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	07/23/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39543 Based on interview and record review the facility failed to ensure orders were in place for a resident with non-pressure skin injuries and failed to ensure a resident's central venous catheter dressing was changed weekly. This applies to 2 of 3 residents reviewed for nursing care in the sample 4. The findings include: 1. R1's 6/6/24 Progress Note from 5:00 PM, showed he returned from his wound care appointment with a PICC line. (Peripherally Inserted Central Catheter, a type of Intravenous (IV) catheter which extends to the large veins in the chest.) On 7/23/24 at 1:30 PM, V1 Administrator stated a resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) should include all the resident's orders and treatments. R1's June 2024 MAR and TAR showed no PICC line dressing order being in place; therefore, no PICC line treatments were documented as being done. R1's July 2024 TAR showed, Change PICC line dressing Weekly and PRN (as needed) every day shift every 7 days for infection control. The TAR showed this order was started on 7/9/24 (over a month after the PICC was inserted). R1's 6/27/24 Progress Notes from 12:26 PM, showed the PICC line dressing was changed. On 7/23/24 at 2:00 PM, V2 Director of Nursing stated she could not find any other documented PICC line dressing changes for R1 before 7/9/24, except for the 6/27/24 dressing change documented in R1's progress notes. V2 said she could not locate any PICC line dressing change orders before 7/9/24. On 7/9/24 at 11:03 AM, V3 Wound Care Nurse stated the purpose of weekly PICC line dressing changes is to allow close inspection of the insertion site and to prevent infection of the site. V3 said R1's nurse on 6/6/24 should have entered the orders for the PICC line dressing change or request clarification if there were no orders. The facility's Central Venous Catheter Dressing Change policy/procedure (revision 2008) showed the dressing should be change at least weekly. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R2's 6/21/24 Progress Note from 2:27 PM, showed R2 returned to the facility from the hospital, and he was placed into hospice care. R2's Skin Evaluation note from 6/23/24 at 4:29 AM, showed he had a surgical wound to his right abdomen. R2's 6/26/24 Skin/Wound Note from 6:59 PM, showed he had a skin tear to the left elbow measuring 3.0 centimeters by 4.0 centimeters with redness surrounding it. The note also showed he had drainage from a biopsy site in his right upper abdomen and it was covered with a dry dressing. On 7/23/24 at 1:30 PM, V1 Administrator stated a residents Medication Administration Record (MAR), and Treatment Administration Record (TAR) should include all the resident's orders and treatments. R2's June 2024 MAR and TAR showed no orders for R2's left elbow or abdominal biopsy site. R2's July 2024 TAR showed the first order to treat R2's abdomen was entered on 7/4/24 and was entered as his left abdomen. This treatment was not documented as being done, was discontinued, then on 7/5/24 an order to treat the right upper abdomen was entered. The order showed, Cleanse RUQ (right upper quadrant) with NS (normal saline) pat dry apply [calcium alginate] and dry dressing EOD (every other day) and PRN (as needed). The TAR showed the first documented treatment was on 7/5/24 (9 days after wounds were identified). On 7/23/24 at 11:03 AM, V3 Wound Care Nurse stated, at the time the skin tear was identified, the facility did not have standing orders for skin tears. V3 stated when wounds are identified the floor nurses should reach out to her or call the physician for orders. V3 said if orders are not obtained and/or the orders are not entered into the computerized charting, the floor nurses do not know what treatments each resident requires. V3 said the purpose of treating wounds is to promote wound healing and to prevent infection. V3 said R2's RUQ was a biopsy site and progressively worsened with swelling. V3 said there should have been orders in place for R2's RUQ wound and his elbow skin tear once they were identified. On 7/23/24 at 1:30 PM the facility's wound care policy was requested. The facility provided a Pressure Ulcer Prevention Program policy. The facility's Pressure Ulcer Prevention Program policy (revision 6/2014) showed the Wound Care Coordinator: Role and Responsibility .Confers with the resident's attending physician regarding treatment recommendations. Documents and transcribes all new physician orders received .