand making contact to the back of her hand. R4's face sheet documented the resident last admitted to the facility on [DATE] with a past medical history not limited to anoxic brain damage, anxiety disorder, delirium, depression, sleep disorder, and insomnia. Brief Interview for Mental Status (BIMS) dated 05/06/2025 showed R4 has severe cognitive impairment. Abuse/neglect screening dated 05/12/2025 indicated R3 is at a low risk for abuse/neglect. Per R4's care plan, the resident has impaired cognitive function (05/12/2025) and is at low risk for abuse/neglect (03/28/2025). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incident Note dated 03/24/2025 at 8:50 AM documented that writer (V3 Assistant Director of Nursing/ADON) was walking in dining room and saw the resident (R4) being slapped on the back of her right hand by peer (R5) that was sitting at the same table. Resident was immediately moved to another table and assessed . Peer stated that this resident (R4) was attempting to take his beverage, so he slapped her hand to stop her. Peer was educated and instructed not to touch other people in any way. On 05/16/2025 at 11:28 AM, R4 was observed sleeping at the dining room table in the main dining room. R4 was non-verbal and did not recall the incident. R5's face sheet documented the resident last admitted to the facility on [DATE] with a past medical history not limited to major depressive disorder, cerebral infarction, chronic pain and nicotine independence. Brief Interview for Mental Status (BIMS) dated 03/21/2025 showed R5 has no cognitive impairment. Abuse/neglect screening dated 03/21/2025 indicated R5 is at a low risk for abuse/neglect. No aggression screening was noted in R5's electronic medical record. R5's care plan documented the resident requires use of psychotropic medication to manage mood and/or behavior issues (rev 04/13/2024); has been involved in prior peer conflict (rev 08/28/2024). Social Service Note dated 03/24/2025 at 4:04 PM documented that social services staff discussed with R5 the incident from that morning. R5 stated his peer (R4) was going to grab his beverage and he slapped the back of her hand. R5 was educated on the importance on not touching other peers. R5 verbalized understanding. Incident Follow Up dated 03/28/2025 at 11:17 AM documented that the interdisciplinary team discussed the peer to peer incident with R5. Seating arrangements were changed to limit contact while in common dining area on date of incident. R5 received 1:1 staff counsel regarding inappropriateness of physical contact with peers and voiced understanding of such on date of incident. Psychiatric provider performed assessment of R5 one day post incident and increased mirtazapine (antidepressant) regimen. R5's active orders as of 05/16/2025 showed order for mirtazapine oral tablet 15 milligrams (mg) give 15mg by mouth in the evening for mood related to major depressive disorder with a start date of 03/30/2025. On 05/16/2025 at 1:23 PM, V3 (ADON) said regarding incident with R4 and R5 that she was walking through the dining room during breakfast when she saw R5 reach out and swat at R4's hand who was reaching for his cup. R5 said she's (R4) trying to steal my drink. V3 then said she moved R4 to another table; was assessed with no injuries. V3 added that no other staff were around and the aides were picking up trays in the dining room, in the vicinity. On 05/16/2025 at 3:10 PM, R5 said regarding incident with R4 that she was trying to take his glass from the table, and he tried to move her arm away and ended up slapping her hand. R5 added that R4 should not have done that to him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse prevention and reporting policy with effective date of 09/2024 reads in part: 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. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents .A resident to resident altercation should be reviewed as a potential situation of abuse .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. 45395 Based on interviews and record review, the facility failed to follow their policy and procedure for pain management by not adequately assessing, documenting or treating a resident's (R3) pain while awaiting further evaluation and treatment post fall with significant injury. This failure applied to one of four residents reviewed for pain management related to falls in a sample size of 6. Findings include: R3's face sheet showed the resident admitted to facility on 03/28/2025 with a past medical history not limited to dementia, neurocognitive disorder, presence of right artificial hip joint (04/29/2025), lack of coordination, anxiety disorder, and obsessive-compulsive disorder. Brief Interview for Mental Status (BIMS) dated 04/10/2025 showed R3 has severe cognitive impairment. R3's admission care plan indicated the resident has impaired cognitive function (rev 04/29/2025); is at risk for falls related to dementia and restless behavior (rev 04/30/2025); is at risk for pain related to left (injury is to the right) femur fracture post-surgery (rev 04/30/2025) with interventions not limited to: pain is alleviated and/or relieved by pain management and repositioning, administer analgesics as per orders, evaluate the effectiveness and monitor/record/report to the nurse any signs or symptoms of non-verbal pain and residents complaint of pain. R3's incident fall assessment completed by V7 (Licensed Practical Nurse/LPN) with an effective date of 04/10/2025 at 12:23 AM, documented a fall incident on 04/09/2025 at 9:25 PM with pain level of three assessed same day at 10:38 PM under section B/assessment and showed under section C for actions/interventions, the physician was not notified until 12:00 AM on same day (should read as 04/10/2025 not 04/09). Under pain assessment, pain scale documented zero and staff assessment for pain was not conducted. V7's incident note dated 04/10/2025 at 12:23 AM documented R3 sustained a fall on 04/09/2025 at 9:25 PM and denied pain, then documented that the resident's pain in not a new onset. R3's progress note dated 04/10/2025 at 10:00 AM documented mobile x-ray was at the facility to perform an x-ray. Results dated the same day showed the resident sustained an acute minimally displaced fracture of the right femoral neck. V4's (Registered Nurse) follow-up note dated 04/10/2025 at 10:25 AM documented in R3's post fall assessment, No pain. The resident's pain in not a new onset. V4's note dated 04/10/2025 at 12:35 PM documented x-ray results were received and reported to V7 (Medical Doctor). V4's progress note dated 04/10/2025 at 3:43 PM documented an order was received from V7 to send the resident to the hospital for evaluation. Emergency transport services (911) were notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Emergency department records for R3 dated 04/10/2025 at 4:34 PM indicated the resident presented with complaints of hip fracture. At 5:40 PM, records indicated R3 complains of pain into his right hip and under physical exam for musculoskeletal, R3's records documented, deformity and signs of injury present. Hospital imaging results for R3 showed the right hip was examined on 04/10/2025 at 5:44 PM for history of right hip pain due to a suspected fracture. Final investigation report dated 04/17/2025 indicated R3 had a witnessed fall on 04/10/2025 and sustained a superficial laceration to the right brow and pain to right hip was noted post fall. In-house mobile x-ray was obtained. R3 was transferred to emergency room for further evaluation and admitted with an acute minimally displaced fracture of right femoral neck that required surgical repair. Second hospital records dated 04/29/2025 and signed by V12 (Medical Doctor) indicated R3 was admitted to this hospital for right hip fracture and underwent a right hemiarthroplasty (partial hip surgical replacement) done on 04/11/2025. Review of R3's medication administration record for April 2025 showed two documented pain levels of 3 on 04/09/2025 and two documented pain levels of 4 on 04/10/2025. Record also showed order for acetaminophen oral tablet 325 milligrams (mg) give [two] tablets by mouth every [six] hours as needed for pain with start date of 03/28/2025 at 7:30 PM and discontinued date of 04/28/2025 at 3:14 PM. No documented administrations for acetaminophen were recorded on this administration record. R3's order summary report dated 05/16/2025 received from facility showed orders not limited to pain assessment every shift and acetaminophen 325mg, give two tablets by mouth every six hours as needed for pain both with order date of 04/29/2025. On 05/16/2025 at 1:41 PM, V6 (Licensed Practical Nurse) said on 04/09/2025 at around 9-10:00 PM, R3 was on the floor in the lounge area of B wing, laying on his right side. V6 then said that R3 yelled out in pain when you touched his legs and indicated that R3 wouldn't straighten out his legs and R3 was in a lot of pain. On 05/16/2025 at 2:13 PM, V4 (Registered Nurse) said she came into work on 04/10/2025 at 6:00 AM and was informed by V6 that R3 fell the night before (04/09/2025) and landed on his right hip. V4 then said she was told in report by V6 that R3 had no complaints of pain during the night until around 5:00 AM. V4 added that she believed V6 had administered acetaminophen to R3 around 5-5:30 AM and that V6 had contacted the physician after R3's fall and after his complaint of pain. V4 then said a resident is sent out emergently after a fall with complaints of pain and/or injury to a specific part of the body. On 05/20/2025 at 12:27 PM V7 (Medical Doctor) said he does not recall being notified of any significant injury for R3 post fall and that he ordered an x-ray be done due to R3's complaints of pain but did not recall the time he was informed of R3's pain complaint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145418	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	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)
F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/20/2025 at 12:08 PM, V8 (Unit Attendant) said on 04/09/2025 at 10:00 PM, she was assigned on 1:1 monitoring for R3. V8 then said that R3 moaned a lot during the night and indicated that when the aides came in and changed his brief at approximately 12:00 AM, he was moaning out in pain and was grabbing at their hands, and after the second time they changed R3's brief around 1:30 AM, he really hollered out in pain and that was when the aides noticed bruising starting to his right hip area. She added that the aides went to get V6 (LPN) at this time and believed R3 had received pain medication from V6. On 05/20/2025 at 3:02 PM, V2 (Director of Nursing) said following R3's fall incident, there was no new order for pain management received. V2 then said her expectation for nursing when administering a pain medication is to complete a pain assessment, document the administration and pain scale then document a follow-up for the effectiveness of medication. On 05/20/2025 at 3:13 PM, V14 (Certified Nursing Assistant) said R3's fall incident occurred about 7:30 PM when he stood up then fell over and landed on his right side. V14 then said about 10:00 PM, R3 started to complain of hip pain during his brief change and continued to complain of pain every time he was checked on which was about every two hours. V14 added that every time R3 was checked on, the nurse (V6) was present and that R3 complained of pain every time staff touched him throughout the night and they placed an ice pack to his hip around 2:00 AM for the pain but R3 wouldn't leave it on. V14 then said that she believed V6 administered acetaminophen to R3 after the fall around 8:00 PM for complaint of head pain and around 4:00 AM and that during last check on R3 at 6:00 AM, that's when R3 was starting to bruise. V14 added that she both V4 (RN) and V6 (LPN) of the bruising to R3's right hip and that he was still complaining of pain. Review of R3's progress notes showed no documentation of resident's complaints of hip pain throughout the night, any pain assessments or monitoring for right hip pain, no administrations of pain medication, or of the bruising noted by V8 and V14 to R3's right hip. On 05/20/2025 at 3:55 PM, V2 (Director of Nursing) said that complaints of pain and the administration of pain medication would be expected post fall with a fracture. Pain management program policy last revised 04/2025 reads in part: to establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program .The pain management program includes the following components but not limited to documentation of pain assessment and monitoring.