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	08/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
	145418	A. Building B. Wing	08/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a residents personal preference and dignity was provided for 1 of 3 residents (R2) reviewed for resident rights in the sample of 8.The findings include:On 7/31/25 at 9:58 AM, R2 was in her room in bed on the locked psychiatric unit of the facility. R2 stated that she never said she was flicked in the eye or face by the nurse. R2 stated what she was upset about was that she was told she could not eat in the main dining room. V5 registered Nurse said she had to eat in the small dining room where the TV is at. R2 stated on Friday after she reported a possible suicide attempt for someone else, she was told she had to eat in the TV/small dining room and not the main dining room. R2 stated sitting in the TV room gives her panic attacks. When she told them that on Friday, they let her eat dinner in the main dining room. On Saturday at breakfast, she thought she would be okay to eat in the dining room; instead V5 made her sit in the TV room and left her there. R2 stated she was having a panic attack and was crying. R2 stated the nurse told her if she would mind her own business she would not be in trouble and could sit in the dining room. R2 stated she told V5 that she did not do anything wrong. R2 stated V9 Certified Nursing Assistant (CNA) was doing a 1:1 for another resident and saw the whole thing. V9 took her to a small TV room and let her eat breakfast there. R2 stated V7 Licensed Practical Nurse (LPN) was texting V4 Assistant Director of Nursing (ADON) while all of this was going on. R2 stated she wasn't allowed to eat in the main dining room until Sunday evening. R2 stated she talked to V1 Administrator, V3 Director of Nursing (DON), V4 ADON, and V8 Social Services about it on Monday.On 7/31/25 at 10:19 AM, V6 Social went over to B hall with the surveyor to view dining room area. The smaller dining room with a TV was the first area that residents can enter before going into the main dining room. There was a doorway that goes from the small dining room/TV area into a large dining room. Inside the dining area to one side is the nurse's station that is open and lacks any privacy. V6 stated the area is split up and due to the wheelchairs and space. Some residents eat in the main dining room, and some eat in the smaller dining room with the TV. Residents can sit wherever they want and there isn't any assigned seating on B hall.On 7/31/25 at 10:37 AM, V5 Registered Nurse (RN) stated, she was instructed to have R2 sit in the TV room because she listens to everyone's conversations. R2 comments on the conversations; she butts in and is listening when she shouldn't. R2 was put in the TV room for breakfast (on Saturday 7/26/25), and she threw a fit. R2 was crying profusely.On 7/31/25 at 11:04 AM, V4 ADON stated nursing staff came to her and stated they were having problems with R2 trying to listen in on their conversations with other residents. On Friday, she asked R2 asked to sit in the other dining room where the TV is located, and she was agreeable. V4 stated she noticed at dinner on Friday, R2 was sitting in the main dining room. The next day V5 asked about it and said R2 didn't want to sit in the other room so I told her to let her sit in the main dining room. As far as I know she continued to sit in the main dining room. Originally on Friday the plan was to have her sit in the other dining room and not the main dining room. On 7/31/25 at 11:33 AM, V2 Assistant Administrator stated she talked to R2 this week and R2 did ask her if I heard about what happened over the weekend. V2 stated she told R2 she would investigate it. V2 stated she talked to V4 who told her she was called this weekend. V4 stated on Friday R2 said she would sit in the dining room/TV room then she got called Saturday because R2 said she didn't want to sit there.On 7/31/25 at 2:12 PM, V9 CNA stated R2 was put in the TV room for breakfast. V5 said R2 had to sit in there and R2 got upset. I didn't see everything but could hear what was going on. V5 said they were told that she is to sit in there. R2 told V5 she talked to the DON, and she could sit in the dining room if she wants to. V5 was being stern, and she was rude to R2. V5 told R2 that it wasn't her job, and she didn't know why this happened. V5 said she could talk to them on Monday. V5 wasn't yelling at R2. This happened on Saturday. I could hear her crying and she was really upset. They were all ignoring her. The nurse and CNAs ignored her. This was right before breakfast was brought out. I went and moved her from the TV room to the smaller tv room on the women's hall.The facility's Residents' Rights policy (11/2018) showed, your rights to dignity and respect: you have the right to make your own decisions. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.The Face Sheet Dated 7/31/25 for R2 showed diagnoses including bipolar disorder, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypothyroidism, necrotizing fasciitis, acute respiratory failure with hypercapnia, primary insomnia, body mass index 70 or greater, intermittent explosive disorder, hypertension, polycystic ovarian syndrome, attention deficit hyperactivity disorder, predominantly inattentive

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	08/01/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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	08/01/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility's direct care staff failed to notify the abuse coordinator of an injury of unknown origin for one of four residents (R1) reviewed for abuse in a sample of eight.The findings include:R1's face sheet indicated an initial admission date of 03/01/2011 with a past medical history not limited to: paranoid schizophrenia, bipolar disorder, major depressive disorder, mood affective disorder, anxiety, anemia, pruritis, history of shock therapy, and long term (current) use of anticoagulants.R1's care plan indicated but not limited to: risk for injury related to limited dexterity and cognitive impairment and risk for falls with date initiated of 10/02/2023.R1's Minimum Data Set (MDS) section C for cognitive patterns dated 04/13/2025 indicated severe cognitive impairment. R1's skin condition report with effective date of 07/26/2025 submitted by V7 (Licensed Practical Nurse) documented bruising to R1's rear right thigh, chin, front left shoulder, and right front lower leg that were purple in color and a new/change in skin condition. Review of facility reported incidents revealed an initial report for R1 related to a bruise of unknown origin with an incident date of 07/26/2025 that was submitted to Illinois Department of Public Health (IDPH) on 07/28/2025. R1's abuse/neglect screen dated 07/28/2025 indicated R1 is at risk for abuse and/or neglect. R1's hospital after visit summary dated 07/28/2025 indicated R1 was seen by V13 (Medical Doctor) in the emergency department and was diagnosed with chronic iron deficiency anemia, posttraumatic hematoma (localized collection of blood) of right lower extremity, contusion of chin (bruise) and schizoaffective disorder. On 07/31/2025 at 09:55 AM, observed R1 propel herself in a wheelchair out of her room on the A wing. Observed a dark purple colored bruise that measured approximately three centimeters in length and width to the area under R1's chin. R1 was exhibiting verbal outbursts and looking for her babies. R1 was unable to indicate how the bruise occurred. Further assessment was not able to be completed due to R1's behaviors. On 07/31/2025 at 10:03 AM V2 (Administrator in Training) said R1 is currently on 1:1 supervision with staff due to falls. At 10:05 AM, V16 (Licensed Practical Nurse) said R1 is on 1:1 supervision due to a recent change in condition and bruising. On 07/31/2025 at 11:18 AM, V1 (Administrator) said she is the abuse coordinator and reports abuse, allegations to IDPH initially within two hours, then a final report within five days. V1 then said an injury of unknown origin in not investigated as abuse initially, but the facility would submit a report to IDPH in the same timeframe as abuse and would initiate an investigation. On 07/31/2025 at 12:20 PM, V3 (Director of Nursing) said she was first notified about R1's bruising on the morning of 07/28/2025 (Monday). V3 added that she was not informed by staff regarding any incidents involving R1 over the past weekend. V3 said she then assessed R1 and observed dark purple discoloration to R1's chin and neck, right inner and upper thigh, right shin and calf areas, and a hematoma to the right shin. V3 then said due to R1's condition and her inability to explain the cause, R1 was transferred to a local emergency room for further evaluation. At 12:40 PM, V3 indicated that during course of her investigation into R1's bruising, it was determined that staff had observed bruising on R1 on 07/26/2025 but did not report the injury to the supervisor on duty/call. V3 added that staff should have reported the initial bruising to on-call supervisor and administrator, should have been reported to IDPH when discovered.On 07/31/2025 at 01:14 PM, V7 (LPN) said she was informed by the aides on 07/26/2025 of R1's bruising and upon her assessment, V7 observed bruising to R1's chin and throat area that were purple in color. V7 then said she informed V4 (ADON) about R1's bruising that same morning (07/26/2025) and again on the morning of 07/28/2025 (Monday) regarding the worsening and other bruises to R1.On 07/31/2025 at 03:09 PM, V14 (Certified Nursing Assistant) said on 07/26/2025 (Saturday) at around 05:00 AM, she noticed a dark spot under R1's chin that looked deep dark purple in color. V14 said when she changed R1's clothes, she saw a light purple colored bruise on her right shoulder and on her belly, she saw a light purple-blueish colored bruise and small dots to her stomach area. V14 indicated that she informed V7 of her findings.On 07/31/2025 at 03:27 PM, V15 (Certified Nursing Assistant) said she first saw bruising on R1 on 07/26/2025 (Saturday) at around 07:30-07:45 AM. V15 then said the bruising to R1's chin, right and left shins and sides of both legs were purple in color, the right leg was dark purple, and the left was light purple in color. V15 said she reported the bruising to V7 shortly after seeing them. On 07/31/2025 at 03:38 PM, V4 (Assistant Director of Nursing) said she was not informed by V7 on Saturday (07/26/2025) about R1's bruising and was first made aware on the morning of 07/28/2025. On 07/31/2025, facility provided documentation for a facility in-service presented on 07/28/2025 which indicated that all injuries noted during transfers, showers, dressing, etc. must be reported to the nurse, any and all new injuries noted to a resident , including but not limited to bruising, skin tears, lacerations and burns

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	08/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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	08/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the safety of a resident by not adequately assessing a resident for risk of falls, not assessing a resident for injury after a fall, and not properly transferring a resident off the floor after a fall incident for one of three residents (R1) reviewed for falls in the sample of eight.The findings include:R1's face sheet indicated initial admission date of 03/01/2011 with a past medical history not limited to: paranoid schizophrenia, bipolar disorder, major depressive disorder, mood affective disorder, anxiety, anemia, pruritis, history of shock therapy, and long term (current) use of anticoagulants. R1's care plan indicated but not limited to: risk for injury related to limited dexterity and cognitive impairment and, is a risk for falls both with date initiated of 10/02/2023; requires use of psychotropic medications (antidepressant, antipsychotic, anti-anxiety) to manage mood and/or behavior issues, date initiated 04/07/2024. R1's Minimum Data Set (MDS) section C for cognitive patterns dated 04/13/2025 indicated severe cognitive impairment.R1's fall risk assessment dated [DATE] documented that R1 is not at risk for falls.Incident Follow Up note with effective date of 07/29/2025 at 04:00 PM that was created by V3 (Director of Nursing) on 07/31/2025 at 08:52 AM documented, via phone interview with (V10 Agency Nurse) on duty 07/27/2025, [Interdisciplinary Team] has ascertained that resident had been noted sitting on the floor next to her bed that night. Nurse did not believe resident to have actually sustained a fall, but to have scooted/sat from her bed as she is prone to do, so full body assessment and fall documentation were not completed at that time. Nurse has been thoroughly educated on assessment and reporting/notification expectations.On 07/31/2025 at 09:55 AM, observed R1 propel herself in a wheelchair out of her room on the A wing. Observed a dark purple colored bruise that measured approximately three centimeters in length and width to the area under R1's chin. R1 was exhibiting verbal outbursts and looking for her babies. R1 was unable to indicate how the bruise occurred. Further assessment was not able to be completed due to R1's behaviors. On 07/31/2025 at 10:03 AM V2 (Administrator in Training) said R1 is currently on 1:1 supervision with staff due to falls.On 07/31/2025, facility provided corrective action forms for V11 and V12 (Certified Nursing Assistants) that indicated a written warning was given due to a improper transfer on 07/27/2025 when both aides lifted resident (R1) from the floor without using a mechanical lift or gait belt and additional in-servicing was provided via phone on 07/29/2025. In-service log on resident safe transfers dated 07/29/2025 was also provided for V10 (Agency Nurse), V11 and V12. V3 provided documentation related to a facility in-service presented on 07/28/2025 which indicated but not limited to.residents must be assessed fully if noted on the floor at any time, unless having been witnessed purposely and safely placing themselves there or known to have been purposely and safely assisted there by staff if care planned to be so.On 07/31/2025 at 12:20 PM, V3 (DON) said during course of investigation for R1's bruising, it was noted that on 07/27/2025, R1 was found sitting on the floor next to her bed. V10 and V11 got her up by the underarms and the back of her pants, and no gait belt was used. V3 added that V10 didn't think to document the incident as a fall because she believed R1 scooted herself to the floor. V3 also said that V10 did not do a full assessment after staff found R1 on the floor so it was unknown whether R1 had sustained any other injury post fall incident. On 07/31/2025 at 12:58 PM, V11 said she was with another resident on 07/27/2025 at around 8:00 PM when V10 came to get her and told V11 that R1 had fallen, and V10 needed help getting R1 off the floor. V11 said when she entered R1's room, she saw her sitting on the floor next to the bed. V11 then said she and V10 picked [R1] up off the ground with our arms under her arms and grabbing the back of her pants. V11 added that the did not put a gait belt on her but should have. V11 said they put R1 in her bed, then she and V10 left the room and that's why V11 assumed V10 already assessed R1 because she left when V11 left the room. V11 also said that she would normally use a mechanical lift when transferring a resident off the floor after a fall that was discussed at the fall training two months ago where staff were educated on using a mechanical lift, and use of a gait belt when not using a lift.On 07/31/2025 at 01:34 PM, V12 said she was with a resident across the hall from R1's room on 07/27/2025 when she heard R1's roommate said R1 had fallen on the floor around 08:30-09:00 PM. V12 went into R1's room and saw her sitting on the floor next to the bed and wanted help getting up. V12 said she went to get the nurse (V10) to help get R1 up. V12 then said she and V10 put their arms under R1's arms and tried to get her up off the floor but V12 couldn't get [her] side up so V12 went to get V11 to assist V10. V12 then said they got her off the floor by pulling her under the arms and by the back of her pants. V12 added that they no gait belt was applied to R1 at any time but they should have. On