

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER Winning Wheels		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35119 Based on observation, interview, and record review the facility failed to utilize a glucose monitoring sensor per physician orders for 1 of 3 residents (R1) reviewed for physician orders in the sample of 4. The findings include: On 1/7/25 at 10:12 AM, R1 was in bed watching TV. R1 said she was upset with V7 (Registered Nurse-RN) because she placed her glucose monitoring sensor wrong and now she had to be poked in the finger to check her blood sugar. R1 said this happened over the weekend. R1 said V7 bent the needle and so it had to be removed. R1 said the nurses told her a new one couldn't be used since the insurance wouldn't pay for it. R1 said insurance only pays for 2 per month and now she has to wait 14 days. On 1/7/25 at 10:30 AM, V5 (Licensed Practical Nurse-LPN) said she was told in report that V7 tried to insert the glucose sensor and bent the needle so it wasn't working and had to be removed. V5 said they have to wait for 2 weeks since insurance only covers 2 per month. V5 said she was not sure if V2 (Director of Nursing-DON) was notified but she was going to tell her today. On 1/7/25 at 1:08 PM, V2 said she had just applied a new sensor on R1. V2 said they had the second sensor in the box for the month and just put that one on. V2 said the facility will pay for a new one in 14 days when it is due. V2 said she had not been made aware of the situation. R1's Physician Orders dated 11/5/24 shows Change (glucose monitoring sensor) every 14 days per manufacturer's instructions. Apply to back of arms only. These same orders shows accucheck in AM and HS (bedtime) two times a day related to type 2 diabetes. R1's Medication Administration Record for December 2024 shows R1's (glucose monitoring sensor) was to be placed on 12/31/24 (7 days prior) and was charted as HOLD. The facility's Medication Administration Policy dated 12/2014 shows The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications to meet the needs of each resident.		

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35119 Based on observation, interview, and record review the facility failed to ensure residents received assistance with activities of daily living for 2 of 4 residents (R1, R2) reviewed for activities of daily living (ADL) in the sample of 4. The findings include: 1. On 1/7/25 at 10:12 AM, R1 was in bed watching TV. R1 said staff have to assist her up to her reclining chair since her electric wheelchair is broke. R1 said she can not propel herself in the reclining chair and staff don't like to deal with the chair. R1 said she has a pendant call light to use when she is not in her room for staff to come help her get back to her room. On 1/7/25 at 11:48 AM, R1 was up in her reclining wheelchair in the dining room. R1 did not have her pendant call light on. R1 said she didn't have it on today, and staff usually don't put it on unless she asks for it. R1 said the other day at dinner time, she didn't have her pendant on and staff left her in the dining room. R1 stated they just left me down here! I had to holler out for help! The kitchen staff heard me and went and got someone but it was a long time. R2 said it was V6 (Certified Nursing Assistant-CNA) and V8 (Agency CNA) that left her in the dining room. On 1/7/25 at 12:15 PM, V6 said she did work that day but was not assigned to R1. V6 said V8 and another Agency CNA were assigned to R1. V6 said R1 is supposed to have her pendant on when she is not in the room. V6 said R1 had complained to her that the staff wouldn't help her and told her they didn't have time for her. V6 said she did not see R1 in the dining room, she was helping residents on her hallway. On 1/7/25 at 1:08 PM, V2 (Director of Nursing-DON) said R1 has a pendant that she wears, it's a portable call light since she is unable to move herself in the reclining wheelchair. V2 said R1 should have it when she is not in her room. On 1/7/25 at 12:14 PM, a message was left for V8 (Agency CNA) with no return call. R1's Facesheet shows R1 has a diagnoses of cerebral palsy, chronic respiratory failure, morbid obesity, stiff-man syndrome, heart failure, type 2 diabetes, muscle wasting and atrophy, and chronic fatigue. 2. On 1/7/25 at 9:50 AM, R2 was up in his wheelchair in his room. R2 had a breath activated call light near his mouth. R2 said he had already had breakfast. R2 said he has a hard time getting his teeth brushed in the morning. R2 said the staff will get him changed and up to his chair and then leave. R2 said his teeth had not been brushed today. R2 said the CNA got him up and then just walked out before he could even say anything. R2 said it wasn't just today, it happens all the time and he is sick of it. R2 said he likes to get his teeth brushed before he goes down to breakfast. R2 said he has told the nurses but was not sure if the message got to V2 (DON). R2 said he is afraid of getting tooth decay if he doesn't get his teeth brushed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 10:20 AM, V3 (CNA) said R2 is alert and able to voice what he needs 100%. V3 said in the morning, R2 gets a bed bath, dressed, up to his chair, gets his teeth brushed right away before going to breakfast. V3 said there was an emergency and she did not get to brush R2's teeth yet today. On 1/7/25 at 10:30 AM, V5 (Licensed Practical Nurse-LPN) said R2 has complained to her about not getting his teeth brushed last week and again this morning. V5 said she brushed R2's teeth for him last week. On 1/7/25 at 1:08 PM, V2 (DON) said staff should honor residents preferences for teeth brushing and try to accommodate as able. R2's Care Plan shows R2 is dependent on staff due to limited movement- oral hygiene- total assist of 1 twice daily. R2 is unable to perform own oral hygiene due to left hemiparesis- perform mouth care as per ADL personal hygiene. The facility's undated Daily Personal Care & Privacy Policy shows Every resident shall be given daily personal attention. This personal care shall include, but not be limited to, perineal cleanliness, skin care, nails, hair, and oral hygiene.		