STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005029	A. BUILDING: _____ B. WING _____	C 09/10/2022

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ROYAL OAKS CARE CENTER	605 EAST CHURCH STREET KEWANEE, IL 61443

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S 000	Initial Comments Investigation of Facility Reported Incident August 20, 2022/IL150673	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) 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 300.1210 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 timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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S9999	Continued From page 1 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: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not	S9999		

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S9999	Continued From page 2 subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to protect one resident (R1) from physical assault of four residents reviewed for abuse in the sample of four. This failure resulted in R1 being hit in the face by (R2) with a known history of Explosive Mood disorder. R1 transferred to two different hospitals, suffered a fractured nose, swelling, bruising, and lacerations to left eye, forehead, left index finger, left middle finger, and left ring fingers and bruising to right buttocks. Findings include: The facility's Abuse Prevention Program, revised 11/28/2016, defines: "Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." "Serious Bodily Injury: an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation." "Establishing a Resident Sensitive Environment: Resident Assessment: As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any	S9999		

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problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents."

R1's Cumulative Diagnosis Log includes the following diagnoses: Dementia with Behavioral Disturbance, CVA (Cerebrovascular Accident/Stroke), Eye Globe prosthesis (glass eye), right Kidney removal, DJD (Degenerative Joint Disease), and DDD (Degenerative Disc Disease).

A Physician Telephone Order for R1, dated 8/15/22 at 1:00 pm, documents "Admit to (local) Hospice. Terminal Diagnosis Alzheimer's Disease."

R1's Quarterly MDS (Minimum Data Set) assessment, dated 7/5/22, documents R1 with "severely impaired" cognition and is independent for all ADLs (activities of daily living) except requires set up and supervision for eating and bathing.

R1's current Care Plan, documents R1 with impaired cognition related to Dementia with Behavioral Disturbances, Blindness related to right eye prosthetic, Impaired psychosocial well-being alteration in participation in interpersonal relationships and/or altered leisure planning, and "known to wander." This care plan documents a new intervention was added on 8/20/22 for R1 to have private room at this time with 15-minute visual checks. There is no other documentation regarding goals or interventions listed related to the 8/20/22 incident.

R2's Cumulative Diagnosis Log includes the following diagnoses: MR (Mental Retardation), Anxiety, Intellect Disability, Depression, and

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S9999	Continued From page 4 Explosive Mood Disorder. R2's annual MDS assessment, dated 7/6/22, documents R1 is cognitively intact, independent with all ADLs, including walking, except requires set up and supervision for eating and bathing. R2's current Care Plan, documents R2 with impaired cognition related to MR and intellect disability and chooses to be nonverbal, impaired Psychosocial well-being-alteration in participation in interpersonal relationships and/or altered leisure planning, altered mood state (anger/easily upset) potential for altered social reaction related to explosive behavior, known/has history of displaying inappropriate behavior and/or resisting care/services, and requires use of psychotropic medication to manage mood and/or behavior issues. This same Care Plan documents R2 with behaviors exhibited - explosive moods, psychosis, anxiety, aggression, and self-isolation. A new intervention was added on 8/20/22 that documents R2 moved to behavioral Health unit, 15-minute visual checks, one-to-one for 72 hours and SSD (Social Service Director) immediate counseling education then one time a week for 4 weeks for aggression. R2's Care Plan includes the following interventions: "Introduce to peers who are compatible in temperament. Monitor compatibility of roommate relationships. Reduce excessive stimulation by maintaining a calm environment. If resident expressing anger with self or others: attempt to determine source of anger and encourage appropriate outlets for expression of same writing feeling down. Maintain a calm environment with limited clutter/distraction." On 9/3/22 at 10:30 am, R1 was sitting in a wheelchair in the common area, near the nurses'	S9999		

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station. R1 had visible blue, purple, green and yellow discoloration to his left eye, left check, and forehead. R1's left index, left middle and left ring finger had visible yellow discoloration and left index finger with dried blood on it. R1 was not cognitively intact at the time of the interview.

The facility's Final Report, dated 8/22/22, documents on 8/20/22 R1 and R2 were in an alleged physical altercation after being temporarily placed in a room together due to COVID-19. "(R2) wrote that (R1) had been messing with his things and was standing over him while (R2 was) lying in bed. (R2) is nonverbal. (R2) also wrote that he had given (R1) a piece of paper that said, 'stop messing with me.' (R2) was asked why he did not come to staff and (R2) looked to the floor with no response. (R2) stated (R1) struck him in the shoulder and in the hand. (R2) stated (R1) was on him so he pushed him off and (R1) landed into the wall with his back. (R2) then got his belt and struck (R1) in the eye and on the hand with the belt. The CNA (Certified Nursing Assistant/V5) then heard yelling from down the hall and went to investigate. The CNA (V5) stated when she entered the room (R1) was against the wall and (R2) struck (R1) with the belt. When (R2) saw the CNA (V5) he immediately stopped and (R1) was taken off of the COVID unit. (R1) was assessed by the nurse (V6 RN/Registered Nurse) with lacerations noted to his left hand and left eye. (R1) was also noted to have discoloration to right buttock. Neuros (neurological checks) were initiated on (R1). Edema for eye was noted to worsen. (R1) was sent to local ER (Emergency Room) for evaluation and treat (treatment). (R1) was transferred to outlying hospital for ophthalmology consult. (R1) is expected to return 8/22/22. Upon return (R1) will be placed in a private room and

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remain on 15-minute checks. (R1's) areas of injury will be monitored per MD (Medical Doctor) orders. (R2) was moved to the behavioral health unit and placed on one-on-one attention for 72 hours after incident. (R2) was counseled by SSD (Social Service Director) on aggression and impulse control. (R2) was also educated on coming to staff for conflicts with peers. (R2) will remain on the behavioral health unit on strict 15-minute checks. (R2) will meet with SSD 1x (one time) weekly x4 (times four) weeks for psychosocial counseling."

On 9/4/22 at 4:15 pm, V5 CNA stated, "I witnessed (R2) flipping a leather belt at (R1's) face." V5 stated she saw (R1) standing against the wall with blood on his face and hands and saw the leather belt make contact with (R1's) face and noticed blood on (R1). (R1) had injuries to his left hand, cut on his forehead and left eye, left eye was cut and he was bleeding out of his eye. R1's left hand and forehead were also bleeding. V5 stated when she walked into the room and R2 saw her he stopped and walked over and laid on his bed and she took R1 out of the room into the common area and got V6 (RN). R2 was moved to the A wing behavioral unit and has not been back. V5 stated R1 and R2 were both on B side of the facility prior to the incident but were put into the same room on the B side COVID unit due to having COVID. V5 stated the rest of the night R1 was complaining of pain and the nurse was in and out of his room a lot. V6 RN took care of (R1's) wounds and stopped the bleeding. V5 stated R1 did not go to the hospital during her shift, that ended at 10:00 pm.

On 9/5/22 at 10:27 am, V6 (RN) stated "(V5) CNA saw the incident and reported it to me." V5 reported that R2 had hit R1 with his belt. V6

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stated, "I didn't see anything happen. I just separated the two residents." V6 stated she called V1 (Administrator) and V3 (RCC/Resident Care Coordinator) and reported what happened and was instructed to treat R1 at the facility if she could instead of sending (R1) out to the hospital and to move (R2) to the A wing behavioral unit and put him on one-on-one with a staff member. V6 stated she was able to get the bleeding stopped and noted a laceration underneath R1's left eye, that "looked like a skin tear" and she placed wound closure strips on it. V6 stated R1 also had some lacerations on his hands that she put adhesive bandages on and R1 was monitored. V6 stated V13 (LPN/Licensed Practical Nurse) assisted her in doing the treatments and "We didn't send him in (to the hospital) right away because it didn't look that bad. V6 stated when she came back to work the next morning "R1's left eye was very swollen, and he looked bad, and I sent him out to the hospital. They (local hospital) did a CT (computed tomography) scan and R1 had a retrobulbar hematoma (a condition that involves blood congestion deep in the soft tissue of the posterior orbital septum) to the back of his left eye. V6 stated R1 is a very mild resident, has Alzheimer's and was on hospice services and never had any problems with him. V6 stated R2 does have a history of behaviors, but nothing like this. V6 stated R1 and R2 had both been on the B wing COVID unit but was only temporary. Usually the resident, with behaviors, start out on the behavioral unit and then transition to the B wing. V6 stated R1 got moved to C hall after he came out of isolation for COVID.

On 9/4/22 at 12:26 pm, V1 (AIT/Administrator in Training) stated R2 told her that R1 had been walking around (R1's) bed and standing over R2

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and was taking R2's personal belongings. V1 stated R2 does not speak but will nod head and wrote on paper. R2 had written on paper that he "Had enough it", R1 pushed him first and R2 pushed (R1) back. R2 said that R1 hit the wall and R2 then hit him in the eye. V1 stated R2 wouldn't say anything about the belt other than it was his belt in the closet. V1 stated V5 (CNA) told her yelling "Stop" and when she opened the door R2 had a belt in his hand.

On 9/6/22 at 10:32 am, V1 (AIT) stated she is the Abuse Coordinator and completed the investigation for the incident involving R1 and R2. V1 stated the incident occurred on 8/20/22 and when V6 (RN) initially looked at R1 he had small lacerations and didn't require anything but first aid. V1 stated "The next morning it looked really bad so (V6 RN) sent him out, to ER (hospital emergency room.)" V1 stated R1 and R2 were placed in a room together on 8/16/22 on the COVID unit because they both tested positive. V1 stated after the incident on 8/20/22 R2 was moved over to the A wing behavioral health unit and R1 stayed on the COVID unit until he was off quarantine and then we moved him to a private room on the C wing with 15-minute checks.

"A"