Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010094	A. BUILDING: ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNING WHEELS	701 EAST 3RD STREET PROPHETSTOWN, IL 61277

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S 000	Initial Comments Complaint Survey #2413270/IL172379 Complaint Survey #2413414/IL172615	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999		

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the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) 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 each resident's comprehensive resident care 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be

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made by nursing staff and recorded in the resident's medical record.

6) 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 evidenced by:

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 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 2/19/24 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

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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.

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

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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

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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

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S9999	Continued From page 6 shows: 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	S9999		

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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 ...

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.

(B)