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 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS CARE CENTER	605 EAST CHURCH STREET KEWANEE, IL 61443

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S 000	Initial Comments Complaint Investigation: 2327374/IL164035	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240d) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

This REQUIREMENT is not met as evidenced by:

A. Based on observation, interview, and record review the facility failed to prevent verbal abuse from staff V4 (Certified Nursing Assistant) to a resident for one of three residents (R1) reviewed for abuse in the sample of three. This failure resulted in V4 yelling at R1"Stop f*****g talking to me (V4). You are an ass!" resulting in R1 crying and experiencing mental anguish.

B. Based on observation, interview, and record review the facility failed to remove an alleged perpetrator V4 (Certified Nursing Assistant) from resident cares following staff (V4) to resident verbal abuse, failed to protect residents from an alleged abuser (V4), and failed to recognize verbal abuse for one of three residents (R1) reviewed for abuse in the sample of three. These failures resulted in V4 returning to work with all residents within the facility after verbally abusing R1, resulting in R1 feeling angry and experiencing fear. These failures have the potential to affect all 134 residents residing within the facility.

Findings include:

The facility's Abuse Prevention Program policy dated 05/2021 documents, "This facility affirms the right of our resident to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. The facility is committed to protecting our residents from abuse by anyone including facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual,

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S9999	Continued From page 2	S9999		

family members, or legal guardians, friends, or any other individuals. Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Protection of Residents: The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway. Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse, or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed."

The facility's CMS (Centers for Medicare and Medicaid Services) Form 672 dated 9-8-23 and signed by V1 (Administrator) documents 134 residents reside within the facility.
R1's MDS (Minimum Data Set) Assessment dated 8-22-23 documents R1 is a 36-year-old admitted to the facility on 8-9-23. This same MDS documents R1 is cognitively intact and requires extensive assistance of staff for all ADLs (Activities of Daily Living).

R1's Illinois Department of Public Health Notification Form dated 9-6-23 and signed by V1 (Administrator) documents, "On this date (R1) reported that two CNAs (Certified Nurse Assistants) were verbally abuse (sic) towards him. Time of Incident: 12:30 PM."

R1's Incident Investigation Form (undated) and

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S9999	Continued From page 3 signed by V1 (Administrator) documents, "I (R1) was in the dining room, and I was joking around with another CNA. (V4 CNA) called me a name. (V4) called me an a**. I didn't like it." The facility's Incident Investigation Forms (undated) and signed by V1 (Administrator) document R1, V3 (CNA), and V7 (CNA) reported to V1 that V4 verbally abused R1 in the dining room on 9-6-23 at 12:30 PM. V3's (CNA) written statement (undated) documents R1 refused to allow V4 to help him and V4 stated to R1, "You are acting like an a**!" V7's (CNA) written statement (undated) documents, "(R1) called (V4 CNA) a f*****g b***h in the dining room and (V4) said to (R1) stop f*****g talking to me." The facility's Inservice Attendance Form dated 8-25-23 and signed by V1 (Administrator) documents V4 was in-serviced regarding the facility's abuse policy on 8-25-23. On 9-8-23 at 8:30 AM V3 (CNA) stated, "I was in the dining room on Wednesday (9-6-23). Around 12:30 PM (R1) asked (V4) for help with eating his Chinese. (V4) refused to help (R1). (R1) started to yell at (V4) for not helping him and (V4) yelled back at (R1) to stop f*****g talking to her and called (R1) an a**. (V4) should not be able to talk to (R1) that way. I immediately took (R1) to (V8's/Social Service Assistant) office and reported this to (V8 and V1)." On 9-8-23 at 10:07 AM V8 (Social Service Assistant/SSA) stated, "On Wednesday (R1) reported to me that (V4) had called him an a** and refused to help feed him. That is definitely verbal abuse. I know (V3) witnessed the abuse.	S9999		

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S9999	Continued From page 4 (R1) was very angry and told me he was tired of it and that something better be done about (V4), or he was going to take legal action. I immediately got (V1) and had (R1) report his concerns to (V1). (R1) is newer to the facility, but I have never known (R1) to make up false allegations." On 9-8-23 at 10:10 AM R1 was sitting in a wheelchair in his room. R1 was alert and orientated to person, place, and time. R1 stated with tears in his eyes, "On Wednesday (9-6-23) at lunchtime I was trying to eat Chinese food that I had for lunch. (V4) is always mean to me and never wants to help me. I asked (V4) for help eating and (V4) said to me "I am not helping you. You are an a**. I called (V4) names and (V4) said to me, "Stop f*****g talking to me!" I have reported this to (V1 Administrator) and V8 (SSA). Something needs to be done with (V4) or I am going to get legal advice. (V4) should not talk to me that way. I felt abused and it made me cry. I am still upset over it. (V4) is still here today. I do not want her (V4) anywhere around me." On 9-8-23 at 10:25 AM R1 was sitting in the sitting area in front of the nurse's desk. V4 was standing within one foot of R1 at this time. R1 had his head down. On 9-8-23 at 10:30 AM V4 stated, "(R1) refuses cares from me and on Wednesday (9-6-23) (R1) was talking about his egg roll. I said something about the egg roll and (R1) said to me "It is none of your business you f*****g b***h." I responded to (R1) and asked him to not talk to me and please leave me alone. I was allowed to return to work today and was not told that I could not take care of (R1). I am able to help take care of all of the residents within the facility whenever other CNA's need help or when I am in the dining	S9999		

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S9999	Continued From page 5 room." On 9-8-23 at 11:00 AM V7 (CNA) stated, "I was in the dining room on Wednesday (9-6-23) around 12:30 PM I heard (R1) ask (V4) for help and (V4) refused to help (R1). (R1) yelled at (V4) and told (V4) she was a f*****g b***h. (V4) told (R1) to stop f*****g talking to her. (V4) was mad and not joking with (R1). (V4) was verbally abusive to (R1)." V7 also stated V4 was working today (9-8-23) with the residents. On 9-8-23 at 11:35 AM V1 (Administrator) stated, "I did not consider it willful when (V4) cussed at (R1). I did not feel like cussing at (R1) was verbal abuse. I allowed (V4) to return to work today. (V4) really should not have been able to work with (R1), but I did not make that clear to (V4). (V4) really should not have been on the hallway with (R1) today." "A"	S9999		