STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010094	A. BUILDING: _____ B. WING _____	C 05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNING WHEELS	701 EAST 3RD STREET 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
S 000	Initial Comments Complaint Investigation 2314180/IL160056	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2) 300.1210d)5) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. (Section 3-202.2a of the Act) 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	S9999		

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S9999	Continued From page 2 following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to recognize and treat a resident with an infected Stage 4 pressure injury for 1 of 3 residents (R1) in the sample of 7. This failure resulted in R1 being hospitalized for a systemic infection due to an infected Stage 4 pressure injury requiring surgical debridement. The findings include: R1's face sheet showed a 62-year-old female with diagnosis of nontraumatic intracranial hemorrhage, hemiplegia and hemiparesis affecting left non-dominant side, Type 2 diabetes, anxiety disorder, epilepsy, dysphagia, left shoulder contracture, major depressive disorder, and hypertension.	S9999		

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S9999	Continued From page 3 On 5/23/23 at 9:14 AM, V4 wound nurse, said R1's wound declined from 5/12-5/15/23. On 5/15/23 there was thick green purulent drainage, the surrounding tissue had changed. There was no indication of an infection. Signs of infection would include a fever, increased pain, increased sleepiness. If a wound is infected, it won't heal. It could progress to sepsis and death. V4 said R1 didn't have any recent wound infections. At 9:50 AM, V11 Licensed Practical Nurse (LPN) said on 5/17/23, V12 Certified Nursing Assistant (CNA) reported to her and V15 night nurse that R1 was not acting right. V11 said she V15 and V12 went to R1's room and found her up in her chair lethargic, didn't know who I was, and was unable to speak. V11 said she and V15 did a "full body assessment" and R1 was transferred into the bed without incident. R1 was cold and V11 could not obtain a blood pressure or oxygen saturation. V11 said she had to use a stethoscope over her chest to obtain a pulse. V11 said R1 was clammy, pale and was having 15-30 seconds of apnea. 911 was called and R1 was sent to the hospital. At 9:58 AM, V12 said she is a restorative aid and on 5/17/23 was going to bring R1 to the restorative dining room for breakfast when she found her slumped over to her right side while in the chair in her room. V12 said R1 was "out of it", having periods of apnea, and not recognize staff so she reported this to V11. At 11:42 AM, V1 Administrator said R1 did not see the facility's wound care provider in April 2023 due to her payor source. On 5/24/23 at 1:24 PM, V9 (Surgeon) said on 5/19/23 she assessed R1 in the hospital. R1 had	S9999		

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S9999	Continued From page 4	S9999		

a Stage 4 pressure ulcer to the right trochanter which measured about 4 centimeters (cm) X 4 cm. V9 said the wound had purulent drainage, was foul smelling, necrotic, and the subcutaneous tissue and muscle were involved. It was infected. "It was pouring out pus". The foul odor and drainage were indicative of an infection. The worst tunnel was 2 cm to the bone. Not seeing a wound care provider for 2 months could "absolutely" cause a decline in the wound and infection. V9 said she sees patients with wounds every 1-2 weeks. "It's unacceptable" that R1 was not sent to a wound clinic if the provider could no longer see her at the facility. V9 said she took R1 to surgery on 5/19/23 to clean the wound out.

On 5/25/23 at 8:59 AM, V4 wound nurse said R1 did not see the facility wound care provider after the 3/7/23 appointment until 5/9/23.

R1's 5/23/23 and 5/24/23 hospital infectious disease notes showed R1 had sepsis due to her (infected) decubitus ulcer. This note showed an infected decubitus ulcer in the right buttock.

R1's 3/7/23 wound provider note showed a Stage 3 right buttock pressure wound measured 2 cm X 2 cm X 0.6 cm. There was light serous exudate, 75% thick adherent devitalized necrotic tissue and no change in wound progress. A follow up evaluation by the wound care specialist in 8-14 days with further intervention as indicated was recommended.

There were no further wound provider notes from the 3/7/23 visit until 5/9/23.

R1's 5/9/23 wound provider note showed the Stage 3 right buttock pressure wound measured 1.5 cm X 2.8 cm X 0.5 cm. There was moderate

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S9999	Continued From page 5 serous drainage, 80% thick adherent devitalized necrotic tissue and the wound had deteriorated. R1's 5/16/23 wound provider note showed a now Stage 4 right buttock pressure wound measured 1.5 cm X 2.6 cm X 1 cm. There was an odor and undermining at 7 o'clock. There was heavy serous exudate, 100% thick adherent devitalized necrotic tissue and the wound had again deteriorated. R1's 5/15/23 note authored by the facility nurse practitioner showed R1 continues to complain of pain in her buttocks due to wound. R1's 5/17/23 note, authored by V11 LPN, showed R1 was unresponsive, unable to obtain a blood pressure, pulse was erratic, and could not obtain an oxygen saturation. This note showed R1 was transported to a local hospital at 6:55 AM. R1's 5/19/23 hospital consultation note authored by V9 (Surgeon) showed she was consulted to determine if the pressure ulcer required debridement. This note showed a 4 cm X 4 cm wound over the right trochanter that was foul smelling and purulent. This note showed necrotic tissue was present and there was concern the wound was the source of her infection as other sources (knee and urine) had been ruled out. R1's 5/19/23 operative report showed a large amount necrotic subcutaneous and muscle in the wound. There was a tunnel at the 12 o'clock position that went to the bone. A bone biopsy was obtained. The post debridement measurements were 2 cm width X 3 cm height X 1 cm depth. There was a tunnel at 12 o'clock, a 1 cm tunnel at 3 o'clock, and a 1 cm tunnel at 6 o'clock.	S9999		

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S9999	Continued From page 6 R1's 4/13/23 assessment showed R1 was cognitively intact. R1's 4/14/23 facility assessment showed total dependence on two plus persons physical assistance to transfer, extensive assistance of two plus persons physical assistance for bed mobility, dressing, and toilet use, extensive assistance of one plus person physical assistance for personal hygiene and bathing, and limited assistance of one-person physical assistance for eating. R1's pressure care plan had not been updated since 3/21/23. The facility's 6/2014 Pressure Ulcer Prevention Program showed the facility will promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible). The Wound Care Coordinator confers with the facility wound consultation firm, when appropriate, and implement recommendations. The MDS (Minimum Data Set) Coordinator updates the resident care plan whenever a change occurs in the status of the wound or when the treatment plan is altered. (A) Statement of Licensue Violations (2 of 2) 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 7 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.	S9999		

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S9999	Continued From page 8 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to supervise a resident with difficulty swallowing at mealtime and failed to ensure a cognitively impaired resident with knee pain and a history of self-transfers was supervised to prevent self-transfer for 2 of 3 residents (R1, R2) reviewed for safety and supervision in the sample	S9999		

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S9999	Continued From page 9 of 7. This failure resulted in R1 choking and requiring resuscitation and R2 falling (right leg was fractured) and hitting his head. The facility also failed to notify the State agency of a resident's choking episode. This applies to 1 of 3 residents (R1) reviewed for reporting in the sample of 7. The findings include: 1. R1's face sheet showed a 62-year-old female with diagnosis of dysphagia, nontraumatic intracranial hemorrhage, hemiplegia and hemiparesis affecting left non-dominant side, Type 2 diabetes, anxiety disorder, epilepsy, left shoulder contracture, major depressive disorder, and hypertension. On 5/25/23 at 8:48 AM, V27 Restorative Aide said at lunch on 4/11/23 she was the only staff person assisting residents in the restorative dining area. Usually there are two staff, but she could do it by herself. There were 7-8 residents present. V27 said there were two tables in the restorative dining area. She was seated at a table with four residents who required feeding. R1 was seated at the other table with her back towards V27. R7 was also at R1's table with his spouse (V21) and another resident. V27 said she was alerted by V21, R7's spouse, that R1 couldn't breathe and was choking. V27 said R1 had not been eating well, needed to be supervised, and needed assistance to eat. V27 said she's not sure what R1 choked on. At 10:32 AM, V21, R7's spouse said they're short staffed sometimes and on 4/11/23, there was only one staff person in the restorative dining area during lunch. The girl that was helping was at the	S9999		

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S9999	Continued From page 10 other table. R1, me and R7 were at the other table. I'm here almost every day for lunch. R1's back was toward the girl (staff) and R1 was facing me and R7. R1 has trouble eating. V21 said she looked at R1 and she (R1) couldn't talk. Her face was white, lips were blue, eyes were open wide, startled and she mouthed to me that she couldn't breathe. I yelled at the girl in the dining area, V27, that R1 couldn't breathe. R1's 4/11/23 nurses note showed R1 was found choking in the restorative dining area. There was no evidence of air exchange. R1's lips and mucous membranes were cyanotic. The Heimlich maneuver was done three times without success. R1 became pulseless and not breathing. Cardiopulmonary resuscitation (CPR) was started. R1 became conscious. R1was sent to the emergency room for further assessment due to choking with loss of consciousness, respirations and pulse. At 8:59 AM, V4 wound nurse said on 4/11/23 she did compressions and abdominal thrusts on R1, and some food was expelled. R1's 4/11/23 Emergency Room (ER) note showed she was seen after a choking and CPR episode at the facility. R1 was awake and interactive in the ER. R1 was discharged back to the facility on 4/11/23. R1's 4/3/23 facility assessment showed (R1) required supervision and one-person physical assistance for eating. R1's 3/3/22 care plan intervention showed to monitor for signs and symptoms of choking and to serve meals in the restorative dining room for supervision and assistance.	S9999		

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S9999	Continued From page 11 R1's 3/31/23 speech therapy note showed patient required supervision at mealtime prior to onset of therapy, staff will be trained on safe swallowing strategies to provide prompts to patient during mealtimes and consistent cueing was required for mastication and oral clearance. This note showed patient had a recent choking incident that required the abdominal thrust and CPR, as patient coded. On 5/24/23 at 11:42 AM, V1 Administrator said he did not report R1's 4/11/23 choking episode to Illinois Department of Public Health (IDPH). At 12:21 PM, V1 Administrator said, "maybe you can give me some guidance on that"? "I looked in my Administrator's Manual and the watermelon book (referring to the State Operations Manual) and I can't find anything that says I'm supposed to report a choking episode. V1 said R1 "was fine". We only sent her to the hospital as a precaution 2. R2's face sheet showed a 47-year-old male with diagnosis of diffuse traumatic brain injury, monoplegia affecting the left upper non-dominant side, epilepsy, schizoaffective disorder, anxiety disorder, and major depressive disorder. On 5/25/23 at 2:55 PM, V30 R2's orthopedic physician assistant-certified said he was viewing the x-ray and there was no bone cancer, so the fracture was not pathological. V30 said the bone spur was on the opposite side of the knee as the fracture and had nothing to do with the injury. The bony abnormality had nothing to do with the fracture. It was an otherwise normal x-ray. The fracture was from a fall. He must have fallen at the nursing home. On 5/25/23 at 8:16 AM, V25 R2's mother said R2	S9999		

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has no history of issues with his right leg. V25 said R2 called her and complained of right knee pain on 4/16/23. V25 said she called the facility to tell them about it and they were aware.

R2's 4/26/23 fall risk assessment showed 1-2 falls in the past 3 months, R2 was chairbound, required use of assistive devices for gait/balance, had intermittent confusion and was at risk for falls.

R2's 4/17/23 at 10:10 AM provider note showed R2 complained of right knee pain, unknown injury and acetaminophen was not effective. An x-ray was ordered.

R2's 4/17/23 therapy note showed R2 had acute right knee pain and refused to ambulate in the restorative gym.

R2's 4/17/23 at 10:32 AM order showed to do a right knee x-ray due to pain.

R2's 4/18/23 right knee x-ray report showed the results were reported at 10:13 AM and there was a depressed fracture of the medial margin of the tibial plateau presumably acute.

R2's 4/18/23 9:25 PM fall incident showed blood on the floor and a large hematoma to the left temple and resident was sent to the hospital. This report showed R2 was confused, had a gait imbalance and impaired memory, there was poor lighting and the incident occurred during a (self) transfer. (Fall occurred less than 12 hours after receiving x-ray report showing a fracture)

R2's 4//21/23 progress note authored by V30 orthopedic physician assistant showed R2 complained of right knee pain on 4/16/23 and fell

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WINNING WHEELS	701 EAST 3RD STREET 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 13 4/18/23. This note showed a fracture to the medial aspect of the right tibial plateau and a large osteophyte (bone spur) to the lateral distal femur. R2's 4/19/23 incident note showed the knee injury (fracture) occurred prior to the fall (on the evening of 4/18/23). R2's current care plan showed R2 had a history of falls. R2 fell on 10/20/21 with minor injury; on 12/20/21 R2 fell with a minor injury after a self transfer. R2 had a fall after a self transfer on 4/18/23 with injury. R2's care plan also showed short term memory deficits and is unable to recall any education given. R2's care plans do not show interventions to prevent self-transfers. R2's 5/24/23 at 8:40 AM nurse note showed R2 was found on the floor in his room after a self-transfer. The facility's Fall Prevention Program policy with a revision date of 3/17 showed, the facility will identify residents at risk for falls, develop care plans for residents at risk for falls, develop and implement interventions to prevent falls and investigate to determine root causes of falls and implement interventions to prevent reoccurence of falls. (A)	S9999		