		AND HUMAN SERVICES			FORM	: 01/28/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		145556	B. WING	G	08/0	9/2012
NAME OF F	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COL	)E	
WINNING	G WHEELS			701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 456	The Physician Prob R5's diagnoses to i Left Hemiparesis, T Spasticity, and Seiz On 8/8/12 at 10:25 stated, "The staff sl me know if there is wheelchair. I fix the thoroughtly inspect make sure they are 4. On 8-8-12 at 8:19 main dining room in The left foot pedal of outward from his ch his foot. The paddir and the plastic supp of the pedal were b E8 stated that he has for R22's foot rest of can order the part, may take a while for FINAL OBSERVAT Licensure Violation 300.610a) 300.1210d)5) 300.1220b)3 300.3240a) Section 300.610 Re a) The facility shall procedures, govern	AM, E8 (Maintenance Staff) hould fill out a work order to let a problem with the resident's em as fast as I can. I try to 10 wheelchairs per week to a in good condition. " 5 AM, R22 was leaving the his motorized wheelchair. of the wheelchair was facing hair, not under or supporting ng of the foot rest was frayed ports on the bottom and back roken. On 8-8-12 10:30 AM, ad not received any work order or pedal. E8 stated that he but it has to be approved and ir it to be replaced.	F 4			

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145556	B. WI	NG .		08/0	9/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WINNING	G WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th written, signed and meeting. Section 300.1210 C Nursing and Person d) Pursuant to subscare shall include, a and shall be practic seven-day-a-week 5) A regular program pressure sores, hea breakdown shall be seven-day-a-week enters the facility w develop pressure s clinical condition de sores were unavoic pressure sores sha services to promote and prevent new pr Section 300.1220 S Services b) The DON shall s	cy Committee consisting of at ator, the advisory physician or ry committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a General Requirements for hal Care section (a), general nursing at a minimum, the following sed on a 24-hour,	F9	999	9		

Facility ID: IL6010094

If continuation sheet Page 19 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/28/2013 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145556	B. WI	NG	i	08/0	9/2012
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WINNING WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F9999	each resident base comprehensive ass and goals to be acc and personal care a representing other activities, dietary, a are ordered by the the preparation of t plan shall be in writ modified in keeping indicated by the resis shall be reviewed a Section 300.3240 A a) An owner, licens agent of a facility sh resident. These requirement Based on Observat Review the facility ulcer on R7's right f Stage III and failed R1 and R2 before the failed to provide pre- the pressure ulcer of failed to determine R2 and R19's press provide preventative breakdown.	b-to-date resident care plan for d on the resident's sessment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, nd such other modalities as physician, shall be involved in he resident care plan. The ing and shall be reviewed and with the care needed as ident's condition. The plan t least every three months. Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a s are not met as evidenced by ion, Interview and Record failed to identify a pressure oot prior to it becoming a to identify pressure ulcers for becoming stage II. The facility causative factors for R7, R1, sure ulcers and failed to e measures to prevent skin Ited in R7 developing a stage	F9	99	19		

If continuation sheet Page 20 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/28/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145556	B. WI	NG _		08/09	9/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WINNING	WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 20	F9	999	,		
		8 residents (R7, R1, R19, essure ulcers in a sample of					
	The findings include	e:					
	shows that R7 has	Order Sheet dated 8/2012 diagnoses including traumatic phrenia and Contractures.					
		Pressure Ulcer Scale dated R7 scored a 10. (10 or less=					
	treatment order: cle	d 7/26/12 states, "New eanse arch of right foot. Apply d cover with protective					
	shows that the pres measured 3.5 x 4 x beefy red, 50 % slo amount of serosang	tails Report dated 7/26/12 sure ulcer on R7's right foot 0 cm. It is described as 50% ugh, edges macerated, small guinous (drainage), Stage III. ven regarding the causative ure ulcer.					
	On 8/7/12 at 9:00 A "The foot wound de	M, E3 (Treatment RN) stated, eveloped here. "					
	changed the dressi inner aspect of R7's sized pressure area	M, E3 was observed as she ng on R7's right foot. On the s right foot there was a quarter a. The area was covered with w tissue (slough). No rved.					

If continuation sheet Page 21 of 26

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING			(X3) DATE SU COMPLE	JRVEY
		145556	B. WI	NG _		08/09	9/2012
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET		
WINNING WHEELS					PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	On 8/7/12 at 1:55 F the wound on his rig guess, if I had to be the way the shoe s found the wound ar last week and it has he was still wearing he is so flat footed shoe." R7's Care plan date approaches to reme R7's right foot to pr getting worse or to ulcers from develop The facility ' s Press Program showed, prevention of press Care Protocol: Nurs aides are to notify t the skin while perfo will start a newly ac sheet is turned in to Nursing) for assess The DON or her de to current staging g ulcers. Weekly doc location, stage, size wound bed charact ulcer margins, surro Use proper position techniques to minin and shear forces. "	M, E3 was asked how R7 got ght foot. E3 stated, "If I had to e psychic, I would say it is from its on the foot rest. The CNA hd told me. We got the boot is helped because before that his shoe. It could be because and there is an arch in the ed 8/1/12 does not list any ove or reduce pressure from event the pressure ulcer from prevent additional pressure	F9	999	9		

If continuation sheet Page 22 of 26

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145556	B. WI	NG _		08/09	9/2012
NAME OF PROVIDER OR SU	PPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WINNING WHEELS					701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
PREFIX (EACH DEI	ICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
shows R1 is ulcers. On 8/7/12 at observed ch hand over th pressure wo pressing his abdomen. E stiff and in se stated the C a resident's a assessing th The wound of wound show 8/1/12 and n The wound of the wound a the wound a the wound a the wound b On 8/7/12 at observed lyin back reclinin hand were v R1's hand. I toward the p lifted off the 3rd and 4th f in the skin. around the in area, an inde red circular area not resolved E3 stated sh	The M at risk 2:30 F anging e first l und wa hand a oth of everely NA sta skin an e area locume s the u heasur locume 1.0 cr ed. 2:40 F ag on t g whee ery stif alm of arm re ingers Deep r indenta entation rea. T s on th when e was	PM, E3 (Treatment Nurse) was a wound dressing on R1's left knuckle. E3 stated the as caused by pressure from R1 against his bare skin on his R1's hands and arms were contracted positions. E3 ff are to report any changes in d she will follow up with	F9	999	9		

If continuation sheet Page 23 of 26

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145556	B. WI	NG _		08/09	9/2012
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WINNING	G WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	definitely be helpful stated thoroughly w hand would help re The Physician Orde palm guard with fin- hand. Passive Rar are to be done twic not identify the risk hands and does no prevent pressure to On 8/6/12 at 2:50 F the whereabouts of stated she was not R1. The undated facility Program states dai by CNA during care any findings. 3. On 8/7/12 at 3:1 sitting in a wheelch on the leg and foot R19 was unable to arm or left leg. The padded arm cushio place. R19's foot w with a velcro strap. were pressed firmly rest where it attach edge was noted be skin. R19 stated, " should be there to p the skin on my leg. leg and can't tell if t	ge 23 to alleviate the pressure. E3 yashing the inside of R1's right solve the odor from the hand. er Sheet dated 8/1/12 shows a ger tabs is to be used on R1's nge of Motion to all extremities e a day. R1's care plan does factors for pressure to his t list preventative measures to his hands and fingers. PM, E11 (CNA) was asked for R1's right hand splint. E11 aware of any hand splints for Pressure Ulcer Prevention ly skin inspection of residents as, and to notify the nurse of 5 PM, R19 was observed air with his left leg positioned rest attached to the chair. independently move his left e left hand was lying on a n; a hand splint was not in vas strapped to the foot rest R19's knee and upper leg v into the upper part of the leg es to the chair. A sharp metal tween the leg rest and R19's I think there is a pad that prevent that from digging into I have very poor feeling in my he pad is in place. E7 was asked to check R19's	F9	999			

Facility ID: IL6010094

If continuation sheet Page 24 of 26

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) M	<u>ин</u> т		FORM	01/28/2013 APPROVED 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDI	NG	COMPLE	
		145556	B. WI	NG _		08/09	9/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WINNING	G WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	leg placement. E7 skin indentations w upper calf area. The Care Plan date for skin breakdown Obesity. R19 is de and requires extens The care plan show hand splint to be us does not list interve caused from the leg 4. On 8/7/12 at 9:28 up in his wheelchai feet on his foot rest was observed layin touching the bed su R2 's Nurse 's Not a blister on his right cleanse and apply s until healed.; 5/25/ prep to the blisters foot until healed.; 8 prep to right great t The Monthly Note f " R2 has a potentia related to decrease skin alterations. R2 inner heel and arch putting skin prep or On 8/8/12 at 10:15a Nurse/Registered N blister on the right g applied to the bliste from popping. I do skin sheet assessm	lifted R19's leg and deep red ere noted on his knee and ed 5/9/12 states R19 is at risk due to Left Hemiparesis and pendent of staff for transfers sive assist for bed mobility. vs on 6/13/12 a left resting sed for R19. The care plan entions to alleviate pressure g rest of the wheelchair. 5am R2 was observed sitting r wearing tennis shoes with his rs. On 8/7/12 at 9:38am R2 g in bed with his heels urface. tes showed, " 1/2/12 - R2 has t heel. New treatment to skin prep and daily as needed 12 - New order to apply skin to right inner heel and arch of 8/1/12 - New order: Apply skin to right inner heel and arch of 8/1/12 - New order: Apply skin to right inner heel and arch of 8/1/12 - New order to right of R2 dated 6/12/12 showed, I for alteration in skin integrity ed mobility. R2 has a history of 2 also has a blister to right of right heel that we are n after cleansing. "	F9	9999			

If continuation sheet Page 25 of 26

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145556	B. WI	NG .		08/0	9/2012
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WINNING	G WHEELS				701 EAST 3RD STREET PROPHETSTOWN, IL 61277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	don ' t know what c " R2 ' s Care Plan da Document on all sk appearance and pr weekly. " R2 ' s Ca showed no interver pressure ulcers to I The facility ' s Pres Program showed, loss of dermis pres with a red/pink wou also present as an serum-filled blister. The Physician Orde for R2 showed Diag	of Nursing - DON) about that. I aused the blister to R2 ' s toe. ated 6/21/12 showed, " in alterations, measurements, ogress or lack of progress are Plan dated 6/21/12 ations for the prevention of R2 ' s feet. sure Ulcer Prevention " Stage II: Partial thickness enting as a shallow open ulcer ind bed, without slough. May intact or open/ruptured	F9	999	9		

Facility ID: IL6010094

If continuation sheet Page 26 of 26