Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	02/27/2026

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** Based on observation, interview, and record review the facility failed to ensure residents were free from physical and verbal abuse. This applies to 3 of 3 residents (R1-R3) reviewed for abuse in the sample of 11.The findings include: 1. The Final Abuse Report dated 2/11/26 shows R1 is [AGE] year-old male with diagnoses including dementia, anxiety and chronic pain. R1 has moderate cognitive impairment. R2 is a [AGE] year-old male with diagnoses including dementia, COPD, and hypertension. R2 is cognitively intact. On 2/6/26, V13 (RN) heard shouting between residents when he entered the room (R1, R2) were on the floor side by side. (R2's) arm was loosely wrapped around (R1's) neck holding him to the ground and (R1) was attempting to get loose. On 2/27/26 at 10:18 AM, R2 was in his room lying in bed, he said there was something that happened between him and another resident (R1). R2 said he put R1 in a choke hold, it was a big mistake. R2 said R1 was at the wrong place at the wrong time and the staff took care of it. On 2/27/26 at 10:27 AM, R1 was in the activity room interacting with other residents. R1 was alert to self, and he was not able to answer questions. R1's speech was incoherent and gibberish. On 2/27/26 at 1:40 PM, V13 (RN) said on 2/6/26, he was in the nurses office and could hear shouting. He entered R2's room and saw R2 and R1 on the floor. R2 had his arm wrapped around R1's neck loosely like they were wrestling. R1 was yelling to get R2 off him. V13 said he separated the residents and assessed both residents. V13 said R2 did not sustain any injury or bruise to his neck and R1 had wandered into R2's room. On 2/27/26 at 12:38 PM, V1 (Administrator) said R1 and R2 shared a bathroom. R2 was new to the facility. During the night R1 went to the bathroom and exited the bathroom into R2's room. That startled R2, he reacted and placed hands on R1. V1 said she did substantiate the physical altercation. V23's (CNA) statement dated 2/9/26 shows he heard (R1) yelling profanity from another resident's room. He went into R2's room and found both residents on the floor. (R2) had (R1) in a choke hold and (R1) was pulling (R2's) hair, he yelled for V13. 2. The facility's Final Abuse report dated 2/11/26 shows allegation of verbal altercation between a resident and staff. (R3) is a [AGE] year old male with diagnoses including edema, type 2 diabetes, antisocial personality disorder, bipolar, and major depression. (R3) is cognitively intact. On 2/5/26, (R3) admitted he called a dietary staff member racial slurs.V12 (Dietary Staff/Former Employee) said he was verbally protecting himself against the racial slurs. Staff members interviewed said (R3) was screaming racial slurs at (V12). (V12) began shouting back at (R3) then moved toward him indicating that he would strike. Staff member stepped in between (R3) and (V12) and both were separated.Evidence noted (V12's) response to (R3) was inappropriate and was terminated. On 2/27/26 at 10:45 AM, R3 was in his room lying in bed. He said he got into it with the cook (V12). R3 said V12 came at me like he was going to hit me. R3 said V12 came out of the kitchen and asked what my problem was and told me I could not talk to him like that (calling him racial slurs). R3 said the facility got rid of V12 after the incident. On 2/2726 at 12:41 PM, V4 (ADON) said on 2/6/26, staff notified her of the (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: 145418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026

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Avenues at Royal Oak	605 East Church Street Kewanee, IL 61443

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident with R3. When she entered the dining room, R3 and V12 were screaming, yelling back and forth using profanity. R3 was using racial slurs towards V12. V12 was starring R3 down saying come at me and I'll whoop you're a**, nobody talks to me like that. On 2/27/26 at 12:57 PM, V5 (Social Services) said on 2/5/26, she was walking down the hall getting ready to clock out and heard yelling. She went to the dining room. V12 called R3 a b**** and R3 called V12 the N word. V12 then was walking towards R3 as if he was going to strike him. V5 said she stepped in between them with her hands up to keep them separated and to deescalate. On 2/27/26 at 12:40 PM, V2 (Assistant Administrator) said she was walking out the building when staff reported there was one incident with R3 and V12. R3 and V12 were arguing back and forth. R3 was using racial slurs and V12 responded verbally back. She directed V12 to go into the kitchen and was suspended during the investigation. On 2/27/26 at 12:38 PM, V1 said R3 was using racial slurs. R3 called V12 the n word and cotton picker. V12 responded extremely inappropriately and responded verbally to R3. At the end of the investigation, V12 was terminated. V12's Interview statement dated 2/9/26 shows I was in the kitchen (R3) started yelling N****.I came out of the kitchen and asked, What's your problem. Then (R3) kept cursing at me. I did get upset and started cussing back at him because he has been calling us N*****. The facility's Abuse and Reporting Policy dated 12/25 states, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of good and services by staff or mistreatment.physical abuse is the infliction of injury on a resident that occurs other than by accidental means.Verbal abuse includes the use of oral, written or gestured communication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to safely discharge a resident for1 of 3 residents (R6) reviewed for safe discharge in the sample of 11.The Findings include:R6's Face Sheet documents, R6 has diagnoses that include diabetes and bipolar disorder. R6 was discharged last 1/30/26. The same face sheet documents discharged to-Nursing Home unknown.R6's facility assessment dated [DATE] show R6 has no cognitive impairment.R6's vital summary shows R6 weighs 426 pounds (lbs.)On 2/27/26 at 10:10 AM, V5 (Social Service) said R6 was transferred to another Nursing Home that took bariatric residents (approximately 145 miles away) from this facility. As far as I know R6 was still at the facility up to this time. V5 said she had not called the facility to check on R6 since the time of transfer. V5 said she provided the receiving Nursing Home R6's information but cannot recall who she spoke to at the facility. V5 also confirmed she did not document this information in R6's medical records.On 2/27/26 at V15 (Administrator of the Nursing Home R6 was referred to) said R6 was never a resident in their facility.On 2/27/26 at 11: 36 AM, R6 said the time she was transferred to another Nursing Home, (1/30/26) the receiving Nursing Home said they were not ready for her and that they did not have the bed and wheelchair that would fit her. R6 said it was by that time very late, so she was brought to a hospital. At this time, she was in a different facility (not the facility she was supposed to transfer to).On 2/27/26 at 10:30 AM V14 (R6's family) said when R6 got to the Nursing Home where she was supposed to be transferred to, the Nursing Home did not have the bariatric bed or bariatric wheelchair for R6. R6 got so anxious and had palpitations so she was sent to the emergency room (ER). The hospital found a different Nursing Home that would take R6 and have the medical equipment she needed (not the Nursing Home she was referred to.)On 2/27/26 at 1:41 PM, V16 (License Practical Nurse) said she was the Nurse that discharged R6 on 1/30/26. V16 said she sent with R6 her discharged medications but did not provide any additional discharge papers to R6 because she was not instructed to do that. On 2/27/26 at 12:48 PM, V3 (Director of Nursing-DON) said when discharging a resident including a transfer to another Nursing Home, the discharging Nurse should have provided discharge instructions that included (but not limited to) list of meds and instructions, list of medical equipment that the resident need and a copy kept in the medical record to ensure continuity of care and resident's safety.The Facility Policy on Notice of Transfer and discharge date d 12/20/25 documents: When the facility transfers or discharges a resident, the facility must ensure that the transfer or discharge is documented in the residence medical record, appropriate information is communicated to the receiving healthcare institution. Discharge from the facility will include review of all necessary items to maintain the individual's highest practicable well-being, this includes necessary DME (durable medical equipment) and provision of medication prescriptions, appointments and treatments.