FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6005029 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER KEWANEE, IL. 61443 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (XIS) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S 000 Initial Comments S 000 Annual Licensure Survey S9999 **Final Observations** S9999 Statement of Licensure Violations Lof II: 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by:

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on observation, interview, and record review the facility failed to prevent physical abuse

for one (R117) of four residents reviewed for

abuse in the sample of 40. This failure resulted in R117 receiving an open laceration to his left

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6005029	B. WING		10/26/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER		CHURCH S E, IL 61443	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	jaw requiring three	sutures.				
	Findings include:					
	11/28/2016, docume right of our resident neglect, misappropriand exploitation." "T protecting our reside including but not liming residents, consultar other agencies provindividual, family me friends, or any other includes hitting, slap controlling behavior punishment."					
	dated 10/18/23, doc "Physical" abuse oc	r Physical Abuse of R117, cuments an allegation of curred on 10/18/23 at 12:15 and R92 and the police was				
	documents "It was rethat (R92) made phy (R92) stated that he with (R117) by bring that he offered (R11 it back into (R92) sp stated that he becan towards (R117). (R1approached him with (R92) was trying to oblocked him resulting	r Physical Abuse of R117, eported to (V1 Administrator) ysical contact with (R117). was trying to make peace ing him his tray. (R92) stated 7) the tray and (R117) pushed illing it on him. (R92) the me angry and threw the tray 117) states that (R92) in the tray and thought that dump the tray on him and g in the food going on (R92).				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005029	B. WING		10/2	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER		CHURCH S E, IL 61443	TREET		
244.12	CIMMADV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(XS) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
33333	tray and threw it like the left side of his fa separated. Staff int grabbed a tray from approached (R117) (R92's) approach at with the tray. (R92) and (R117) went to assessed. (R117) sto be pressed and winformed of this desthe facility in police assessed by the nube assessed by the nube assessed at the (R117) initially decliment for assessmer after receiving three not return to facility. up belongings with (R92) expressed not return to facility. up belongings with (R92) expressed not return to facility. Up the longings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not facility. Up belongings with (R92) expressed not facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R92) expressed not return to facility. Up belongings with (R	e a Frisbee that hit (R117) on ace. Residents were then terviews stated that (R92) had the serving table and. (R117) attempted to block and then (R92) made contact was removed from the area Social Services office to be stated that he wanted charges when police arrived, they were sire. (R92) was removed from custody. (R117) was ree and was recommended to ER (emergency room). The contract of the facility of the sutures to left jaw. (R92) did. (R92) called facility to pick friend off facility grounds. The desire to return to facility. The sutures to left jaw line. Bam, R117 was lying in bed to left jaw line. Bam, R117 stated he was in a R92 approached (R117) with hid was touching all R117's led the tray toward R117. Inot know if R92 was trying to or dump the tray on him, so blocking the tray which spilled and R92 then flung the meal isbee and hit him in the face, led up getting three stitches as against R92 and R92 has be facility.	33333			
	confirmed an allega	00 pm, V1 (Administrator) ition of physical abuse was 3 of R92 hitting R117 in the				

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005029 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER** KEWANEE, IL 61443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 face with a meal tray. V1 stated there were witnesses in the dining area that he obtained statements from. V1 stated R117 did go to the hospital for an evaluation and received three stitches to his left jaw. V1 stated R117 wanted to press charges and the police took R92 to jail. V1 stated R92 was released from jail but did not want to return to the facility. "B" Statement of Licensure Violations II of II: 300.610a) 300.1210a) 300.1210b) 300.1210d)1)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's quardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that

Illinois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005029 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER** KEWANEE, IL 61443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and property supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This REQUIREMENT is not met as evidenced by:

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		IL6005029	B. WING		10/2	26/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER	605 EAST	CHURCH S	TREET		
		KEWANEI	E, IL 61443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 99 99	Continued From pa	ge 5	59999			
	Based on observation review, the facility farmedication as order basis for four of four R285) reviewed for These failures results.	on, interview, and record ailed to administer pain red and assess pain on a daily r residents (R88, R117, R233, pain in the sample of 23. ted in R285 having intractable that resulted in a fractured rib.				
	dated 12/7/17, "It is for, reduce the incid pain in an effort to n problems, maximize Living) functioning a Responsibility: All ni therapists, occupation physician, Interdiscip Treatment Plan: a p gathered during a reidentifies the resider appropriate intervent extent feasible and in Pain Management F those residents with medication, daily paranticipate pain (i.e., etc.). Information of Assessment Form wimplement a resident Plan documented in	rill be used to formulate and t specific Pain Treatment the resident's care plan."				
	oriented sitting up in	0:50 AM, R285 was alert and a wheelchair in the dining mors to his bilateral hands.				

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6005029	8. WING		10/2	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
ROYAL	AKS CARE CENTER		CHURCH S' E, IL 61443	TREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(XS)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)		COMPLETE DATE
S9999	Continued From pa	ge 6	S9999			
	bed. I fell back onto on my back side. T pain medication) for awful, and it's still n is a sharp stabbing even breath or talk myself up in bed, an pretty sure I passed R285's Pain Evaluad documents that R2	last week getting up out of o my side rail and broke a rib hey were out of my (narcotic r a few days. The pain was ot good. Right now, my pain '7' (scale of 0-10). I can't without it hurting. I tried to pull nd the pain got so bad I'm d out. My pain was a 10+." ation, dated 10/11/23, 85 has almost constant pain to ating it at a "9" on a scale of				
	documents, "Reason pain. Diagnoses: Oright side. Mood discontusion of right side documents that he (Hydrocodone/Acet (milligrams) every frand a follow up app 10/23/23 at 8:00 a.m. R285's Pain care placements, "The research of the second pain and the second pain are placements, "The research of the second pain and the second pain are placements, "The research pain					
	revision to include I	R285's pain related to his rib of the right side as a result				
	dated 10/23, docum (Hydrocodone-Acet every six hours as a severe pain on 10/1 needed doses on 1	cation Administration Record), nents that R285 started meminophen) 5-325 mg one needed for moderate and 14/23. R285 received an as 0/14/23 at 8:00 p.m. for pain 1/15/23 at 3:30 a.m. for pain at				

Illinois Department of Public Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005029	B. WING		10/2	8/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
DOVAL A		EAS EAST	CHURCH S			
ROYAL	DAKS CARE CENTER	KEWANEI	E, IL 61443			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTING (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
				DEFICIENCY)		
S9999	Continued From pa	ge 7	S9999			
	a level 7, at 11:52 a 5:30 p.m. for pain a 4:01 a.m. for pain a for pain at a level 8. pain at a level 4, at and at 11:21 p.m. for 10/18/23 at 6:57 a.r 2:46 p.m. for pain at a level 9. 10/23/23 at 3. The MAR has no assessment to asse R285's pain control. R285's Controlled S dated 10/15/23, dod delivered two doses (Hydrocodone-Acet received them on 16	.m. for pain at a level 5, and at t a level 8. On 10/16/23 at t a level 9, and at 10:57 a.m. On 10/17/23 at 5:43 a.m. for 5:25 p.m. for pain at a level 9, or pain at a level 8. On n. for pain at a level 9 and at t a level 9. On 10/19/23 at t a level 9. On 10/19/23 at t a level 9. 10/21/23 at 10:15 vel 3. 10/22/23 at 6:35 a.m. 0 and at 1:17 p.m. for pain at a 4:30 a.m. for pain of a level documentation of a daily pain less the effectiveness of substances Proof of Use, euments that the pharmacy				
	dated 10/16/23, doo delivered seven dos (Hydrocodone-Acet:	aminophen) 5/325 mg and he				
	p.m., and 5:25 p.m.; 3:00 p.m.; 10/19 at	0/17/23 at 5:53 a.m., 12:00 ; 10/18 12:00 a.m., 6:00 a.m., 5:30 a.m. After the 5:30 a.m. 5 had no doses remaining.				
	dated 10/21/23, doc delivered twenty dos (Hydrocodone-Aceta	aminophen) 5/325 mg on this eceive his first dose from this				
lingia Domar	ment of Public Health					

PRINTED: 11/29/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING _ COMPLETED B. WING **IL6005029** 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER** KEWANEE, IL 61443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 8 S9999 The facility transportation calendar dated 10/23-10/25/23, has no documentation of an appointment for R285 to be transported to his pain clinic appointment. On 10/25/23 at 09:59 AM, V16 (Licensed Practical Nurse) stated, "There is no formal pain assessment or pain flow sheet that we do regularly scheduled pain assessments. We do the assessments as needed when they need PRN (as needed) pain medication. (R285) receives (Hydrocodone-Acetaminophen) prn around the clock. I would hope that with him receiving it as often as often as he does, he wouldn't have a pain level as high as he does when he asks for it. Sometimes it's as high as a 9 when we administer it. I don't know how effective that is. When he went to the ER, they set up the pain clinic appointment because of his rib fracture. With the fracture and how much pain he has that he gets the (Hydrocodone-Acetaminophen) around the clock that pain clinic appointment was very important. He can't wait for three months to go to it." V16 confirmed that R285 did not have any (Hydrocodone-Acetaminophen) available after the 5:30 a.m. dose on 10/19/23 until 10/21/23's dose at 10:15 p.m. On 10/25/23 at 10: 30 a.m., V13 (Care Plan Coordinator) stated, "(R285's) pain care plan wasn't revised after he fell and got the fracture."

Illinois Department of Public Health

for some time in January.

On 10/25/23 at 12:15 p.m., V1 (Administrator) confirmed that R285 did not attend his pain clinic appointment on 10/23/23 and it was rescheduled

2.) Current Physician's Order Summary indicates R233 was admitted to the facility on 9/14/23 with

Illinois D	Illinois Department of Public Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	IL6005029		B. WING		400		
11115 051	2001/2001 00 01/201/20				10/2	26/2023	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, 9 CHURCH S	STATE, ZIP CODE			
ROYAL	DAKS CARE CENTER		E, IL 61443	INGGI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 9	59999				
		de Chronic Pain Syndrome, Disorder and Anxiety Disorder.					
	9/14/23 indicates R	Pain Assessment dated 233 had vocal complaints of nd acute pain related to right					
	both lower legs wra R233 stated that sh and was having pai well as a headache ask for "Tyleno! (an ordered it to be give day." R233 stated the for the nurses to bri bring it unless she a	n R233 was in bed and had pped with elastic bandages. e had wounds on her left leg in her left leg at that time as. R233 stated that she must algesic)" but thinks the doctor in without asking "four times a nat sometimes she must waiting the Tylenol and they do not asks. R233 stated the nurses pain when she asks for					
	Nurse/RN) stated the did not give R233 T	lam V21 (Registered nat she was R233's nurse and ylenol when she gave R233 nations because "she did not					
	dressings changed. were soaked with disoaking through musoaking through to removed, R233's lef 50% intact skin and with several full thick time R233 stated thout of 10 when the several full with several full thick time R233 stated the several full thick time R233 stated the several full thick full full full full full full full ful	m R233 had bilateral lower leg R233's left leg bandages rainage from wounds - litiple layers of bandages and the bed sheet. Once It lower leg was approximately 50% open, ulcerated tissue kness affected areas. At that at the pain in her leg is "10 areas are touched" and eg throbbing after areas were					
		ed. R233 also reported g when self-propelling her					

STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6005029	B. WING		10/2	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER		CHURCH S E, IL 61443	TREET		
(X4) ID	SIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ON .	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 999 9	Continued From pa	ge 10	S9999			
	wheelchair with her	feet.				
	dated 10/12/23 indid wound of left leg/ful	and Management Summary cates R233 has a venous I thickness with only 60% summary objective to control infection."		€		
	Current Physician's Order Summary Report indicates R233 has orders for Acetaminophen/Tylenol 650mg (milligrams) every four hours as needed for pain/fever, ordered on 9/14/23.					
	Record) indicates R 11 times from 9/16// R233 rated her pair once. MAR indicate Tylenol administration scale of 1 (mildest) October 2023 MAR Tylenol 650 mg eve 10/8/23 and 10/21/2	AR (Medication Administration t233 received Tylenol 650 mg 23 to 9/30/23. MAR indicates as an "8" five times and "10" as R233 rated pain at time of ons between 4 and 10 on the to 10 (most severe). indicates R233 received ry day except on 10/1/23, 23. MAR indicates R233 "8" 10 times and a "10" six				
	bilateral lower extre 10/3/23 at 6:31pm F generalized discommenter to 10/7/23 at 8:14pm F lower extremity pair knees. 10/13/23 at 7:38pm bilateral knee pain a pain.	R233 complaints of chronic mity pain.		*.		

Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		1L6005029	B. WING		10/2	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER		CHURCH S E, IL 61443	TREET		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 11	S9999			
	Reports I feel like I 10/20/23 at 10:34pr upset upon assessr generalized pain. T	d requests medication. want to die." n R233 observed tearful and nent, reports severe tylenol administered. R233 want to die" related to her				
	11:28am indicates F hurting in the past fi scheduled pain med	n Interview dated 10/13/23 at R233 denied having pain or ve days, did not receive dication, did not receive prnedication, and did not receive rventions for pain.				
	Nurse/RN) stated R and would definitely medication which w R233's pain better.	5am V12 (Registered 233 "asks for pain meds a lot" qualify for scheduled pain ould probably help manage V12 stated any nurse could ad request scheduled pain				
		nprehensive Care Plan did not /problem identifying acute or				
	Coordinator) confirm R233's pain assess developing and revis stated that R233 did the care plan meetir pain assessment into wasn't aware of R23 assessment or the fipain. V10 acknowle progress note that did pain and wanting to	Oam V10 (Care Plan ned that she completed ment and is responsible for sing resident care plans. V10 In't say anything about pain in 10 (held on 10/3/23) or in the erview. V10 stated that she 13's admission pain requency of Tylenot given for 10 stated that she ocumented R233 reported die. V10 stated she should 233's medical record and				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6005029	B. WING		10/20	B/2023
NAME OF	PROVIDER OR SUPPLIER	0.011=152		STATE, ZIP CODE		
ROYAL	DAKS CARE CENTER		CHURCH S E, IL 61443	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 12	S9999			
	communication issuand not getting the and not getting the and not getting the scheduled pain med stated there should every shift - not just used to be pain ass resident MAR's, "I deeing done."	are plan. V10 stated there is a see between staff/departments total information. V10 stated her (R233) should have a dication regimen." V10 also be pain assessments done with prn's. V10 stated there essments included with on't know when they stopped 0:35 am, R88 was sitting at a				
	table in the dining refurrowed brow and sknees, and hip that pain scale. R88 states ther knees, torn mer and if her legs dang pain. R88 also state causes more pain. a pillow to put under wheelchair and will idining room up to a the table to help relisometimes she doe much pain. R88 states pain or she would te	som with facial grimacing and stated she has pain in ankles, R88 rated 10 out of 10 on ted she has no cartridge in hiscus, can't lift her left leg, le down it causes greater ed her feet swell up which R88 stated she must request rher feet while in the have the staff take her to the table so that she can lean on eve pain. R88 stated sn't eat because she is in so ted no one asks her about all them.				
	R88, dated 10/1/23 the following diagno and Thrombosis of I extremity, Necrotizir Arthritis, Polycystic Critical Illness Myop Diabetes Mellitus an Vulva.	on Administration Record) for through 10/31/23, includes ses for R88: Acute Embolism Deep Veins of upper ng Fasciitis, Rheumatoid Ovarian Syndrome, Obesity, athy, Psoriasis, Type 2 and Inflammation of Vagina and an for R88 documents "(R88)				
linois Rong		(related to) Rheumatoid			_	

PRINTED: 11/29/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED **[L6005029** B. WING 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER** KEWANEE, IL 61443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 13 S9999 Arthritis." The Order Summary Report for R88, dated 10/25/23, documents the following physician orders and pain medications as: Tramadol 50 mg (milligram) every six hours as needed for moderate or more severe pain; Tizanidine 4 mg, one tablet two times a day for Rheumatoid Arthritis/muscle spasms. Do not give with Tramadol. Monitor bilateral feet for any discoloration or abnormalities that may present related to incident every shift for 7 days, every day and night shift for 7 days until finished: Rheumatology appointment for bilateral feet neuropathy; Collagenase Powder to right third toe topically every day shift every Tuesday, Thursday, Saturday for non-pressure wound; and Collagenase Powder to sacrum topically every day shift for infection. This same Order Summary Report does not include assessing R88's pain level. The MAR (Medication Administration Record) dated 10/1/23 through 10/31/23, EHR (Electronic Health Record) and Paper Chart for R88, do not include any documentation of routine pain assessments occurring or having been completed for R88. 4.) On 10/23/23 at 10:30 am, R117 was lying in bed with facial grimacing while stating he has been "in so much pain" that all he does is "just lay around," and affects "all of me" and has continued losing weight. R117 stated his doctor started him on Lyrica, Ibuprofen and Gabapentin at night and takes Methotrexate every week.

The Order Summary Report for R117, dated Illinois Department of Public Health

R117 stated his right hand "sticks" in place at

times and "is painful at times."

PRINTED: 11/29/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6005029 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **605 EAST CHURCH STREET ROYAL OAKS CARE CENTER** KEWANEE, IL 61443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 14 S9999 10/24/23, documents the following Diagnoses for R117: Ankylosing Spondylitis of multiple sites in Spine, Rheumatoid Arthritis. This same Order Summary Report documents the following Physician Orders: Gabapentin 600 mg (milligrams) at bedtime; Ibuprofen 800 mg three times daily; Lyrica 75 mg every morning and bedtime; and Methotrexate 2.5 mg, Give 5 (five) tablets one time a day every Thursday. The current Care Plan for R117 documents "The resident has Rheumatoid Arthritis." "The resident is on pain medication therapy." "The resident has pain r/t (related to) rheumatoid arthritis and Ankylosing Spondylitis. Receives Inflectra infusions via outpatient services at local hospital." One intervention listed on R117's Care Plan is to "Complete pain assessment as needed." There are no routine pain assessments being completed for R117. The MAR (Medication Administration Record) dated 10/1/23 through 10/31/23, EHR (Electronic Health Record) and Paper Chart for R117, do not include any documentation of routine pain assessments occurring or having been completed for R117. "B"

Illinois Department of Public Health STATE FORM