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	IL6010094	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNING WHEELS	701 EAST 3RD STREET PROPHETSTOWN, IL 61277

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S 000	Initial Comments Complaint #2316224/IL162520	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240b) 300.3240e) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was free from abuse for 1 of 3 residents (R2) reviewed for abuse in the sample of 3. This failure resulted in R2 feeling unsafe and in fear of R3.

The findings include:

R2's face sheet printed on 8/1/23 showed he was admitted to the facility on 5/1/23 with diagnosis

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S9999	Continued From page 2	S9999		

including but not limited to injury at the C4 level of cervical spinal cord and paraplegia. The facility assessment dated 5/8/23 showed no cognitive impairment. The same assessment showed R2 needs extensive staff assistance for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.

On 8/1/23 at 9:15 AM, R2 was lying in bed with a lap top device and cellular phone on the table over him. R2 was fully alert and oriented. R2 said there are a lot of wandering residents, but one that is especially bad (R3). He is in the room right next door to me and comes in here yelling and cussing. He has brain issues and once I even saw him eating his own feces. That is how bad he is. He hits other residents and even the staff. I saw him grab a nurse's necklace and yank it so hard she was bruised. I hear him yelling "F#*k you" all the time. He yells to be put to bed, then 2 minutes later, is screaming and crawling around on the floor. The aides have to watch him continually or he wanders into my room. I can push my call light with my head, but it takes them time to get here, especially later in the day. I am so afraid of him. Just last night after about 3 AM, I heard something in my room. I could see him crawling on the floor near my bathroom door. He was growling and coming towards my bed. I immediately called my mom on my cell phone (using voice activation). I was terrified! I can't use my arms or legs well. If he grabbed me, there is nothing I can do to protect myself. I keep praying this man stays away from me. He comes in here 3-4 times weekly. I am completely afraid for my safety and the safety of others. I understand this guy has brain problems, but I shouldn't have to live like this.

On 8/1/23 at 9:41 AM, R3 (does reside in room

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S9999	Continued From page 3	S9999		

next door to R2) was lying in bed on a low mattress and fall mats were on the floor. R3 did not respond to his name or react to this surveyor's presence. At 9:45 AM, R3 was heard moaning loudly and observed crawling on the floor of his room and about to exit into the hallway. V4 and V5 (Certified Nurse Aides) entered the room and assisted R3 into a wheelchair. V4 said he gets out of bed and crawls on the floor a lot. He can walk alone too, although he is not supposed to. At 9:55 AM, V6 (R3's case worker) said R3 has cognitive loss and lots of behaviors. He has a history of acting out aggressively at times and will hit others. Right now, I am unaware of any changes in the behaviors.

On 8/1/23 at 10:00 AM, this surveyor entered R3's room and attempted to hold a brief conversation. R3 mumbled in reply and then suddenly began yelling and screaming. R3 yelled "F*#k you b*&th*" repeatedly. This surveyor exited the room while R3 easily wheeled himself out of the room and down the hall, while continuing to scream profanities. R3 did not stop until a staff member approached and took him back into his room.

On 8/1/23 at 11:20 AM, V10 (R2's family member) stated R2 called her this morning around 3:30 AM. V10 said he was "absolutely terrified". R2 was whispering into the phone saying a man was crawling on the floor in his room. He was whispering because he was afraid to arouse the man and cause him to be attacked. V10 said she could see fear and terror (via face time) on R2's face. He said the man was coming right toward his bed. V10 said she heard a staff member taking the man out of the room. V10 said R2 explained it was the man that lives next door

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S9999	Continued From page 4	S9999		

(R3). V10 said R2 has told her he has seen R3 being physical to other residents and staff members. V10 said R3 repeatedly wanders into other rooms. V10 said he wandered into the room the last time she was visiting. V10 said, "How is it safe for an aggressive resident to wander into rooms in the middle of the night?!" V10 stated, (R2) was afraid last night when he called me.

R3's face sheet printed on 8/1/23 showed diagnoses including but not limited to concussion with loss of consciousness, postencephalitic Parkinsonism, traumatic brain injury, dementia with agitation, bipolar disorder, insomnia, restlessness and agitation. R3's facility assessment dated 6/19/23 showed R3 was unable to complete the cognitive assessment. The same assessment showed R3 has physical behaviors toward others, verbal behaviors toward others, and other behavior symptoms directed toward self. The assessment showed R3's symptoms put others at significant risk for physical injury and significantly intrude on the privacy of others.

The last three months of facility incident reports were reviewed and showed a resident-to-resident incident on 6/8/23. R3 was arguing with another resident and propelled toward him. R3 struck the resident in the left shoulder. An incident report dated 7/5/23 showed R3 propelled by another resident and kicked her in the left shin. (Both reports showed no resident injury and that the Illinois Department of Public Health was notified.)

On 8/1/23 at 11:37 AM, V7 (Social Service) stated R3 is physically and verbally aggressive to staff and other residents. He growls, yells out, and swears. He is being treated by the psychiatric staff and I think there have been changes to his

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S9999	Continued From page 5	S9999		

medications. We try to do a lot of one-on-one activities with him and would do counseling too but he can't comprehend that.

On 8/1/23 at 11:55 AM, V9 (Registered Nurse) said R3 is aggressive at times. We all have to pitch in to keep an eye on him. He has had a lot of medication changes in the past. He gets clonazepam (anti-anxiety) twice a day. It is typically effective unless he was up a lot the night before. He does get up a lot during the night. He is hit or miss on how he will act each day. One minute he is fine, and the next minute he is acting out.

On 8/1/23 at 12:05 PM, V8 (Licensed Practical Nurse) stated R3 does have lots of behaviors and gets agitated easily. He does see psychiatric services and they are here on a weekly basis. I know there have been lots of medication changes in the last three months or so. We give him snacks and do one on one supervision until he is calmed down. He does crawl on the floor and wander into other resident rooms. We redirect him and it varies on how well that works.

On 8/1/23 at 12:15 PM, V4 and V5 (Certified Nurse Aides) said R3 gets overstimulated easily and that causes him to escalate quickly. He yells and swears. He does get out of bed by himself and crawls around on the floor. He is able to self-propel his wheelchair around. He goes in and out of other resident rooms. We try to keep a banner across other resident doors, so he doesn't go in there. (R2's door banner was wrapped up and tucked under the wall handrail during the entire survey.) We redirect him with TV, movies, or discuss something to get him off focus. It is generally effective. If he still won't calm down, we tell the nurse.

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S9999	Continued From page 6	S9999		

On 8/1/23 at 1:24 PM, R2 was interviewed again and stated every once in a while they put the banner over my doorway, but it depends on who is working. (R3) is terrifying. He scares the crap out of me when he gets close to me. I hardly leave my room because I know when I come back he will be in here. I try to redirect him the best I can. I call my mom on face time when he is agitated because I don't know if staff will get to me in time. I am only 21 years old and I hate admitting that I am scared.

On 8/1/23 at 12:52 PM, V2 (Director of Nurses) stated R3 is seen by psychiatric services every two weeks. There have been several medication adjustments and some his mother would not allow. We have been trying to get R3 into a facility near Chicago, but they do not have the space yet.

On 8/1/23 at 1:20 PM, V1 (Administrator/Abuse Coordinator) stated he would consider hitting or kicking others as abuse. V1 said he would agree with abuse as defined in the facility's policy. V1 said R3 does have a history of hitting or kicking others and does wander in and out of R2's room. V1 said he believed R2 and R3's were friends and did not realize it was an issue until now. V1 stated there is a video camera in the hall right outside R2 and R3's room. He would review it and get back to the surveyor. At 2:00 PM, V1 said the camera did show R3 crawling on the hallway floor around 3 or 4 AM but he could not see exactly if R3 entered R2's room. V1 said staff are afraid of R3 too and that is why we have been trying different avenues for him.

The facility Abuse Program policy last revision dated 3/17 states: "PURPOSE: To ensure on-going safety of resident. DEFINITIONS: 10.

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S9999	Continued From page 7 RESIDENT TO RESIDENT ABUSE is the willful inflection or injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish by one resident towards another." (B)	S9999		