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	IL6001150	A. BUILDING: _____ B. WING _____	C 12/24/2024

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APERION CARE BRIDGEPORT	900 EAST CORPORATION BRIDGEPORT, IL 62417

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S 000	Initial Comments Investigation of Facility Reported Incident of 11/27/24/IL182830	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3)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 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	S9999		

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care needs of the resident.
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 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 as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was properly restrained while being transported in the facility van for 2 (R1 and R4) of 4 residents reviewed for accidents in a sample of 4. This failure resulted in R1 sustaining a laceration to her head requiring 14 staples and 8 sutures, a fracture to the second digit of the right foot, left nasal bone fracture with deviation of the septum, and bruising to the lower abdomen and upper thighs.

Findings include:

1. R1's Admission Record documented an admission date of 11/30/20 with diagnoses that included Parkinson's disease, difficulty in walking,

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unsteadiness on feet. R1's Minimum Data Set (MDS) dated 7/10/24 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 was cognitively intact.

On 12/19/24 at 10:25 AM, R1 was sitting in a wheelchair and had bruising noted below both eyes and a pink scar on her forehead disappearing into her hair line. R1 said she was involved in an accident in the facility transport van. R1 said she was buckled in her wheelchair with a belt on her lap. R1 said when the accident occurred R1 was thrown from her wheelchair and landed in the floor of the transportation van.

On 12/19/24 at 2:49 PM, R1 said there was no seatbelt over her shoulder when the accident occurred. R1 said she was only restrained by the lap belt. R1 said when she had been thrown from her wheelchair her foot had gotten tangled in the lap belt causing pain.

On 12/19/24 at 11:13 AM, V3 (Certified Nursing Assistant/CNA) said that on 11/27/24, she had transported R1 to the hospital for an appointment and was on the way to pick up another resident with R1 in the transportation van. V3 said while she was driving, she hydroplaned and thought someone had rearended the transportation van and then hit another vehicle that was stopped in the road. V3 said during the accident R1 had fallen out of her wheelchair into the floor of the transportation van. V3 said she did not know how R1 had fallen out of her wheelchair because R1 was buckled in. V3 said the seatbelts in the new transportation van are hooked to the rear brackets in the floor that hold the rear wheelchair wheels. V3 then demonstrated while sitting in a chair how the seatbelt is passed under the armrests of a wheelchair and buckle around the

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lower abdomen. V3 said the new transportation van did not have any seatbelt that went over the resident's shoulder. V3 said residents have the ability to unbuckle the seat belt but the transportation van has a sensor that tells you if the resident's seatbelt is unbuckled. V3 said the sensor was not on alerting her of R1's seatbelt being unbuckled. V3 said R1 had never unbuckled the seatbelt. V3 said some residents will unbuckle themselves when they arrive at their destination while V3 is getting the wheelchair ramp out but R1 never unbuckled herself. V3 said R1 would never unbuckle herself while the transportation van was moving.

On 12/19/24 at 11:45 AM, V3 returned with V1 (Administrator) and said she was confused earlier and R1 had been wearing a seatbelt that went over R1's shoulder at the time of the accident. V3 said the new transportation van held two wheelchairs and the wheelchair in the middle of the van did not have a seatbelt that went over the resident's shoulder, but the back wheelchair area did have a seatbelt that went over the resident's shoulder. V3 said R1 had been wearing the over the shoulder seat belt when the accident had happened.

On 12/19/24 at 1:40 PM, V4 (Chief of Police) said he was the first to respond to the accident on 11/27/24. V4 said when he arrived, V3 was standing outside of the transportation van on the phone. V4 said R1 was lying in the floor of the transportation van with quite a bit of blood coming from her head wound. V4 said when the paramedics arrived, V4 had removed the wheelchair from the transportation van and did not recall R1's wheelchair having a seatbelt that went over R1's shoulder. V4 asked how would R1 have been thrown out of her wheelchair if she

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was wearing a seatbelt that went over her shoulder.

On 12/19/24 at 2:53 PM, V5 (Registered Nurse/ RN) said when R1 returned to the facility after the 11/27/24 vehicle accident, R1 had bruising to her lower abdomen and upper thighs and had taken pictures of the bruising. V5 said R1 did not have any similar bruising to the shoulder or chest area that looked like it had come from a seatbelt like the bruising to R1's lower abdomen and upper thighs.

On 12/20/24 at 10:02 AM, V3 said the facility had received the new transportation van around the end of October 2024. V3 said she had not received any training on how to properly secure residents in the new transportation van.

On 12/20/24 at 12:17 PM, V9 (Physician) said he treated R1 at the hospital after the vehicle accident. V9 said he did not see any signs of seatbelt bruising to R1's shoulder and chest area. V9 said if R1 had been properly restrained, R1 would not have been thrown out of her wheelchair sustaining injuries. V9 said any person not properly restrained in a motor vehicle accident has a probability of dismemberment or death.

The facility's Report to the State Survey Agency's Regional Office of the 11/27/24 incident documented in part " ... ON 11/27/24 at 4:15 PM, facility was notified by facility transportation driver (V3) that a vehicle accident had occurred during transporting resident (R1) from appointment with (sic) resulted in resident injury. Resident was assessed by EMT (Emergency Medical Technicians) at the scene of the accident as (sic) was transported via ambulance to (Hospital) to (evaluate) and treat. Resident returned to facility

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via facility transport at 9:45 PM the same day with diagnosis: 14 staples and 11 stiches to top of forehead, minimally displaced left nasal bone fracture, potentially acute second distal phalanx fracture ..."

V3's written statement dated 11/27/24 documented in part " ... I slammed on the brakes to stop quick and (R1) went forward in her (wheelchair) hitting her head on the center console of the van and sliding out of her (wheelchair) onto the back floor of the van. I called the Administrator and let her know that I was in a wreck and then called 911 while checking on the patient that I had (R1). The police showed up and then the ambulance showed up and took over ..."

R1's Emergency Medical Services (EMS) ambulance report dated 11/27/24 documented in part " ... Upon arrival EMS observed a wheelchair transport van with moderate front end damage. Law Enforcement on scene advised the van purposedly hydroplaned and struck the vehicle in front of it. The driver (V3) was uninjured. The passenger (R1) ... was lying prone in back of van with moderate bleeding from her head. (R1) was seated in a wheelchair during the incident. It is unknown if she was wearing a seat belt. (R1) advised she went forward and struck her head and complained of head pain ... Large laceration to top of head. Approximately 4 inches in length. Skull can be seen. Moderate bleeding ..."

R1's hospital record dated 11/27/24 documented in part " ...presents after MVA (Motor Vehicle Accident) involving a facility wheelchair van. The patient was not restrained in the wheelchair and sustained a head injury after hitting the center console. She denies losing consciousness during

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the accident ... complains of pain in her head, right ankle, both shoulders, and nose. She reports the ankle pain is new following the accident .... The patient's shoulders are tender from the fall, and she describes her nose pain as feeling like someone hit her ... ED (Emergency Department) Course ... (R1's) imaging was notable for a left nasal bone fracture with deviation of the septum to the right ... also has a questionable right ankle fracture and 2nd digit fracture of the right foot ... (R1's) right ankle is mildly tender to palpation. We will place in a walking boot and have the patient follow up. Her laceration was repaired without complication. Due to the fact that part of the laceration involved the scalp and part of it involved the forehead (R1) received 14 staples for the portion of the laceration that involved the scalp, and 8 sutures for the portion of the laceration that involved her forehead..."

The facility provided an undated manufacture's User Instruction guide for securing passengers in the transportation van documenting in part " ... Secure Passenger ... 1. Attach Lap Belts- Use integrated stiffeners to feed belts through openings between seat back and bottoms, and/or armrests to ensure proper belt fit around occupant. A. On the aisle side, attach belt with female buckle to the rear tie-down pin connector ... ensuring buckle rests on passenger's hip. B. On the window-side, attach belt with male tongue to rear tie-down pin connector ... and insert into female buckle. 2. Attach Shoulder Belt- Extend shoulder belt over passenger's shoulder and across upper torso ... and fasten pin connector onto lap belt ... 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort ... Warning ... Never rely on wheelchair's lap belt or a postural support belt unless properly

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S9999	Continued From page 7 approved & crash tested..." The facility's undated Motor Vehicle Safety Program documented in part "...H. Seat belts and should harnesses (occupant restraint systems) shall be worn or used whenever the vehicle is in operation. The vehicle may not move until all passengers have fastened their restraints..." 2. R4's Admission Record documented an admission date of 5/12/23 with diagnoses that included cerebral infarction, anxiety disorder, hemiplegia. R4's 10/28/24 MDS documented a BIMS score of 14, indicating R4 was cognitively intact. R4's Electronic Medical Record (EMR) documented R4 was transported to a medical appointment on 11/5/24. On 12/20/24 at 12:30 PM, R4 said he had been transported to an appointment in the new facility transportation van in his wheelchair. R4 said there was a seatbelt that went across his lap but there was no seatbelt that went over his shoulder. (A)	S9999		