

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 12/21/2025
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to protect 6 residents (R1,R2,R3,R4,R5,R6) from misappropriation of medications. This applies to 6 of 6 residents reviewed for misappropriation in the sample of 14. The findings include:The facility's investigation dated 10/8/25 showed, Between 9/29-9/30 from 11:55PM until about 4:00AM, (V5) is seen in the medication room sleeping. Around 4:00AM, (V5) is seen on (unit) with her medication cart. She can be seen in the medication drawer dispensing medications from the cards into her bare hands and then putting them into a cup. During this time, (V5) is not seen at any point looking at the EMAR (Electronic Medication Administration Record) .At approximately 5:07AM after pulling medications she is seen putting something in her mouth. Approximately 5:14AM she is seen going through the narcotic box and pulling medications from the cards into her bare hands. It then appears that she puts something in her left front pocket of her hoodie that she is wearing. At 6:00AM, she is seen going through the narcotic box and (Narcotic Reconciliation System) and checking out medications she has removed.R1's September 2025 physician's orders showed R1 receives Oxycodone 5mg two times a day at 12:00PM and 8:00PM and Pregabalin 50mg three times a day at 5:00AM,12:00PM, and 8:00PM. The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 (Licensed Practical Nurse) removed 1 additional dose of R1's oxycodone 5mg and 1 additional dose of R1's Pregabalin and did not document administration of either medication to R1. R2's September 2025 physician's orders showed R2 receives Oxycodone 5mg every 6 hours as needed.The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 removed 1 additional dose of R2's oxycodone 5mg and did not administer this medication to R2.R3's September 2025 physician's orders showed R3 receives lorazepam 0.5ml (1mg) by mouth every 2 hours as needed and morphine 0.5ml (10mg) by mouth every 2 hours as needed.The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 removed 1 dose of R3's lorazepam 0.5ml and morphine 0.5ml and did not document administration of either medication to R3.R4's September 2025 physician's orders showed R4 receives diazepam 5mg two times a day at 5:00AM and 4:00PM and Norco 5/325mg at 5:00AM, 12:00PM, and 8:00PM.The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 removed one additional dose of R4's diazepam 5mg and one additional dose of R4's Norco 5/325mg and did not document administration of either medication to R4.R5's September 2025 physician's orders showed R5 receives Norco 5/325mg every 6 hours as needed.The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 removed two doses of R5's Norco 5/325 and did not document administration of either dose to R5.R6's September 2025 physician's orders showed R6 receives Pregabalin 15ml (300mg) two times a day at 5:00AM and 4:00PM.The facility's narcotic reconciliation record dated 10/2/25 showed on 9/30/25 V5 removed two doses of R6's Pregabalin 20mg/ml solution and did not document administration of either dose to R6.Surveyor corroborated the above investigation through observation of the facility's video camera footage of the facility provided by V1 (Administrator) on 12/20/25.On 12/20/25 at 1:01PM, V4 (Licensed Practical Nurse) stated, I supposed the only way to prove that we gave a medication is to sign it out in (Narcotic Reconciliation System) and document it in the resident's MAR. If both of those things aren't done, then you cannot assume a medication was given. Furthermore, it is possible to just sign a medication out of (Narcotic Reconciliation System) and never give it to the resident. You would catch that on their MAR and it would alert us that they missed a dose. On 12/20/25 at 2:10PM, V6 (Registered Nurse) stated, I followed (V5) after her shift on 9/30 and didn't see anything unusual. I also didn't work with her overnight though and I guess that was a different story. All of the counts were accurate, so I didn't investigate anything further because we don't look at when medications were pulled, just the count to ensure it matches. (R1) complained of pain and he didn't remember getting his pain medicine from (V5) but it was signed off on the MAR (medication administration record) so all I could offer him was Tylenol & Ibuprofen which he accepted. I did report to the DON (Director of Nursing) immediately that he said he did not get his morning medicine and that's when they started looking at the (Narcotic Reconciliation System) records and noticed discrepancies. On 12/20/25 at 2:50PM, V1 stated, It was so obvious that (V5) was diverting medications. She had to have ingested some of them on her shift with the number of times she was falling asleep, dropping items, and spilling things. She looked at the camera almost every time she took a medication from a medication card and whenever she put something in her mouth. We have cameras showing her from every angle taking those medications. At one point she was also vaping while she was down the resident hallways. I reported it to (local police department) and they initiated an investigation. They are opening a larger investigation into</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, failed to report alleged violations of misappropriation for 6 residents (R1, R2, R3, R4, R5, R6) to IDPH (Illinois Department of Public Health) within 24 hours, failed to implement policies and procedures for reporting the possible crime to law enforcement. These failures apply to 6 of 6 residents reviewed for misappropriation in the sample of 14. The findings include: The facility's investigation dated 10/8/25 showed, Between 9/29 to 9/30 from 11:55PM until about 4:00AM, (V5-Licensed Practical Nurse-LPN) is seen in the medication room sleeping. Around 4:00AM, (V5) is seen on (unit) with her medication cart. She can be seen in the medication drawer dispensing medications from the cards into her bare hands and then putting them into a cup. During this time, (V5) is not seen at any point looking at the EMAR (Electronic Medication Administration Record) .At approximately 5:07AM after pulling medications she is seen putting something in her mouth. Approximately 5:14AM she is seen going through the narcotic box and pulling medications from the cards into her bare hands. It then appears that she puts something in her left front pocket of her hoodie that she is wearing. At 6:00AM, she is seen going through the narcotic box and (Narcotic Reconciliation System) and checking out medications she has removed. On 12/20/25 at 12:36PM, V3 (LPN) stated, (V5) had some concerning behaviors when I worked with her on 9/29/25. She's not a very good nurse in my opinion. She appeared to pass medications during med pass time but then would go right to the medication room and was sleeping very sound. She did not wake up to any stimulation. I know they found some medication discrepancies after she left, but I didn't know that or observe that during the shift. I reported my concerns about (V5) to the previous DON (Director of Nursing) around 5am or so on 9/30 as soon as she came to the facility. I was concerned that (V5) was sleeping so sound but I couldn't prove that she was under the influence of anything so I'm not sure what else I could have done differently. If I would have known what I know now about her I would have walked her out of the facility myself and called the DON right away. On 12/21/25 at 8:35AM, V2 (Director of Nursing) stated, V3 made the previous DON aware of her concerns with (V5) when she got to facility that morning (9/30). I would expect the nurses to notify me immediately of any concerns with any staff, not just agency staff. If we would have received a call from (V3) we would have had (V5) leave the facility immediately and another nurse would have worked the rest of the shift. We could have possibly prevented some of this diversion of medications had we been notified of (V5's) behavior sooner. On 12/21/25 at 9:39AM, V1 (Administrator) stated, We didn't really realize the medications had been taken right away. On 9/30, (V6-Registered Nurse) reported to the DON that (R1) was saying he didn't get his medications that morning. That's when we first started looking into the medications. Misappropriation is part of abuse so that needs to be reported within 2 hours I believe. Misappropriation was reported to IDPH on 10/8/25 and to local police on 10/8/25. (9 days after investigation was initiated by the facility). The reason we didn't report anything right away is because we were still looking into everything so initially there wasn't anything missing but once we noticed that there were medications that had been taken, we reported it. The staff usually report unusual behavior to us, but I believe (V3) did not report to us right away because she was busy with her own stuff. I can only assume that she was just busy and focusing on her own residents. At the time (V5) was falling asleep, she was in the medication room, so she wasn't taking care of residents when (V3) started noticing everything. (V3) did go check on the residents to make sure they were ok so at least they ended up getting the cares they needed. We did not get a copy of the police report because it is an open investigation, so the report is not ready yet and we have all the evidence at this time to prove that (V5) stole the medications and we substantiated misappropriation. The facility's policy titled, Abuse Program: Investigation/Reporting/Response dated 3/17 showed, Employees are required to immediately notify the Administrator and the Director of Nurses and staff that is on duty of any complaints of, observation of, or suspicion of resident abuse, mistreatment or neglect .Continue the facility investigation as needed, to be concluded within 48-72 hours, if possible.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to ensure medications were administered per physician's orders for 4 of 6 residents (R4, R5, R6, R14) reviewed for pharmacy services in the sample of 14. The findings include: The facility's incident report dated 10/8/25 showed, On 9/30/25 at 7AM, V1 (Administrator) received a phone call from Director of Nursing, stating that it was reported to her that the agency night nurse (V5-Licensed Practical Nurse) had slept most of the night. Concerns were brought up that (V5) did not complete her wound treatments, failed to sign out medications in EMAR (Electronic Medication Administration Record) .2 residents were identified to have not received their scheduled medications .R4's September 2025 MAR (Medication Administration Record) showed R4 receives Amantadine 100mg, fluoxetine 10mg, lactulose 15ml, omeprazole 20mg, baclofen 10mg, buspirone 5mg, diazepam 5mg, levetiracetam 1000mg, Norco 5/325mg at 5:00AM. No documentation was present showing R4 received his 5:00AM medications from V5 on 9/30/25.R5's September 2025 MAR showed R5 receives fluticasone 50mcg spray, omeprazole 40mg, aspirin 81mg, finasteride 5mg, furosemide 40mg, lidocaine 4% patch, trelegy inhalation 100-62.5-25mcg/act, venlafaxine 225mg, doxycycline 100mg, Eliquis 5mg, metformin 1000mg, metoprolol 12.5mg, oxybutynin 5mg, gabapentin 900mg, and baclofen 20mg at 5:00AM. No documentation was present showing R5 received his 5:00AM medications from V5 on 9/30/25.R6's September 2025 MAR showed R6 receives Escitalopram 25mg, scopolamine 1.5mg patch, tizanidine 4mg, Colace 100mg, famotidine suspension 20mg, levetiracetam 2500mg, Lyrica 300mg, and trihexyphenidyl 2mg at 5:00AM. No documentation was present showing R6 received her 5:00AM medications from V5 on 9/30/25.R14's September 2025 MAR showed R14 receives aspirin 81mg, Colace 100mg, amantadine 100mg, propranolol 20mg, and baclofen 15mg at 4:00AM. No documentation was present showing R14 received her 4:00AM medications from V5 on 9/30/25.On 12/21/25 at 12:27PM, V2 (Director of Nursing) stated, If there is nothing documented in the residents MAR we would have to go through the medication cards to see if they were popped or not and that was not done. It would have shown it was missed or given because our medication cards are dated. We would have been able to see if they were given or not and depending on time if they could receive it or not. I can't recall what was given and what wasn't but that's the process we would take. The residents that are not able minded we just monitored for pain after this incident. The charting system switches when the shift switches over so the next round of meds would have displayed on the screen so it may not have triggered for the next nurse to see that medications weren't given. Surveyor was unable to view the medication cards from September 2025 for R4, R5, R6, R14.The facility's policy titled, Medication Administration dated 2/25 showed, 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 .15. After the resident has taken the medication, immediately sign out on MAR. Never delay this action.</p>		