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 11/15/2016

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 IRI of 11/3/16/IL89779- F223 cited.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.3240a) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to keep a resident free from physical abuse on November 3, 2016. This failure resulted in E4 hitting R1 in the face with a closed fist three times which resulted in physical injuries to the right side of the face and a change in R1's behavior as manifested by anxiety and paranoid behaviors, and documentation of symptoms of post-traumatic stress disorder. This applies to 1 resident (R1) reviewed for	S9999		

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S9999	Continued From page 2	S9999		

abuse.
The findings include:
The May 25, 2016 physician history and physical for R1 documents he was admitted to the facility on May 21, 2016 with multiple diagnoses including Bipolar disorder, CVA (Stroke) secondary to an aneurysm (age6). The October 31, 2016 quarterly MDS (Minimum Data Set) documents R1 to have a BIMS (Brief Interview for Mental Status) of 15, cognitively intact. The MDS section G documents R1 is totally dependent on staff with a mechanical lift for all transfers to and from his wheelchair. The MDS documents R1 has verbal behavioral symptoms towards staff and other residents and refuses personal care assistance from the staff.
The October 31, 2016 psychotropic medication assessment shows R1 has behaviors which alter his ability to function including: resist care, verbally abusive, physically abusive, yelling out, anxious complaints, and combative behavior.
On November 15, 2016 at 12:15 PM, R1 stated on the night of November 3, 2016, E6 and E4 CNA ' s (Certified Nursing Assistants) pushed him into his room for his shower. R1 said E6 was in the room and turned the shower on and E4 attacked him. R1 said E4 was standing over him and hit him in the face. R1 said he had not provoked her or had any issues with E4, and this assault came out of nowhere.
On November 15, 2016 at 9:30 AM, E6 said he took R1 to his room to be showered and needed to use the mechanical lift to transfer R1 into the shower chair. E6 said E4 was in the room to assist with the transfer. E6 said as he was attempting to raise R1 with the lift, and R1 swung his arm at E4. E6 did not see if R1 had hit E4 or if he had missed her. E6 said E4 then hit R1 on the right side of his face with a closed fist 3 times. E6 said after E4 hit R1 she removed her gloves

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and left the room. E6 said R1 appeared to be confused and scared. E6 said he stayed with R1 until the nurse arrived to assess him. E6 said R1 has swung him at before but has never hit him. E6 said R1 has been different since he was hit by E4, and R1 is calmer now, and does not have the physical behavior as he did before.

On November 15, 2016 at 9:00 AM, E7 (CNA), said she entered R1's room just in time to see R1 swing his arm at E4 and then E4 hit R1 in the face with a closed fist 3 times. E7 said after E4 hit R1 she removed her gloves and left the room. E7 said R1 was in his chair crying and looked dumbfounded about what had just happened. E7 said E4 had worked with R1 prior to this incident. E7 said if R1 is having behaviors the staff is to give him time to think about what he needs to do and then re-approach him. E7 said if R1 does not like the aide, and then ask someone else to help. E7 said after E4 hit R1 he had a black eye and his face was swollen for days. E7 said since this incident R1 is a lot more cooperative, and a little edgy around staff.

On November 15, 2016 at 9:35 AM, E9 LPN (Licensed Practical Nurse) said she was on duty the night R1 was hit by E4. E9 said she was in the medication room when E7 reported to her E4 had just hit R1 in the face. E9 said E4 was standing behind E7 crying trying to say R1 had hit her. E9 said she kept E4 in the medication room while she assessed R1 for injuries. E9 said R1 appeared very upset and was telling her that no one had ever hit him before. E9 said R1's face had already started to appear swollen and a dark area on his skin was starting to appear around his eye and cheek area, and was complaining of neck pain. E9 said R1 has asthma and was having shortness of breath and documented his oxygen saturation level at 82%, so she applied oxygen. E9 said after her assessment of R1, she

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called the administrator and the local police. E9 said the police arrived and took statements from all of the staff involved and suggested R1 be sent to the hospital for examination by a physician. E9 said she notified the nurse practitioner and R1 was sent to the local emergency room. E9 said when R1 returned to the facility his right eye was swollen shut and his cheek bone was bruised and the right side of his face appeared to be swollen as well. On November 4, 2016 at 3:00 AM, E9 documents R1 returned from the emergency room and the CT scan was negative and no pain medications were given.

On November 15, 2016 at 9:00 AM, E5 (CNA), said R1 had hit her in the mouth once while she was attempting to provide care. E5 said she made sure he was safe with another staff member and left the room. E5 said she left because that is what the staff is trained to do when dealing with R1 ' s behaviors.

On November 15, 2016, E11 (CNA), said R1 is combative when trying to provide care. E11 said R1 will kick and swing his right arm trying to hit staff. E11 said she has had no problems when caring for R1 and if any aide has difficulty with him, the aide can trade places with someone who works better with R1.

R1's care plan for May 27, 2016 document a problem with physical aggression toward staff and others. This includes yelling, swearing, calling names. R1 has a history of refusing cares, hitting and pushing staff away during cares. The interventions for this behavior are to allow R1 time and opportunity to express self and verbalize frustrations. Allow him time to calm down, re-approach at a later time. Call for assistance as needed. Do not argue or force R1 into something he does not want to do.

R1's care plan for being at risk for abuse and neglect shows he has episodes of refusing cares,

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which leads to hitting, kicking, scratching and pushing staff. At times resident behavior/actions can cause peers to become upset.
The November 4-13, 2016 daily nurses notes document R1 had swelling to his right eye, and bruising of his eye and cheek bone area. On November 10, 2016 the nurse documents the bruising had extended down to the jawline. On November 13, 2016, the nurse documents bruising to the right eye and right side of his face, and bruising is visible below his neck and appears dark purple.
On November 15, 2016 at 12:20 PM, 12 days after the incident, R1 was observed to have a purple area above his right eye. Bruising was noted in an approximate one inch wide line from his right ear, under his chin, to the bottom of his left ear.
On November 15, 2016 at 10:50 AM, E8 (social services), said he was aware of R1 ' s behaviors and had encouraged him to speak with a psychiatrist and deal with what issues he may have. E8 said R1 has had an increase in his behavior as his stay continues. E8 said R1 has always refused to talk with anyone about his problems, but since the incident he had agreed to speak with the facility psychiatrist.
On November 15, 2016 at 11:00 AM, E5 said since the incident R1 has changed his behaviors and he is not as physically aggressive and swinging at staff like he was before. E5 said she thinks R1 is afraid of being hit again.
On November 15, 2016 at 12:15 PM, R1 stated he feels like he is always looking over his shoulder now when he is out of his room.
The November 4, 2016 social service progress notes document R1 had continued to refuse psychological services. On November 8, 2016, E8 approached R1 again with the suggestion of psychological services and R1 accepted, and

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agreed to see the psychologist.
On November 8, 2016, R1 was seen by Z1 (Psychologist) and Z1 documented R1 asks himself why it happened to him, explaining that he is a nice guy and gets along with people. Z1 documents that R1 showed signs of post-traumatic stress disorder (PTSD), due to R1 frequently thinking about the incident and having dreams about it. Z1 documented a diagnosis of PTSD. The summary/recommendations show once the patient had some understanding that what he is experiencing is often what occurs with people who are so traumatized, he seemed to be receptive to counseling to deal with the issue. Z1 documents R1 will be followed for supportive psychotherapy.
The undated facility policy for resident abuse and neglect shows that the organization strictly prohibits the abuse, neglect, mistreatment, involuntary seclusion of residents. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes hitting, slapping, pinching and kicking. Procedures: 3. Prevention: Staff are trained to be proactive, and interventions are taught to promote intervention before situations get out of control. Staff receives ongoing training through the MANDT program (positive behavior support), behavior modification training and individual resident behavior management programs.

(A)

Winning Wheels
Survey Date: November 15, 2016
IRI of 11-3-2016 IL89779
Violation: A

IMPOSED PLAN OF CORRECTION

300.610a)
300.1210b)
300.3240a)
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 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

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)

e) *Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.* (Section 3-611 of the Act)

Attachment B
Imposed Plan of Correction

This will be accomplished by:

I. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding accident hazards/assistance devices/adequate nursing supervision. This review will ensure that the facility's policies and procedures address, at a minimum, the following:
   A. Recognition of situations that could lead to resident injury and/or death.
   B. Appropriate reporting procedures for staff.
   C. Appropriate and thorough investigations of alleged abuse or neglect
   D. The facility's responsibilities to prevent further potential abuse and or neglect while the investigation is in progress.
   E. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct MANDATORY in-services for all appropriate staff within 10 days that addresses, at a minimum, the following:
   A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
   B. All appropriate staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   C. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

III. The following actions will be taken to prevent re-occurrence.
   A. The above In-Service Education will be reviewed with all appropriate staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations regarding fall prevention (reporting and follow-up) are followed.
   C. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.
   D. An audit shall be conducted and documented by the facility's nurse consultant monthly for three months to ensure that, successful completion of the above policies. Should any omissions be found, staff shall be re-trained, counseled and or disciplined as appropriate.

Monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of the Imposed Plan of Correction.