STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145556	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winning Wheels	701 East 3rd Street Prophetstown, IL 61277

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure a resident (R4) was free from sexual abuse (by R5) for 1 of 8 residents reviewed for abuse in the sample of 8. The findings include: The facility incident report sent to the Illinois Department of Public Health showed on 4/27/24 that R5 touched R4's breast while both were sitting outside on the front patio. R4's computerized face sheet printed on 4/30/24 showed diagnosis including but not limited to paraplegia and malignant neoplasm of spinal cord. R4's facility assessment dated [DATE] showed no cognitive impairment and no memory problems. R4's assessment showed the use of a manual wheelchair and the ability to operate it independently. R5's computerized face sheet printed on 4/30/24 showed diagnoses including but not limited to multiple sclerosis, paraplegia, and cognitive communication deficit. R5's facility assessment dated [DATE] showed moderate cognitive impairment and no upper extremity impairment. R5's assessment showed the use of a motorized wheelchair. R5's care plan showed a focus area start dated 4/15/20 related to the potential to make sexually inappropriate comments to females. On 4/30/24 at 11:18 AM, R4 was seated in a wheelchair at an activity table. R4 was alert and oriented. R4 stated she was talking with R5 over the weekend (4/27) on the front patio. R4 said it was a pleasant conversation about religion and past medical issues. R4 said R5 reached out with his right arm and tapped her left shoulder in an encouraging manner. R5 then grabbed her left breast and caressed it. R4 said she immediately wheeled herself backward and told R5, Don't you ever do that again! R5 replied, Never? R4 answered, Yes, never! Don't touch me ever again. R4 said R5 said okay and just sat there without any type of apology. R4 stated she wheeled herself away from the area and out of arms reach. R4 said her family arrived for a visit approximately five minutes later. R4 and her daughter went into the facility and reported the incident to V12 (LPN). R4 stated there were no other staff or residents in the immediate area to witness the incident. R4 said she had past conversations with R5 and was dumfounded that he would do anything like that. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 11:42 AM, R5 was seated in a wheelchair on the back patio. R5 was alert and able to carry on a conversation. R5 refused to answer any questions related to R4 and the breast grabbing incident. R5 repeatedly said he did not remember anything. R5 said a staff member talked to him about keeping his hands to his self but refused to give any details why. R5 demanded this surveyor stop asking any more question about the incident but was willing to hold a coherent conversation related to other topics. On 5/1/24 at 9:40 AM, R5 was seated in a wheelchair at the front receptionist desk. R5 easily recalled speaking together the day before. R5 was able to reach out and touch this surveyor's lanyard and clip board with his hands. Again, R5 refused to answer any questions related to the weekend incident with R4. On 4/30/24 at 1:31 PM, V12 (Licensed Practical Nurse) stated she was notified by R4 and her daughter that R5 had grabbed her breast (on 4/27). R4 said it was outside on the front patio and just a few minutes ago. V12 said she contacted V1 (Administrator) right away and told her what was reported. V12 said R4 was not upset and went back outside to visit with family. V12 said R5 is slightly confused a times and will tap her arm frequently during medication administration. V12 said R5 has made sexual comments in the past to her, but never grabbed at her. V12 said R5 can not move his motorized wheelchair by himself and has no way to get close to other residents. On 5/1/24 at 9:27 AM, V16 (CNA-Certified Nurse Aide) stated she wheeled R5 outside to the front patio the day of the incident. V16 said R5 can not reach the wheelchair controls at the back of the wheelchair and always needs help from staff to move it. V16 said R5 is alert and knows what is going on around him. V16 said she left R5 outside and away from any other residents. V16 said she heard about the incident the next day from R4. R4 was embarrassed telling her about it but otherwise her normal self. On 5/1/24 at 9:57 AM, V15 (CNA) stated R5's cognition can vary but he can express his needs and recall things. V17 said R5 has made sexually inappropriate comments to her in the past and can get grabby during care but is easily redirected. On 4/30/24 at 2:11 PM, V1 (Administrator) stated she was notified on 4/27/24 by V12 (LPN) that R5 had touched R4 in a sexual manner. V1 said she spoke to R4 and was told R5 grabbed R4's breast during a normal conversation. V1 said R4 demonstrated to her how it happened and that R4 was able to wheel backward to stop it. R4 said she yelled at R5 to never touch her again. V1 said the definition of sexual abuse is any unwanted touching between two individuals. On 5/1/24 at 9:53 AM, V2 (Director of Nurses) stated R4 is alert and oriented. R5 has intermittent confusion but is alert and can express his needs. V2 said the definition of sexual abuse is any unwanted physical touching. The facility's Abuse Program policy last revision dated 3/17 states under the purpose section: To ensure on-going safety of resident. The definition section states: 3. Sexual abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault. 10. Resident to resident abuse is the willful inflection of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish by one resident towards another.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36186 Based on interview and record review the facility failed to report an allegation of abuse. This applies to one of three residents (R1) reviewed for abuse in the sample of 8. The findings include: The facility face sheet for R1 shows diagnoses to include hypoxic ischemic encephalopathy (type of brain damage caused by a lack of oxygen to the brain), major depression disorder with psychotic features, anxiety, dementia and cardiomyopathy. The brief interview for mental status (BIMS) dated 2/19/24 shows R1 cognitively intact. R1's facility assessment shows her to be able to walk independently. On 4/26/24 at 11:43 AM, V2 Director of Nursing said R1 was taken to the hospital on 4/24/24 after she eloped from the facility and became aggressive with the staff. V2 said the facility was notified from the hospital R1 was sent to, that R1 was being sent to another hospital for inpatient care. V2 said she assumed it was for psychiatric care. V2 said the next morning they were contacted by a forensic nurse at that hospital saying R1 was claiming to have been sexually abused. V2 said records were faxed to them and the records showed the abuse happened at the hospital so she did not think an abuse investigation needed to be completed or reported. On 4/26/24 at 10:30 AM, V1 Administrator said the facility was notifed on 4/25/24 that R1 was alleging she had been sexually abused. V1 said the records from the hospital R1 was at showed the abuse happened at the hospital so an abuse investigation was not completed or reported. V1 said R1 makes sexual abuse allegations often as she is hallucinating about past abuse. V1 said this was a behavior of R1. V1 said she has two hours to report abuse and to start an investigation, it's important to protect the residents. On 4/25/24 at 1:54 PM, V6 Forensic Nurse at hospital said she spoke with the facility staff at 4:50 AM on 4/25/24 and reported to them that R1 was refusing a rape kit, but did make allegations that another resident has sexually abused her in her room. V6 said R1 named R2 as the man who raped her. The hospital report that V6 faxed to the facility shows R1 refused the rape kit but did accuse R2 of raping her. The note shows R1 at first stated she woke up to him raping her, but that it didn't happen at the facility but at the hospital. The note goes on to show R1 saying it was R2 that raped her. The note also shows she said it was the resident that she sits with at meals at the facility. The facility policy with a revision date of 3/17 for abuse investigation/reporting/response shows 9. Allegations of abuse or neglect regardless of source or subjectivity belief concerning the truthfulness of the allegation shall be reported to the administator and the appropirate agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 36186 Based on interview and record review the facility failed to investigate an allegation of abuse. This applies to one of three residents (R1) reviewed for abuse in the sample of 8. The findings include: The facility face sheet for R1 shows diagnoses to include hypoxic ischemic encephalopathy (type of brain damage caused by a lack of oxygen to the brain), major depression disorder with psychotic features, anxiety, dementia and cardiomyopathy. The brief interview for mental status (BIMS) dated 2/19/24 shows R1 cognitively intact. R1's facility assessment shows her to be able to walk independently. On 4/26/24 at 11:43 AM, V2 Director of Nursing said R1 was taken to the hospital on 4/24/24 after she eloped from the facility and became aggressive with the staff. V2 said the facility was notified from the hospital R1 was sent to, that R1 was being sent to another hospital for inpatient care. V2 said she assumed it was for psychiatric care. V2 said the next morning they were contacted by a forensic nurse at this hospital saying R1 was claiming to have been sexually abused. V2 said records were faxed to them and the records showed the abuse happened at the hospital so she did not think an abuse investigation needed to be completed. On 4/26/24 at 10:30 AM, V1 Administrator said the facility was notifed on 4/25/24 that R1 was alleging she had been sexually abused. V1 said the records from the hospital R1 was at showed the abuse happened at the hospital so an abuse investigation was not completed or reported. V1 said R1 makes sexual abuse allegations often as she is hallucinating about past abuse. V1 said this was a behavior of R1. V1 said she has two hours to report abuse and to start an investigation, it's important to protect the residents. On 4/25/24 at 1:54 PM, V6 Forensic Nurse at hospital said she spoke with the facility staff at 4:50 AM on 4/25/24 and reported to them that R1 was refusing a rape kit, but did make allegations that another resident has sexually abused her in her room. V6 said R1 named R2 as the man who raped her. The hospital report that V6 faxed to the facility shows R1 refused the rape kit but did accuse R2 of raping her. The note shows R1 at first stated she woke up to him raping her, but that it didn't happen at the facility but at the hospital. The note goes on to show R1 saying it was R2 that raped her. The note also shows she said it was the resident that she sits with at meals at the facility. The facility policy with a revision date of 3/17 for abuse investigation/reporting/response shows the purpose of the policy is to ensure that a through investigation is completed .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on interview and record review the facility failed to supervise a resident with exit-seeking behaviors to prevent her from eloping from the building unsupervised. This failure resulted in R1 eloping from the facility and being able to reach a heavily traveled highway. This applies to one of three residents (R1) reviewed for the safety in the sample of 8. The Immediate Jeopardy began on 4/24/24 when R1 was able to elope from the facility. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 4/30/24 at 12:50 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 5/1/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: The facility face sheet for R1 shows diagnoses to include hypoxic ischemic encephalopathy (type of brain damage caused by a lack of oxygen to the brain), major depression disorder with psychotic features, anxiety, dementia and cardiomyopathy. The brief interview for mental status (BIMS) dated 2/19/24 shows R1 be cognitively intact. R1's facility assessment shows her to be able to walk independently. The elopement risk assessment dated [DATE] shows R1 to be at high risk for elopement. The facility incident report dated 4/24/24 shows R1 was seen by maintenance staff in the back parking lot, wandering. R1 became physically aggressive with the staff by picking up a block of wood and threatening to hit staff. R1 had cut off her code alert bracelet from her ankle. On 4/26/24 at 8:20 AM, V1 Administrator said R1 left the building on 4/24/24 out the front door, she had cut off her wander guard alert bracelet. R1 was seen on video going over the fence and walking away. On 4/26/24 at 10:00 AM, V3 Certified Nursing Assistant (CNA) said she was outside at the back of the building around 12:30 PM - 1:00 PM on her break, when she saw R1 walking alone in the back parking lot. V3 said she called to the staff inside the building with her cell phone, alerting them that R1 was outside alone. V3 attempted to redirect R1 from leaving the property but R1 would not listen to her. On 4/26/24 at 11:10 AM, V4 Maintenance said he was outside having his break and saw R1 walking alone outside. V4 said he approached R1, trying to get her to stop walking. V4 said R1 was in the back parking lot. On 4/26/24 at 11:43 AM, V2 Director of Nursing said by the time she got to the back parking lot, there were several staff trying to redirect R1. V2 said she was told R1 had picked up a stick from the ground and attempted to hit the staff. V2 said she phoned 911 for help with the situation. V2 said R1 had removed her code alert bracelet and she was not sure how this happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/26/24 at 10:45 AM, V5 Occupational Therapy Assistant said she was at the entrance to the facility when she heard R1 was outside. V5 said she ran to the back of the building and saw R1 with two CNA's trying to redirect R1 back into the building. V5 said R1 was walking to the road and picked up a piece of wood she found and attempted to hit the staff. R1 was yelling and swearing at the staff. V5 said a car drove by on the road and V5 flagged them down asking them to stop and put on their flashers to alert other people passing by to slow down. When R1 saw the flashers, she turned and walked away from the road back towards the facility. On 4/26/24 at 10:30 AM, V1 said the video of R1 going over the fence showed she had fallen on the other side. The video showed R1 used the building to help lift herself over the fence. V1 said it was about two minutes between the time stamp on the video and when the first CNA called the building to alert us R1 was outside alone. V1 said when she got outside, R1 was walking up the hill towards the road, yelling at the staff. R1 picked up a stick off the ground and attempted to hit the staff. V1 said a car drove by and put on their flashers and this made R1 turn around from the road and go back to the parking lot. V1 said 911 was called and arrived to help with the situation. V1 said R1 cut off her wander guard somehow. On 4/30/24 at 9:10 AM, V7 RN said she was working with R1 on the day she eloped out the front door on 4/24/24. That morning R1 met her at the back door, R1 was knocking on the kitchen door. R1 was hallucinating and saying she needed to leave to get to the hospital because her kids were sick. V7 said R1 has been hallucinating for a while now. R1thinks her family has been killed or are sick and she needs to help them. V7 said she walked with R1 back to her room, and R1 was sitting on the bed talking to the smoke detector she thought were talking to her. R1 said in a whisper, I gotta run out the door, and then put her shoes on. V7 said she told R1 she was fine and she needed to rest. V7 said R1 laid down on the bed and went to sleep. V7 said R1 has not been sleeping other than a few hours at a time for the last 4-5 days prior to being sent out. A facility alerts listing report dated 4/21/24 shows R1 was trying to climb the fence surrounding the facility. (Three days prior to when R1 eloped at the same fence) On 4/30/24 at 9:38 AM, V1 said on 4/21/24, R1 did make it to the fence and was shaking the fence. She was hallucinating and thought she had to get to the hospital to see her kids. On 4/30/24 at 10:20 AM, V8 CNA said she was in another resident's room on 4/21/24 when she saw R1 outside the facility at the front gate. R1 had one leg up on the fence. V8 said she ran outside right away and it was then that she saw the restorative Aide was with R1 trying to talk her down and to come back in the building. On 4/30/24 at 10:30 AM, V9 Restorative CNA said she saw R1 walk out the front doors on 4/21/24. The alarm sounded that someone with a wander guard had gone outside the doors. R1 walked down to the fence and had both feet on the bottom rung of the fence. V9 said she was able to redirect R1 from the fence and bring her back inside. On 5/2/24 at 2:10 PM, V23 Physician Assistant said, When R1 is hallucinating and having exit seeking behaviors she would expect to staff to have very close observation on the resident to keep her safe from harming herself or eloping. Nursing progress notes dated 4/11/24 to 4/24/24 shows: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/11/24 at 5:36 AM, R1 saying her mother and son are dead and her daughter is dying, and she needs to get out of the facility. R1 walked to the front doors. On 4/17/24 at 8:20 AM, R1 saying her mother was dead and she had to get out of the building. She walked to the front lobby and sat down. R1 was saying her mother was dead, she had been raped here, her son had been raped, didn't understand why she could not leave the building. On 4/17/24 2:34 PM was eating lunch in her room and the intercom told her she was getting out of here soon. Hearing voices and wants to leave. On 4/20/24 8:15 PM upset and wandering in the halls saying she needed to get out of here, wants to leave. On 4/21/24 at 2:30 PM R1 trying to climb the fence/gate, trying to open locks. Said her children were dead and today is the funeral. On 4/22/24 5:48 AM, attempted to open the dining room doors saying she had to get out of here. The kitchen staff reported that she attempted to go out the doors again. 4/23/24at 3:24 PM staff unable to redirect as she was saying she needed to get out of the building. On 4/23/24 11:51 PM, yelling and walking fast, saying she needed to get out of here. Walked to the lobby, threw a wet floor sign, punching the glass, picked up a lamp and slammed onto the table. Police were notified. On 4/24/24 6:05 AM, R1 met nurse at the back door asking staff to open the kitchen door her children were dead, and she needs to get to the hospital. On 4/24/24 9:33 AM, R1 went to the dining room as the intercom told her it was time for breakfast, kitchen staff sent her back to her room and given a snack. Sitting on bed, looking at the smoke detector and overheard whispering she had to run out the back door. R1 then put on her shoes and asked the nurse to leave her alone in her room and to turn off the lights. On 4/24/24 at 12:50PM, R1 found by staff in the back parking lot. R1 became physically aggressive with the staff, attempting to hit staff with a piece of wood. Resident said she was leaving. 911 was called. R1's care plan dated 4/15/2020 shows the resident is at risk for elopement risk/wanderer due to tendency to wander into other resident rooms and take items as her own. She has poor cognition and unaware of situations at hand and is risk for elopement due to cognitive deficits. Resident exhibits exit seeking behaviors, thinking she has somewhere to go or that someone is coming to get her. R1's care plan dated 3/25/24 shows R1 is/has potential to be verbally aggressive with yelling out and cursing due to auditory hallucinations . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility policy with a revision date of 3/17 for safety and supervision shows 7. resident supervision is a core component of the systems approach to safety. 8. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the enviroment or if there is a change in the residents condition. The Immediate Jeopardy that began on 4/24/24 was removed and the deficient practice corrected on 5/1/24 when the facility took the following actions to remove the Immediacy and correct the noncompliance. Immediate action to ensure residents' elopement interventions are effective and appropriate to prevent elopement incidents: 1. Social Services will review all care plans of residents at high risk for elopement by 5/7/24. 2. IDT will ensure elopement interventions are implemented following findings of high-risk residents and report to MDS Coordinator starting 4/30/2024. MDS Coordinator will complete audits weekly starting 4/30/2024 x 2 weeks then monthly x 2 months then quarterly x one year (concluding November 2025). Audits will be reported to QAPI monthly starting 5/1/2024 and then quarterly until 11/25/2025. 3. Any residents that are actively exit seeking, will be placed on line of sight supervision while in courtyard, Code alert checks will be increased to q 4 hours and Code alert will be double banded starting 5/1/2024. 4. BeSpoke Hotline will be utilized with new onset of hallucinations. 5. Medical Director will be contacted for support and/or any orders to assist in new onset of hallucinations. 6. Upon R1 return she will be placed on line of sight supervision while in courtyard, Code alert check q 4 hours, and Code alert bracelet will be double banded. Procedures to identify residents at risk for elopement: 7. Upon admission, admitting nurse will complete Elopement Risk Assessments. Social Services or designee will now complete monthly reassessments for high risk residents starting 5/1/2024 and continue Elopement Risk Assessments on all other residents quarterly. Procedures to increase visual monitoring of courtyard: 8. Maintenance staff to place cameras in front courtyard by 5/1/2024 . A monitor will be placed in the front office to have visuals of courtyard by 5/3/2024. 9. Maintenance will immediately complete daily checks x 2 weeks starting 5/1/2024 then weekly starting 5/16/2024 on all door alarms/maglocks, and Code Alert wandering systems. 10. Front outside door to courtyard will be locked at night by nursing staff or designee and unlocked in the morning by maintenance staff or designee starting 4/30/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Procedures in place to prevent elopement for residents with prior elopements: 11. Administrator will audit Social Services immediate care plan review to ensure that Elopement Reassessments are complete on high risk elopement residents by 5/7/2024. 12. Administrator will audit Social Service or designee monthly Elopement Risk Assessments on high risk residents once a month x 6 months starting 5/2024 and ending 10/2024 and results will be reported to QAPI x6 months ending 10/2024. 13. When resident is determined to be at high risk for elopement and has attempted a prior elopement at this facility, resident will be placed on line of sight supervision while in courtyard by nursing administration and/or Administrator. 14. Safety Coordinator or designee will place a Code Alert bracelet on residents that are not high risk with exit seeking behaviors followed by 15 minute checks for a minimum of 72 hours until IDT evaluates. 15. Following an elopement, all exit door codes will be changed by Safety Director or designee. 16. All new hires complete Elopement Training upon hire by Safety Director and all current staff currently complete Elopement Training annually via Company) Training. However due to incident, all staff will now be required to complete immediate and quarterly training on Preventing and Responding to Elopement x one year via (Company) Training. Immediate training will be completed by 5/7/24. 17. Safety Coordinator or designee will make all staff aware of high-risk residents for elopement on PCC communications on 5/1/2024. Safety Coordinator or designee will now place a note at time clock for staff notifying them of any changes to Residents at High Risk for Elopement and to check PCC communications. 18. IT will do weekly maintenance on cameras to ensure they are working properly starting 5/1/2024.