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	IL6010094	A. BUILDING: _____ B. WING _____	C 02/26/2019

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

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b) 300.1210d)3) 300.3240a) 300.3240f) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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. Restorative measures shall include, at a minimum, the following procedures:

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

f) Resident as perpetrator of abuse. 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

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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 are not met as evidenced by:

Based on interview and record review, the facility failed to supervise a resident with aggressive and sexually inappropriate behaviors and failed to provide a safe environment. This failure resulted in 1 of 7 residents (R1) wanting to harm himself and 3 of 7 residents (R3, R4, and R6) feeling unsafe in the sample of 7.

The findings include:

R2's social service intake note shows R2 suffered a traumatic brain injury on September 3, 2017 due to an assault. R2 was admitted to the facility on October 11, 2018.

R2's baseline Care Plan shows R2 can independently get around the facility in the wheelchair and has sexually inappropriate behaviors.

On February 21, 2019, at 9:05 AM, R4 said "R2 grabbed R3's boob, would pull out his "man part" in the hallway and show it to female staff and residents. R2 made me nervous when he grabbed me because I can't move to go anywhere. I was stuck and he wouldn't let go of my arm. Residents were nervous to go down the hallways when he was here. I did not like the way the facility handled the situation."

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At 10:00 AM, R3 said "R2 punched me in the boob and started laughing. R2 punched me in my left arm. I was scared to leave my room. R2 made the residents fearful. I didn't want R2 to know where my room was. The Administrator always stuck up for him (R2). R2 was always going off by himself. There was rarely any staff with him."

On February 21, 2019 at 11:25 AM, V1 Certified Nursing Assistant (CNA) said she knows R2 did grab R1's genitals based on his reaction. "It absolutely occurred". R1 told me R2 grabbed a hold of his privates and wouldn't let go. R1's eyes were fully open and he was uneasy. R2 would grab others' hands and not let go, kick other residents until they fell, push their wheelchairs backwards. I could see R2 made the other residents uncomfortable. I had to move him and his wheelchair out of the hallway because the residents would not go by him."

At 11:50 AM, R6 said "R2 kicked the back of my leg and I fell to the ground. R2 made living here uneasy. People tried to stay away from him. I had to hide in my room to stay away and put a door stop on my door. R2 hit me in the nuts and with a fist a couple of times. R2 made my life hell."

At 12:50 PM, V2 Licensed Practical Nurse (LPN) said "R2 would intentionally antagonize R3 because he knew it bothered her. R2 has punched me a few times.R4 told me she was afraid of R2. R2 grabbed R4's arm and twisted it and then grabbed her breast. R2 grabbed R1's genitals. R2 would masturbate in front of the CNAs. There wasn't enough staff to do 1:1 supervision of R2. R2 has had these same behaviors since he got here. The residents

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wanted to know why he was still here and not gone."

At 1:30 PM, V3 Nurse Practitioner said "R2 had aggressive behaviors, invaded others personal space and was sexually inappropriate toward staff. V3 said she had not seen any 1:1 supervision of R2 until February 4, 2019. R2 grabbed R1's penis area and touched R4's breast. After R2 grabbed R1's genitals, R1 was irate, upset and crying. He was loud and flailing his arms around. I'm sure he felt violated and confused, almost didn't know how to react. All of this was definitely out of R1's character. At 1:57 PM, V4 (R1's father) said when R2 grabbed R1's genitals R1 told me he tried choking himself with intent of killing himself after this incident. R1's current brain injury is a result from a suicide attempt by hanging in 2016. R1 couldn't cope with what happened. He can't protect himself, he can't call out. I took R1 home on February 4, 2019 and brought him back to the facility on February 11th. I picked him up again on February 20th, "it was traumatic to him. He's still not the same". I'm not sure if he will be able to stay at the facility.

At 2:15 PM, R5 said R2 is dangerous. He goes after people to attack them all the time. He makes residents scared. There's no telling what he'll do. He could pretty much do what he wanted without repercussion. It didn't seem like they attempted to deal with R2 and his behaviors.

At 3:00 PM, V6 CNA said "some of the CNA staff were fearful of R2 because he was sexually inappropriate and there was not usually 1:1 supervision of R2. R2's nursing notes dated November 11, 2018, show R2 spit into another resident's face and then threw what looked to be a piece of his wheelchair at the other resident.

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A state agency report dated November 7, 2018, submitted by the facility shows R2 was in his wheelchair and went behind R6 and pushed his lower leg with his foot. The nursing progress note from this incident shows staff asked R2 to stop and R2 laughed and started doing it again.

R2's November 20, 2018 nursing note shows R2 kicked another resident (R6) from behind causing his knees to buckle and him falling. Both residents were separated and R2 grabbed the wrist of R6. This same note shows R2's physical behaviors are willful and purposeful. When separating R2 from other residents, R2 smiles and attempts to return right back to inappropriate behaviors.

R2's nursing note dated November 21, 2018 shows R2 touched R7's (female resident) breast. R2 was told to stop which he did not.
R2's nursing note dated November 24, 2018, shows R2 would get really close to female residents with a smile on his face, scaring female residents. R2 then rolled his wheelchair into the hallway blocking other residents from going through. When nurse asked R2 to move, R2 punched nurse in the breast hard and said "F**k You".
R2's notes dated December 28, 2018 shows he grabbed R7's wrist and when the nurse requested he let go R2 refused.
An investigation summary dated December 28, 2018 shows R2 touched R3's (female resident) breast.

R2's January 6, 2019 nursing note shows R2 hit another (unknown) resident in the breast.
Later the same day, R2 punched R6 in the forearm.

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S9999	Continued From page 6 R2's February 2, 2019 nursing note shows R2 punched R3 in the arm. R2's February 4, 2019 nursing notes show at 9:00 AM, R2 grabbed R4's wrist and twisted the skin leaving a mark. At 11:00, R2's nursing note shows he grabbed a female resident's (R4) breast. At 11:05 AM, R2 grabbed a male resident's (R1) genitals, squeezed and twisted them. R2's care plan for sexually inappropriate behavior dated October 19, 2018 shows to redirect and provide 1:1 with social services for interventions. After a November 21, 2018 incident (care plan shows November 20) when R2 grabbed R7's (female resident) breast, a December 28, 2018 incident when R2 touched R3's (female resident) breast, and a January 6, 2019 incident when R2 hit another resident's breast there were no new interventions implemented. R2's care plan for aggressive behaviors dated October 19, 2018 shows to redirect, divert attention and notify social services for 1:1 as needed. A care plan intervention dated October 29, 2018 shows to provide 1:1 close and constant supervision to monitor whereabouts and proximity to those easily upset by behaviors. After aggressive behavior incidents on November 7, 11, and 20, 2018, December 28, 2018, January 6, 2019, and February 2, 2019 there were no new interventions implemented. The facility's Behavior Management and Cognition Policy dated March 2017 shows when a person served displays cognitive needs and/or exhibits dangerous or maladaptive behavior, it is the responsibility of staff to take steps to protect the client, the staff and the environment.	S9999		

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S9999	Continued From page 7 The facility's Resident Abuse and Neglect Policy dated March 2017 shows it strictly prohibits the abuse and mistreatment of residents. The facility will take an aggressive stance on preventing abuse. This policy defines abuse as "willful infliction of injury, intimidation with resulting physical harm, pain or mental anguish". Sexual abuse includes, but is not limited to "sexual harassment, sexual coercion, or sexual assault". Physical abuse is defined as "hitting, slapping, pinching and kicking". (B)	S9999		