STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENUES AT ROYAL OAK	605 EAST CHURCH STREET PO BOX 600, KEWANEE, Illinois, 61443

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S0000	Initial Comments Complaint Investigation: 2523751/IL191199	S0000		
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1) 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 guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. 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 properly 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 These regulations were not met as evidenced by: 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.	S9999		

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S9999	Continued from page 2 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.	S9999		

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S9999	Continued from page 3 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	S9999		

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S9999	Continued from page 4 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. 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	S9999		

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S9999	Continued from page 5 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. (A)	S9999		