Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ____ C B. WING IL6010094 01/07/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S 000 S 000 **Initial Comments** Facility reported investigation (FRI 12-18-2020-IL129900) S9999 Final Observations 59999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.610a) 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. 300.1210b) 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 Attachment A care needs of the resident. Statement of Licensure Violations 300.3240a)

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

| | epartment of Public | Health | | | | |
|--|---|---|------------------------|-------------------------------|---|--------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| } | | | | С | | |
| | | IL6010094 | B. WING | | 01/07 | 7/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | TATE, ZIP CODE | | |
| WINNING | WHEELS | | 3RD STREE STOWN, IL | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| S9999 | Continued From particles An owner, licensee agent of a facility stresident. (Section 2-107 of These regulations of these regulations of these agent of the findings included to ensure a residents (R1) revision of three. The findings included R1's face sheet should be a sheet | age 1 , administrator, employee or hall not abuse or neglect a the Act) were not met as evidenced by: and record review the facility esident was free from sexual e failures resulted in R1 being his applies to one of three ewed for abuse in the sample esy, osteomyelitis, bipolar, y, and fracture of the fifth R1's facility assessment dated oderate cognitive impairment nations, no delusions, and no | \$9999 | DEFICIENCY) | A A Sept 1 | |
| | shows R1 requires bed mobility, dress hygiene. The asse total staff assistand toilet use, and bath | ing. The facility assessment extensive staff assistance with sing, eating, and personal ssment shows R1 requires ce with transfers, dressing, ning. PM, R1 was seated in a high | | | | |
| | back wheelchair. F coherent. R1 state aides (V4) about o would bring in food the nights she was lot of time together kissing. R1 stated | R1 was alert, talkative, and d he started "dating" one of the ne month ago. R1 said she d and energy drinks to him on sworking. R1 said they spent a r on the night shift talking and V4 tried to put her mouth onto. R1 said V4 would let him lick | | | | |

Illinois Department of Public Health

NDVW11

PRINTED: 03/22/2021 FORM APPROVED

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING 01/07/2021 IL6010094 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 2 S9999 her breasts with his tongue. R1 said it happened "a few times" and always on the night shift. R1 said he did not tell anyone about the relationship in the beginning, but other people were noticing she was hanging out in his room a lot during her night shift. R1 said he did eventually tell another CNA about the sexual encounters with V4. R1 said he told V3 (male CNA) that V4 had allowed him to put his mouth on V4's breasts. R1 said he also eventually told V1 (Administrator) and V2 (Assistant Administrator) about the sexual encounters. R1 said he did deny it the first time V1 asked about the situation. R1 said he decided to admit the two of them were "in a sexual relationship because (V1) is a nice guy and I decided to tell the truth." R1 also stated he has been texting V4 for the past month, via his voice recognition program on his personal cell phone. R1 said V4 also has been responding and communicating back with him through his cell phone. On 1/6/21 at 9:00 AM, V3 (male CNA) stated he was working on 12/18/20 and in R1's room around 2:15 PM changing the bed linens. V3 said R1 asked him if he had heard any rumors about himself and V4. V3 said R1 stated, "You know the rumors are true, right? (V4) let me suck on her (breasts). You heard me. She let me suck on them. But that's just between me and you, ok?" V3 said he asked R1 for clarification and again R1 repeated the same thing. V3 said he has cared for R1 many times and they have a good connection. V3 said he had no doubt R1 was being truthful. V3 said R1 is very alert, oriented, and completely knows what is happening around him. V3 said he left the room and immediately reported the information to V1.

Illinois Department of Public Health

On 1/5/21 at 10:15 AM, V1 (Administrator) stated

PRINTED: 03/22/2021 FORM APPROVED

| Illinois D | epartment of Public | Health | | -KIR-TRE | | |
|---|--|---|---------------------|---|--------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
| | | IL6010094 | B. WING | | 01/07/ | /2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | TATE, ZIP CODE | | |
| TW HOLL OF T | | 701 EAST | 3RD STREE | Г | | |
| WINNING | WHEELS | PROPHET | STOWN, IL | 81277 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE | .D BE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 3 | S9999 | | | |
| | said he was in a reimmediately interviewas in a relationshilove. R1 said V4 pl putting a condom-t V4 lets him put his he also has been honversations with his cell phone. V1 permission to view phone and there where we hack and forth between them and food of R1. V1 said a fullegation was don 12/22/20 after violations. | 12/18/20 by V3 that R1 had lationship with V4. V1 said he ewed R1. R1 confirmed he ip with V4 and that they were in eases him with her hand while ype catheter on him. R1 said mouth on her breasts. R1 said aving repeated text V4 when she is off work, via said they asked R1 for the text history on his cell ere hundreds of text messages ween R1 and V4. V1 said the ed their love between the two V4 was bringing into the facility all investigation into the e and V4 was terminated on ating facility policy. | | | | |
| | Administrator) stat 12/18/20 after V3 r V2 said R1 did initi involvement with V questioning, he did V2 said R1 stated back and forth who said V4 would brinthe nights she was bring him to Kentuhim. R1 said V4 whim put his mouth reviewed the text r | ed she interviewed R1 on reported the sexual incidents. ally deny any intimate 74, but after repeated 8 admit to a sexual relationship. The and V4 had been texting en she was not working. R1 g food and drinks into him on a working. R1 said V4 wanted to cky and she was in love with ould give him oral sex and let on her breasts. V2 said she messages with V1. V2 said sexual on the text messages ation between the two "was riate". V2 said R1 has a spinal lert and oriented. V2 said R1 is ext messages and make calls hrough a voice command | | | | |

Illinois Department of Public Health STATE FORM

NDVW11

| Illinois De | epartment of Public | Health | | | _ | |
|---|--|--|---------------------|--|-------|--------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | * * | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| ANDION | 01 0014 011011 | | A. BUILDING: _ | | ١, | |
| | | IL6010094 | B. WING | <u></u> | 01/0 | , 7/2021 |
| NIA BATE OF F | 200/IDED OR SUBBLISE | | DESS CITY S | TATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | 3RD STREE | | | |
| WINNING | WHEELS | | STOWN, IL | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 4 | \$9999 | | | |
| | terminated from the had something to dharassment by (R1 a lot and requested said she routinely wared for R1 every began "dating" R1 from the facility. V4 her about personal while being a care believes someone sent weird sexual to with R1 over the property to vocational rehab denied any sexual and R1 but also state oriented when I was bringing any food of | PM, V4 (CNA) stated she was a facility on 12/22/20. V4 said it o with an allegation of sexual and the said she did care for R1 to work on his hallway. V4 worked the night shift and time she worked. V4 said she the day after she was fired said the administrator asked texts between herself and giver for R1. V4 said she hacked into her phone and exts to R1. V4 said she did talk none but it was only in regards illitation questions he had. V4 relationship between herself ated R1 was "100% alert and s caring for him". V4 denied or drink into the facility for R1. antic interest in R1. (Text fact opposite.) | | | | |
| | and end dated 12/1 surveyor and show including: "I love you me Sounds kink sleep, before you keep, before you alread the way Are you you still love me af On my way to KY. want to just be friet these texts Laying | essaging start dated 11/19/20 17/20 were reviewed by the ed repeated statements by V4 ou I can't wait for you to see by I miss you babe Go to snow it I'll be there to take care NOS (energy drinks) for you for you I'm home and y I am wearing nothing by getting excited or what Will ter 3 days of me being gone?Call me if you want I don't ends I hope no one can see ng in bed thinking of you me) Are you IN LOVE with | | | | |

Illinois Department of Public Health STATE FORM

NDVW11

| | epartment of Public | Health | | | | |
|-------------------|----------------------|----------------------------------|------------------|---|-----------|--------------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE | SURVEY PLETED |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMIF | CETED |
| | | İ | | | ، ا | o İ |
| IL6010094 | | B. WING | | | 7/2021 | |
| 10010084 | | | | 0111 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| | | 701 EAST | 3RD STREE | Т | | 1 |
| WINNING | WHEELS | PROPHET | STOWN, IL | 61277 | | ĺ |
| 044140 | STIMMADY STA | TEMENT OF DEFICIENCIES | 1D | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| (X4) ID PREFIX | | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROI DEFICIENCY) | PRIATE | DATE |
| | | | | DEFICIENCY) | | |
| S9999 | Continued From pa | nge 5 | S9999 | | | |
| 00000 | · | | | | | |
| | | Program policy revision dated | | | | |
| 1 | | r PURPOSE section: "To | | | | |
| | | afety of resident." The policy | 1 | | | |
| | | se as: "includes but not limited | | | | |
| | to sexual harassme | ent, sexual coercion, or sexual | ĝ. | | | |
| | assault." | | Ř | | | |
| | | | | | | |
| | | Socialization with Residents | | | | |
| | policy revision date | ed 3/2017 states under the | | | | |
| | | "1. Socializing while off -duty | | | | |
| | with residents or th | eir family/guardian while the | 6 | | | |
| | resident it actively | participating in the facility's | > | | | |
| | programs is prohib | ited. This socialization crosses | i- | | | |
| | the professional bo | oundaries between caregiver | | | | |
| | and resident. Socia | alization would includeg. | | | | |
| | | entby telephone, texting, | | | | |
| | meetings, in writing | g or through the internet." | | | | |
| | | - | | | | |
| | | involved in the incident was | | | | |
| | terminated on 12/2 | 2/2020 and has not been | | | | |
| | | ling since. Winning Wheels will | | | | 100 |
| | immediately ensure | e all residents are protected | | | | 6 |
| | from any type of al | ouse which will include, but not | | | | |
| | | cation on recognizing and | | | | |
| | preventing abuse f | rom happeneing and education | | | | 12 |
| | on appropriate stat | ff and resident | | | | |
| | interaction/socializ | ation. This education began | | | | |
| | immediately on 12 | /21/20, will continue during new | | | | |
| | | d will be provided to all staff | | | | 1 |
| | | ear. Winning Wheels is | | | | |
| | committed to revie | wing every resident to ensure | | | | 5 |
| | no additional abus | e has occured. Social services | | | | |
| | | ving and educating every | | | | |
| | | of abuse and socialization | | | | |
| | policies on 01/07/2 | 21. The education for both staff | | | | |
| | | be completed by 01/12/21. | | | | |
| 1 | Temporary License | ed Administrator will perform | | | | |
| | weekly audits on 3 | interviewable residents x8 | | | | |
| | | nat said residents 'feel safe' | | | | |

Illinois Department of Public Health STATE FORM

6899

and that no additional abuse has occurred.

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ____ C B. WING _ IL6010094 01/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

701 EAST 3RD STREET

| WINNING WHEELS PROPHETSTOWN, IL 61277 | | | | | |
|---------------------------------------|--|---------------------|---|--------------------------|--|
| (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 | |
| S9999 | Continued From page 6 | S9999 | | | |
| | Resident audits will be reported to QAPI each month. | | | | |
| | В | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Illinois Department of Public Health

STATE FORM