STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E264	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Litchfield	1024 East Tyler Litchfield, IL 62056

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 interview and record review the facility failed to prevent resident to resident abuse for 2 (R3, R4) residents reviewed for abuse in the sample of 3. Findings include: R3's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including schizophrenia and anxiety. R3's Quarterly Minimum Data Set (MDS) dated , 1/14/2026 documents R3 is cognitively intact and physical behavioral symptoms not directed towards others occurred daily. R3's Nursing Note, dated 2/12/2026 at 5:13 PM documents reported to me by V6, Activity Director that R4's roommate was yelling and cussing, he then slapped R3 in the face, when I went to room R3 was laying on his bed quietly and his roommate (R4) was still angry. (R4) was sent to the ER (Emergency Room) for eval (evaluation.)On 5/19/2026 at 1:40 PM R3 stated a few months ago his roommate (R4) slapped him across the face out of the blue and he was upset about it because he didn't know why he slapped him. R3 stated they are no longer roommates, and he hasn't had any further issues with R4. R4's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, anxiety and depression. R4's Quarterly Minimum Data Set (MDS) dated , 1/26/2026 documents R4 is cognitively intact and physical behavioral symptoms not directed towards others occurred 4 to 6 days. R4's Nursing Note, dated 2/12/2026 at 4:41 PM documents activities reported to me that this resident was being physically aggressive to his roommate, went to room and 1:1 with this resident, he was laying in bed, he was angry and agitated stated he was tired of listening to his roommate's damn radio/Christian music, he is tired of being held prisoner here and he wants out. Unable to redirect, he and his roommate were separated, and he was sent to local hospital ER/emergency room for eval/evaluation and psych updated. On 5/19/2026 at 1:30 PM R4 stated he slapped his old roommate (R3) silly one day because he wouldn't turn down his music and it was driving him crazy. R4 stated staff came into the room immediately after he slapped him and separated them and they aren't roommates anymore and they haven't had any other issues since then. On 5/19/2026 at 12:30 PM V6, Activity Director stated she heard men yelling from her office and on her way to R3's and R4's room she heard what sounded like a loud slap and R3 yelled stop hitting me. V6 stated when she entered the residents' room she witnessed R4 standing over R3 and R4 was yelling at R3 to turn down his music. V6 stated she separated R3 and R4 immediately and reported the altercation to V1 Administrator, V2 Director of Nurses (DON) and the assigned nurse (name unknown.) On 5/19/2026 at 3:00 PM V1, Administrator, stated she is the facility's abuse coordinator, and she substantiated the resident-to-resident physical abuse allegation between R3 and R4 because after interviewing both residents R3 reported that R4 slapped him across the face and R4 admitted to slapping R3. On 5/20/2026 at 8:20 AM V2, Director of Nurses, stated she was at the facility when V6 reported there was a verbal and physical resident to resident altercation between R3 and R4 on 2/12/2026 and she immediately went and assessed both residents including a psychosocial assessment and neither resident was upset or crying regarding the altercation. The Initial and Final Abuse Investigation Report dated 2/12/2026 and 2/19/2026 documents on 2/12/2026 at approximately 12:20 PM, an allegation of a physical altercation between R3 and R4 was reported to (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
	14E264	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Litchfield	1024 East Tyler Litchfield, IL 62056

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	the nurse. Residents were immediately separated. R3 and R4 were assessed for psychosocial and physical injuries with none note. Investigation initiated including resident and staff interviews. Employees and residents were interviewed by V1. R3 was interviewed and voiced he was in his room resting and listening to music when his roommate, R4, started yelling at him. R4 then made contact to R3's face with an open hand. V6 intervened and separated the residents, bringing R3 to her office. R4 was interviewed and stated R3 was continuously listening to music, and he just wanted it off. V6 was interviewed and stated R4 was yelling at his roommate, R3 and she went to intervene, separated the residents and notified the nurse. Nurse assessed both residents and V6 notified V2 and V1 of event. Conclusion and Action Taken: Based on the investigation R3 was in his room resting when roommate R4 became angry and started yelling and made open hand contact to R3's face. Staff intervened and separated residents, then notified nurses.The Abuse Prevention and Reporting - Illinois Policy, last revised 3/2026 documents the facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse of residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E264	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Litchfield	1024 East Tyler Litchfield, IL 62056

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the facility policy and prevent resident to resident abuse for 2 (R3, R4) residents reviewed for abuse in the sample of 3.Findings include: R3's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including schizophrenia and anxiety. R3's Quarterly Minimum Data Set (MDS) dated , 1/14/2026 documents R3 is cognitively intact and physical behavioral symptoms not directed towards others occurred daily. R3's Nursing Note, dated 2/12/2026 at 5:13 PM documents reported to me by V6, Activity Director that R4's roommate was yelling and cussing, he then slapped R3 in the face, when I went to room R3 was laying on his bed quietly and his roommate (R4) was still angry. (R4) was sent to the ER (Emergency Room) for eval (evaluation.)On 5/19/2026 at 1:40 PM R3 stated a few months ago his roommate (R4) slapped him across the face out of the blue and he was upset about it because he didn't know why he slapped him. R3 stated they are no longer roommates, and he hasn't had any further issues with R4. R4's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, anxiety and depression. R4's Quarterly Minimum Data Set (MDS) dated , 1/26/2026 documents R4 is cognitively intact and physical behavioral symptoms not directed towards others occurred 4 to 6 days. R4's Nursing Note, dated 2/12/2026 at 4:41 PM documents activities reported to me that this resident was being physically aggressive to his roommate, went to room and 1:1 with this resident, he was laying in bed, he was angry and agitated stated he was tired of listening to his roommate's damn radio/Christian music, he is tired of being held prisoner here and he wants out. Unable to redirect, he and his roommate were separated, and he was sent to local hospital ER for eval and psych updated. On 5/19/2026 at 1:30 PM R4 stated he slapped his old roommate (R3) silly one day because he wouldn't turn down his music and it was driving him crazy. R4 stated staff came into the room immediately after he slapped him and separated them and they aren't roommates anymore and they haven't had any other issues since then. On 5/19/2026 at 12:30 PM V6, Activity Director stated she heard men yelling from her office and on her way to R3's and R4's room she heard what sounded like a loud slap and R3 yelled stop hitting me. V6 stated when she entered the residents' room she witnessed R4 standing over R3 and R4 was yelling at R3 to turn down his music. V6 stated she separated R3 and R4 immediately and reported the altercation to V1 Administrator, V2 Director of Nurses (DON) and the assigned nurse (name unknown.) On 5/19/2026 at 3:00 PM V1 stated she is the facility's abuse coordinator, and she substantiated the resident-to-resident physical abuse allegation between R3 and R4 because after interviewing both residents R3 reported that R4 slapped him across the face and R4 admitted to slapping R3. On 5/20/2026 at 8:20 AM V2 stated she was at the facility when V6 reported there was a verbal and physical resident to resident altercation between R3 and R4 on 2/12/2026 and she immediately went and assessed both residents including a psychosocial assessment and neither resident was upset or crying regarding the altercation. The Initial and Final Abuse Investigation Report dated 2/12/2026 and 2/19/2026 documents on 2/12/2026 at approximately 12:20 PM, an allegation of a physical altercation between R3 and R4 was reported to the nurse. Residents were immediately separated. R3 and R4 were assessed for psychosocial and physical injuries with none note. Investigation initiated including resident and staff interviews. Employees and residents were interviewed by V1. R3 was interviewed and voiced he was in his room resting and listening to music when his roommate, R4, started yelling at him. R4 then made contact to R3's face with an open hand. V6 intervened and separated the residents, bringing R3 to her office. R4 was interviewed and stated R3 was continuously listening to music, and he just wanted it off. V6 was interviewed and stated R4 was yelling at his roommate, R3 and she went to intervene, separated the residents and notified the nurse. Nurse assessed both residents and V6 notified V2 and V1 of event. Conclusion and Action Taken: Based on the investigation R3 was in his room resting when roommate R4 became angry and started (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E264	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Litchfield	1024 East Tyler Litchfield, IL 62056

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yelling and made open hand contact to R3's face. Staff intervened and separated residents, then notified nurses.The Abuse Prevention and Reporting - Illinois Policy, last revised 3/2026 documents the facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse of residents. Physical abuse is defined as the infliction on a resident which includes hitting and slapping.