FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED C IL6010094 B. WING 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments \$ 000 Complaint investigation 2212553/IL145307 S9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies 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.

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b)

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

each resident's comprehensive resident care

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

TITLE

Attachment A Statement of Licensure Violations

(X6) DATE

PRINTED: 04/27/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED C IL6010094 B. WING 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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. 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: 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 safely transport a wheelchair bound resident for 1 of 3 residents (R1) reviewed for accidents in the sample of 8. This failure resulted in R1 suffering an upper arm fracture that required surgical repair. Findings include: The facility report dated 3/25/2022, documents R1 requires staff assistance to propel her power wheelchair and as she was being propelled in the facility, R1's swung out her arm and struck the

arm.

wall. An x-ray at the facility showed a fractured

The facility face sheets documents R1 has diagnosis to include cerebral palsy, osteoporosis, epilepsy and kyphosis. The facility assessment dated 1/19/2022, documents R1 to be oriented

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED IL6010094 B. WING 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 and has modified independence in daily decision making. The same assessment documents R1 to be totally dependent on 1 staff for locomotion on and off the unit. R1's care plan for functional performance dated 5/27/2021 documents one staff to drive the wheelchair. The care plan for falls dated 5/26/2021 documents to ensure wheelchair is off to decrease risk of hitting joy stick with resident spasms. On 4/5/2022 at 9:45 AM, R1 said the activity lady was not watching where she was going as she assisted her to the activity. R1 said her arm was broken, and she needed surgery to repair the injury. On 4/5/2022 at 10:00 AM, V3 Activity Aide said she was assisting R1 to the activity in the dining room. V3 said she had never helped R1 before because V3 is new to the facility. V3 said as she was controlling the electric wheelchair, she came upon a wet floor sign in the entry of the dining room and had to move over closer to the wall. V3 said at the same time R1 swung out her arm and it hit the wall as she continued to advance her forward. . V3 said she had never been trained on how to use R1's wheelchair and that it is different from any kind of wheel chair she (V3) had seen before. On 4/5/2022 at 9:40 AM, V4 Certified Nursing Assistant (CNA) said R1 flails her arms around so when she is being transported in the wheelchair and you come to a door way or have to get close to the wall, the staff should put there body between the wall and R1. On 4/5/2022 at 9:45 AM, V5 CNA said R1's arm will swing out while being transported (in her

electric wheel chair) and the staff must protect

FORM APPROVED Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: -COMPLETED IL6010094 B. WING 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET WINNING WHEELS PROPHETSTOWN, IL 61277 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 her arms from hitting the wall or getting caught in the doorways. On 4/5/2022 at 10:21 AM, V6 Licensed Practical Nurse (LPN) said R1 has very brittle bones and caution is needed with her transfers and transports out of her room. R1 needs to be reminded to keep her arms in, the wheel chair should be driven slowly and make wider turns that a normal wheel chair. On 4/5/2022 at 2:35 PM, V2 Assistant Director of Nursing (ADON) said V3 was not familiar with R1's wheelchair and it can be switched to manual mode and can be pushed. V2 said he would expect the staff to protect R1's arms while transporting her by either using the manual mode or putting themselves between R1 and the wall. V2 said staff should be trained with anything they are not familiar with. V2 said he was not aware if V3 had been properly trained since the incident has happened. R1's nursing progress note dated 3/25/2022. documents R1 was being transported by the activity staff when her right arm swung out and got stuck to the wall while her chair continued forward. That same day a nursing note showed an x-ray was completed and R1 had an unofficial humerous (upper arm) break. R1 was transferred to the local hospital.

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The hospital discharge record dated 3/30/2022, documents a right humeral fracture with surgical

experiencing pain and required pain medication.

The facility policy on safety and supervision with a

repair. The record also shows R1 was

revision date of 3/17 shows implementing interventions to reduce accident risks and

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STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6010094		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DAT	(X3) DATE SURVEY COMPLETED	
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