STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510398	A. BUILDING: _____ B. WING _____	C 07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT ROMEOVILLE AL	605 S EDWARD DR ROMEOVILLE, IL 60446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Complaint Investigation 2575154/IL194004- no findings Facility Reported Incident to 5/7/25 IL193620-295.6000a)1) cited	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed the ensure the residents were treated in a dignified manner for 1 of 3 residents reviewed for dignity in the sample of 6. The findings include: On 7/3/25 at 10:15 AM, R1 was sitting in a chair	A6000		

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A6000	Continued From page 1	A6000		

in her room. R1 was dressed and well groomed. R1 said R2 and herself after breakfast sit on a bench in the hallway and wait for the nurse to give them their medications. R1 said on the day of the incident, her and R2 were sitting on the bench after breakfast like everyday. R1 said E9 Licensed Practical Nurse was at the medication cart talking to other ladies about her daughter and her going to prom. R1 said she was upset that they were waiting so long. R1 said it went on and on and she got tired of waiting, so she went up to E9 and said that they were here for their medications. R1 said E9 said,"no one talks to me like that." R1 said she could tell E9 was ticked off. R1 said E9 continued to talk instead of giving us our medications. R1 said she felt like she was scolded like a little kid being and punished by having to wait longer.

On 7/3/25 at 9:50 AM, R2 was dressed and sitting on the couch in room. R2 said R1 and herself were waiting for the nurse (E9) to give their medications on the stool in hall. R2 said it was a ridiculous long wait, there were no other pt just herself and R1. R2 said E9 was talking to other nurse friends and R2 got mad and went up to E9 and said "I don't like this, we are waiting for medications," R2 said E9 got mad and was raising her voice. R2 said she was not in viewing site, but could hear E9 from around the corner say "you don't disrespect me!" R2 said it broke up and we got our meds, and it was over. R2 said E9 has been ok with her, but it was inappropriate the way she was talking to R1.

On 7/3/25 at 11:17 AM, E9 said on the day of the incident, it was a typical day, R1 and R2 came after breakfast and were sitting on bench waiting to get their medications. E9 said she was preparing the cart and 2 housekeepers she

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A6000	Continued From page 2	A6000		

hadn't seen in awhile came over and they were talking about prom. E9 said R1 came up and was yelling that she needed to come on and get meds, R1 was not going to wait on her. E9 said she told R1 to wait a minute, and stated "why would you disrespect me, I never treat you like that, why should you treat me like that." E9 said she continued on what she was doing with the cart and R1 and R2 were sitting on the bench. E9 said then she did R1's blood pressure and gave her medications.

On 7/3/25 at 1:26 PM, E3 Assistant Wellness Director said the investigation was completed and abuse was not substantiated. E3 said E9 did receive and in-service on communication and her tone when talking to residents.

R1's Wellness Evaluation dated 5/8/25 shows R1 "communicates clearly, understands and expresses wants and needs, alert and oriented to person, place, time, and situation."

The facility's Witness statement dated 5/7/25 from E10 Caregiver shows "The care partner described the nurse's response as "overkill, and the nurse could have chosen more professional verbiage."

The facility's Witness statement dated 5/7/25 from E8 Caregiver shows "I observed the nurse informing the resident that her action was rude and she needed to be patient."

The facility's Witness statement dated 5/7/25 from E10 Caregiver shows "I overheard the nurse talk to R1 basically stating that R1 should not disrespect her and that R1 will wait for her meds because she felt disrespected."

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A6000	Continued From page 3 The facility's In-Service Training log dated 5/8/25 shows E9 received an in-service on "the way we communicate," which reviewed passive, passive aggressive, assertive, and aggressive communications methods.	A6000		