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
	IL6005300	A. BUILDING: ______ B. WING ______	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 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 the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	Attachment A Statement of Licensure Violation[illegible]	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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. 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. These Requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview and record review, the facility failed to assess a resident for pain and ensure timely care for 1 of 7 residents (R44) reviewed for pain and quality of care in the sample of 53. This failure resulted in delay in treatment for 27 hours after a fall before R44 was transferred to the local emergency room and determined to have sustained 6 rib fractures. Findings include: R44's Undated Face Sheet, documents diagnoses include repeated falls, multiple fractures of ribs, left side subsequent encounter for fracture with routine healing, age-related osteoporosis without current pathological fractures, restless leg syndrome (RLS), Diabetes Mellitus (DM.) R44's Quarterly Minimum Data Set (MDS), dated 12/16/2022, documents resident is moderately cognitively impaired, bed mobility and dressing supervision of 1-person physical assist, walking in room supervision and setup only. Yes-pain interview should be conducted. Pain within last 5 days: "yes- occasionally. Pain has made it hard for resident to sleep at night and has limited resident's day to day activities. Worst pain within last 5 days is rated at 5/10 (rated as a 5 on a scale of 1-10). R44's Undated Care Plan documents resident has a potential for pain r/t (related to) diagnosis of DM, RLS, hx (history) of repeated falls, osteoporosis. Interventions: administer medications as ordered, anticipate the resident's needs for pain relief and respond to any complaint of pain.	S9999		

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On 1/19/2023 at 2:05 AM, V31, Licensed Practical Nurse (LPN), documents, "Res (resident) observed sitting on the floor in her room on her buttocks with legs stretched out in front of her. walker was next to her. Stated she was getting her clothes ready. Had been rummaging through her closet. ROM (range of motion) x 4 WNL (within normal limits). No c/o (complaint of) pain or discomfort. Neuro-checks WNL. MD (physician) aware with NNO (no new orders.) Cont (continue) to monitor. Call out to family."

R44's Nursing Note, dated 1/19/2023 at 7:06 AM, V31, LPN, documents, "Res c/o soreness/tenderness to left ABD (abdomen.) No bruising, warmth or redness noted but tender to touch. L/S (lung sounds) clear bilat (bilateral.) No resp (respirations) distress noted. C/o pain with inspiration (breathing in.) SPO2 (blood oxygen saturation) 98% on O2 (oxygen)@ 2L (liters)/NC (nasal cannula). Call out to (V24, MD).

R44's Physician's Order Recap Report, dated 1/19/2023 documents, "Tylenol 325 milligrams give 2 tablets by mouth every 6 hours for pain PRN (as needed)."

R44's Post Incident Eval, dated 1/19/2023 at 2:09 AM, V31, LPN documents "Incident: fall, sitting on her buttocks with legs out in front, most recent pain level 0 (zero) on 1/12/2023 at 6:10 PM. Pain: N/A (not applicable) (use N/A if no pain reported.) Actions taken: monitor resident."

R44's Nursing Note, dated 1/19/2023 at 6:44 AM, V31, LPN, documents, "POA (power of attorney) aware of fall."

R44's Nursing Notes have no documentation of

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physician response between 7:07 AM through 2:21 PM on 1/19/2023.

R44's Nursing Note, dated 1/19/2023 at 2:22 PM documents, "Phone call made to (V24's) nurse due to resident complaints of pain in abdomen on left side, inquiring if doctor wanting to order portable X-Ray. Nurse states give Tylenol 650 mg (milligrams) per standing order for now q (every) 6 hours PRN (as needed), will check w/ (with) doctor about X-Ray and call back."

R44's Medication Administration Record (MAR) dated 1/19/2023 documents Tylenol 650 mg for pain 5/10 and was "E" effective at 2:30 PM.

R44's Follow-up: Fall dated 1/19/2023 at 7:16 PM, documents "most recent pain level: 1/19/2023 at 5:16 PM pain "1."

R44's Nursing Note, dated 1/19/2023 at 8:43 PM, V36, LPN, documents "(V24's) NP (Nurse Practitioner) received message regarding fall and abdominal pain, no X-Ray orders at this time. Continue to monitor resident for injury and any GI issues (black tarry stool/worsening abdominal pain/nausea/emesis)."

R44's Neurological Assessment Flow Sheet, dated 1/19/2023 and 1/20/2023 documents R44 had an appropriate pain response but no documentation if she had complaint of pain was documented on the flow sheet.

R44's SBAR (Situation, Background, Assessment, Recommendation), dated 1/20/2023 at 8:55 AM, V8, LPN, documents, "Abdominal pain. Resident complained of severe pain to her left Rib/Abdomen area. Resident is holding her left rib area and is unable to sit up."

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R44's Change in Condition Evaluation, dated 1/20/2023 at 9:20 AM, V8, LPN, documents, "Resident complained of severe pain to her left rib/abdomen area. Resident is holding her left rib area and is unable to sit up. Change in condition was reported to the primary care clinician on 1/20/2023 at 9:00 AM with recommendations to send to ER (emergency room) for eval (evaluation) and tx (treatment.)

R44's Nursing Note, dated 1/20/2023 at 9:30 AM, V8, LPN, documents, "Family representative returned call. Aware of resident's change in condition and being sent to local ER for evaluation."

R44's SNF (Skilled Nursing Facility)/NF (Nursing Facility) to Hospital Transfer Form, dated 1/20/2023 at 9:30 AM. Most recent pain level "1" 1/19/2023 5:16 PM pain location: abdomen acetaminophen (Tylenol) administered 1/19/2023 at 2:30 PM.

R44's Nursing Note, dated 1/20/2023 at 9:43 AM, V8, LPN documents, "Writer called for transport to local ER."

R44's Nursing Note, dated 1/20/2023 at 10:00 AM, documents, Emergency Medical Services here to transport resident to local ER. Papers sent with EMT's (emergency medical technicians.) Report given to EMT's.

R44's Nursing Note, dated 1/20/2023 at 8:17 PM, documents, "Family representative called w (with)/ update. Resident has 4-9 left rib fx's (fractures.) Will be admitted. F/u (follow up) to be documented."

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S9999	Continued From page 6 R44's Hospital History & Physical dated 1/20/2023 at 1:14 PM, documents resident is a 87 y/o (year old) female who presented to the ED (emergency department) after a fall. Pt (patient) is confused at bedside so is unable to provide thorough history. Pt does report she had fallen at some point in the day after standing up. She then fell onto a nightstand. She denies hitting her head or LOC (loss of consciousness.) Pt report left upper quadrant abdominal pain extending to left chest wall. Of note pt reporting burning with urination. Pt denies SOB (shortness of breath.) No HA (headache), vision changes, N/V (nausea/vomiting), numbness/tingling. Pt noted to have a history of recent falls 2/2 to lightheadedness. Integumentary (skin) assessment: bruise to LUQ (left upper quadrant) abdomen. Resident is alert and pleasantly confused. CT (cat scan) chest, abdomen, pelvis: there are acute fractures of the left fourth through ninth ribs laterally coupled which are minimally displaced. R44's IL (Illinois) Facility State Report, dated 1/22/2023 at 10:32 AM, V2, Director of Nurses (DON), documents (R44) is 87 years of age with a past medical history of dementia, amnesia, muscle weakness, unsteadiness on feet, age related osteoporosis and respiratory failure. (R44) was observed at 1:00 AM sleeping in her bed with her C-Pap (continuous positive airway pressure machine) on. At 2:00 AM (R44) was observed by the nurse sitting on her bedroom floor without oxygen or C-Pap on. When asked what she was trying to do (R44) stated that she was trying to rearrange the clothes in her closet. ROM (range of motion) was performed and patient tolerated without pain. (R44) was assisted from floor with help from staff, (R44's) room was dark, and walker was next to her. It appeared that (R44)	S9999		

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walked to her closet door and lost her balance falling on the left side. (V24, R44's physician) and POA were called and updated. At 7:00 AM pt c/o pain to left side of abdomen, no bruising was observed area was tender. (V24's) team was called, nurse requested a portable X-Ray and it was declined and to monitor patient. 2:22 PM (V24's) office was called and X-Ray was declined, nurse was informed to monitor for GI issues. During this time, patient pain was managed with Tylenol, the following morning, patient presented with pain that was uncontrolled and (R44) was send to the local hospital. (R44) was admitted with left rib fractures 4-9 and a UTI (urinary tract infection.) POA called to update the facility and to inform that (R44) would be returning after her hospitalization.

On 6/22/2023 at 11:10 AM, V31, LPN, stated she was assigned to R44 on night shift from 11:00 PM on 1/18/2023 to 7:00 AM on 1/19/2023. V31 stated she wouldn't administer pain medication after a resident falls because she doesn't want to mask (cover up) the pain. She was waiting for (R44's) physician to call the facility back and give orders on how to proceed. She stated she gave the day shift nurse (name unknown) report and let them know (R44) fell and had complained of pain and awaiting a call back from the physician.

On 6/21/2023 at 10:15 AM, V8, LPN, stated she was assigned to resident on 1/20/2023 day shift and recalled when she went to give (R44) meds and res complained of side pain and wasn't able to sit up in bed. V8 assessed R44 and didn't assess any bruising at that time. V8 didn't recall if a CNA (Certified Nursing Assistant) reported to her that the res had pain or not because the incident occurred over 6 months ago.

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S9999	Continued From page 8 On 6/22/2023 at 12:50 PM, V26, CNA, stated she was familiar with (R44) and took care of her often. V26 stated R44 transfers and dresses herself independently and walks with a wheeled walker. V26 stated she worked day shift on 1/19/2023 from 6:00 AM to 2:00 PM and was assigned to R44. V26 stated she couldn't recall what nurse told her R44 fell but they did and she always goes and checks to ensure her residents are OK when she arrives to the facility. V26 stated the initial check on R44 on 1/19/2023, she was asleep in bed. V26 stated when she went into R44's room at approximately 8:00 AM, R44 was sitting up on the side of the bed and was holding her left side and complained of pain. V26 stated she reported R44 complained of pain to the nurse (name unknown) and recalled R44 got out of bed and walked to the dining room for meals with her wheeled walker but as the day went on R44 was in increased pain because she started complaining of pain even more and told her she wanted to go to the hospital. V26 stated everyone knew R44 was in pain and she wanted to go to the hospital because she was telling everyone her left side hurts. V26 stated she was assigned to R44 again on day shift on 1/20/2023. V26 stated when she arrived she went straight to R44's room to check on her and she was lying in bed holding her left side and moaning. V26 stated on the morning of 1/20/2023, R44 asked V26 to help with getting dressed because she didn't want to move her arms due to increased pain and was holding her left side so she assisted R44 to get dressed and R44 asked her to assist her to stand from bed. V26 stated she reported it to the nurse (name unknown) and R44 was transferred to the ER a few hours later. On 6/22/2023 at 1:00 PM, R44 is lying in bed with her eyes open. R44 stated she recalled falling in	S9999		

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January 2023 and stated her left side hurt so badly and no one did anything about it. R44 stated at one point after she fell it hurt to breath in so she was no longer able to breath normally, she was taking short shallow breaths. R44 stated she wanted to go to the hospital way before the nurse sent her but no one would listen. R44 stated her left side didn't hurt if she wasn't moving but as soon as she would move she was sent to the moon with pain. R44 stated a nurse (name unknown) gave her pain medication one time after she voiced complaint of pain after she fell and she didn't understand why it took so long to go to the hospital, it was as if she needed to be granted permission to go to the hospital and she didn't feel that was right.

On 6/22/2023 at 2:45 PM, V32, CNA, stated she was assigned to (R44) on the evening shift on 1/19/2023 from 3:00 PM to 11:00 PM stated she didn't recall R44 fell and didn't recall if resident complained of pain.

On 6/23/2023 at 11:45 AM, V2, Director of Nurses (DON), stated when a fall was not witnessed V2 expects staff to assess the resident's neuro checks which includes a pain assessment and if the resident complains of pain during a neuro check she expects the nurse to document a progress note including an accurate description of location of pain, pain scale 1-10, signs/symptoms of pain and if resident was experiencing pain. When a resident complains of pain the nurse is expected to administer PRN pain and not wait for the resident's physician to call back. When a resident has a fall then complains of pain the nurse should notify the physician of the new complaint of pain.

On 6/23/2023 at 10:39 AM, V24, R44's physician,

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S9999	Continued From page 10 stated when a resident falls at the facility he expects a nurse to assess the resident immediately and move all extremities to ensure there are no major injuries and to assess the resident more frequently for at least 24 hours after the fall per the facility post fall policy and to document the assessment in the resident's medical record. The nurse should notify the physician when a resident falls by calling the office or on call physician during non-office hours. V24 stated there is no documentation in his records that the facility staff called on 1/19/2023 regarding the resident falling. V24's office received a fax dated 1/19/2023 at 6:48 AM documents (R44) had a fall, ROM and neuro checks within normal limits, no complaint of pain documented on fax report. V24 stated the nurse shouldn't have faxed his office when a resident has a fall, they should have called the off hours number and reported the fall that way. V24 stated there was no communication documented to his office that (R44) complained of pain with inspiration and/or left side pain he would have ordered a STAT chest X-Ray or send resident to the emergency room for further evaluation and treatment. V24 stated when the resident expressed pain during inspiration and had left side pain that was considered a change in condition and staff should have called either the physician's office or the on-call physician during off hours and he would have ordered a STAT chest X-Ray or ordered the resident to be transferred to the emergency room for further evaluation and treatment. When staff call the physician's office or the on call physician phone if the physician doesn't call back or they can't get ahold of the physician, and the resident is complaining of pain post fall, the nurse can transfer the resident to the emergency room per nurse judgement.	S9999		

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The Facility's Change in Condition policy, revised 12/7/2011, documents, "It is the policy of (corporate name) that a licensed staff member will notify the attending physician and responsible party of change in the resident's condition. Procedure: the physician/responsible party will be notified when the change is sudden in onset or represents a marked changed in relation to usual signs and symptoms or the signs and symptoms are unrelieved by measure already prescribed. Notification parameters are based on interact II change in condition file cards referencing AMDA (American Medical Directors Association) Clinical guidelines - acute changes in condition in the long-term care setting 2003, as attached to the policy. Physician/responsible party notification is to include but is not limited to: any unusual occurrence resulting in injury and significant change in resident's physical status. If the physician cannot be reached, the Medical Director will be contacted to report the change in condition until the attending physician can be contacted. Calls will be made to the family/responsible party until they are reached. The nurse will document in the clinical record. Documentation and assessment will be ongoing until condition has stabilized."

The Facility's Pain Management Policy, revised 6/19/2019, documents Policy: it is the practice of (corporate name) to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission, in part through an effective pain assessment and management program; providing our resident the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals

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S9999	Continued From page 12 through screening and accurately assessing pain in residents, encouraging residents to self-report pain and monitoring treatment efficacy and side effects. A standardized method for assessing, monitoring, evaluating and documenting pain in all residents will be utilized. Pain is defined as "whatever the experiencing person says it is, existing whenever the experiencing person says it does" Procedures: physician communication and involvement: a new onset, worsening intensity and/or in the absence of effective pain and/or side effect interventions. Nursing assessment responsibilities: when pain is identified, the nurse will implement the resident plan of care for appropriate management using pharmacological and/or non-pharmacological interventions. Administer order sets in the EMR (electronic medical record) will trigger an "Admission Pain Assessment and Management" order that require the nurse to document pain presence and rating every shift. The comprehensive pain assessment: will be triggered for completion 5 days after admission/readmission. Pain Rating Scale Selection: when gathering subjective and objective data for the pain assessments, the nurse will determine the most appropriate pain screening tool based upon resident presentation. When documenting pain, the nurse will identify the pain scale used and specify the parameters, so the meaning of the pain rating is clear, consistent and relevant for the resident. The following scales are accepted standards for use: numeric rating scale and FACE. Plan of care: the nurse will develop baseline and comprehensive plans of care addressing pain based upon information derived from the assessments. Appropriate resident centric pharmacological, non-pharmacological interventions will be utilized, and their effectiveness evaluated during established care plan reviews. Pain Management	S9999		

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Documentation will be provided by the nurse in the EMR for the administration of scheduled and/or PRN medications. Effectiveness of PRN pain pharmacological interventions ordered by the physician/practitioner will be measured and recorded following administration and using the appropriate pain screening tool.

(B)

Statement of Licensure Violations (2 of 2)

300.610a)
300.1210b)
300.1210c)
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

b) The facility shall provide the necessary

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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:

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 interview and record review, the Facility failed to ensure residents were safely secured in the Facility vehicle prior to transport for 1 of 7 residents (R375) reviewed for accidents in the sample of 53. This failure resulted in R375 sustaining a right hip fracture and right tibia fibula (lower leg) fracture requiring surgical repair after falling to the floor on the bus.

Findings include:

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R375's undated Face Sheet documents diagnoses including type 2 diabetes mellitus (DM) with diabetic neuropathy, essential (primary) hypertension, depression, peripheral vascular disease, acquired absence of left leg above knee, stage 2 pressure ulcer of right heel, and unstageable pressure ulcer to right ankle. R375's Face Sheet describes her hip fracture as "displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing" and her shin bone fracture as "displaced oblique fracture of shaft of right tibia, subsequent encounter for closed fracture with routine healing."

R375's Minimum Data Set (MDS) dated 3/13/2023 documented R375 was cognitively intact, required extensive 2+ person assistance with bed mobility, required total dependence of 2+ persons for transfer, and used wheelchair mobility device.

R375's Care Plan dated 3/27/2023 documents, "The resident needs assistance with ADL's (Activities of Daily Living)." "(R375) has an ADL self-care performance deficit r/t (related to) left AKA (above the knee amputation), impaired balance and limited mobility. 4/14/23 res (resident) has a power chair which has a seatbelt on it. Res reports she does not use seatbelt." "(R375) is at risk for falls. Balance issues d/t (due to) left AKA, DM, gait/balance, problems and impaired functional ability, osteoporosis, neuropathy, and takes medication that could have adverse reactions that could interfere with her safety."

R375's "Admission/Readmission Screener" dated 7/23/2022 documented R375 was at risk for falls.

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S9999	Continued From page 16 R375's Incident Reportable dated 5/30/23 documents, "(R375) is 82 years of age with a BIMS (Brief Interview for Mental Status score) of 15 (cognitively intact), who admitted to (Facility) in July of 2022 r/t post-surgical care after left above the knee amputation and sepsis. (R375) has a past medical history of Diabetes (Mellitus), PVD (Peripheral Vascular Disease), COPD (Chronic Obstructive Pulmonary Disease), Osteoporosis, Osteopenia, severe Osteoarthritis, Vitamin D Deficiency, current smoker, Alcoholism, RA (Rheumatoid Arthritis), and abnormal posture and a history of fractures. Recently (R375) requested a ride from transportation to go pick up new eyeglasses at (Optical Store). (R375) who uses a motorized w/c (wheelchair) was told by the driver that she needed to use the seat belt on her motorized w/c for this outing. (R375) refused and then agreed to the use of the seat belt for the outing. During the interview with the bus driver, (V16), he reported that when he put (R375) on the bus, she was refusing to wear her seatbelt that was attached to her motorized w/c. According to (V16), (R375) stated, "I never wear it, I don't understand why you're making a big deal about me wearing it." (V16) stated, "I told her that I couldn't transport her to the eye appt. (appointment) if she didn't wear it and that wearing the seatbelt was for her own safety." Finally (R375) agreed to wear the van seatbelt but would not put on the seatbelt to her motorized chair. (V16) reports that he felt everything was secure (four areas of harness on the van floor, and seatbelts) and they left for her appointment. While driving on (Local Street), several cars in front of him suddenly stopped and he had to put his breaks on abruptly, but he denies slamming his breaks. (V16) stated that he heard a noise and looked back, and (R375) was on the floor of the bus, laying on her stomach about 2 feet in	S9999		

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S9999	Continued From page 17 front of her chair. The w/c remained upright in the four areas of harness on the bus floor. He says he immediately pulled over and asked her if she was ok. (R375) denied pain, but insisted that (V16) get her up. According to (V16), (R375) was insisting on smoking a cigarette and getting back to the facility. (V16) stated that he called his supervisor who asked if he needed to dispatch an ambulance and he said that (R375) said she was ok and did not have any pain. (V16) stated that he asked (R375) if she wanted to go to the hospital and she stated No, get me up so I can have a cigarette to calm my nerves. (V16) stated that he was so nervous and upset that he helped her out to smoke a cigarette and she said she was fine and had no pain. Once in the bus, (V18), the 2nd van driver, arrived and began talking to (R375), and (R375) told her that her right shoulder was hurting a little. (V18) transported (R375) to (Local Hospital) where she was admitted r/t right hip fracture. (V18) reports that before (R375) went to (Local Hospital) that she smoked a cigarette, stated, "I really need to calm my nerves." Writer spoke with (V19), R375's Family, who reports that (R375) is just very fragile with all of her conditions, such as her RA, Osteoporosis, and Osteoarthritis. She reports that her mom came through the surgery ok and is being treated for pain control before she will return to (Facility). All safety harnesses and seat belts were checked on the bus and are in good working condition. The driver detail report does not show any hard breaking or stops during the trip in question. Van/Bus drivers were re-educated regarding safety/emergency procedures. (R375)'s plan of care will be updated upon her return to (Facility)." R375's Progress Note dated 5/29/23 at 2:47 PM documents, "Writer called (Local Hospital) for an update on resident. Resident was admitted to	S9999		

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hospital with diagnosis of fx (fracture) R (right) hip."

R375's "Orthopaedic Surgery Consult Note" from (Local Hospital) dated 5/26/23 documents, "CC (Chief Complaint): Motor vehicle accident. HPI (History of Present Illness): The patient is a pleasant 82-year-old female who is wheelchair-bound after a left above-knee amputation. The patient is wheelchair-bound and has chronic right knee and right hip contracture. In addition, she has a right lower extremity ulcer that is being treated conservatively. The patient was riding in motor vehicle today when the driver slammed on the brakes and the patient went flying down the center of the van. Currently the patient reports pain in her right hip, right distal tibia, right shoulder, and neck. She denies numbness and tingling right lower extremity." "XR (X-ray) pelvis demonstrates an acute right intertrochanteric femur fracture with subtrochanteric extension." "XR right tib-fib (tibia-fibula) demonstrates an acute nondisplaced distal tibia metaphyseal fracture." "The patient is a pleasant 82-year-old nonambulatory woman with significant flexion contractures of her right hip and right knee who sustained a right intertrochanteric femur fracture with subtrochanteric extension and a right nondisplaced distal tibia metaphyseal fracture. Plan for OR (Operating Room) Sunday with (V34, Orthopedic Surgeon) for right hip closed versus open reduction and cephalomedullary nailing."

On 6/22/23 at 2:21 PM, R375 was sitting in her wheelchair in her room. When asked about the accident on the bus, she stated, "No. I'd like to tell you, but it's too bad."

On 6/21/23 at 3:17 PM, V16, Bus Driver's phone

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S9999	Continued From page 19 went directly to voicemail. Voice message with return contact information was left. Additional attempts were made to contact V16 on 6/22/23 at 8:54 AM, 10:05 AM, and 1:40 PM, and 6/23/23 at 9:50 AM, but all calls went directly to voicemail with no answer. On 6/23/23 at 9:15 AM, V33, Director of Transportation, stated, "Residents are required to wear van seatbelts at all times. If they refuse to wear the van seatbelt, we will not transport them. We will transport them if they are not wearing their wheelchair seatbelts. They are not required, but are highly recommended. The van seatbelts are guaranteed, so I have no idea how (R375) ended up on the floor. The only thing I can come up with is maybe she loosened the belt. I wasn't there, but I talked to (V16) after it happened, and he thought everything was good. He didn't know how it happened either." On 6/22/23 at 10:29 AM, V2, Director of Nursing (DON), stated, "I would expect residents to wear seat belts connected to their motorized wheelchairs. I was not aware of R375 refusing to wear her seat belt prior to that incident, but I would have expected the driver to tell me. I did not find out about that until after it happened." On 6/22/23 at 2:00 PM, V1, Administrator, stated, "(R375) was not wearing her seat belt on her motorized wheelchair throughout the facility prior to the accident. When she got on the bus that day, she was refusing to wear the wheelchair seatbelt. She did allow the driver to put the van seatbelt on, but not the motorized wheelchair belt. She remembered the van seatbelt clicking, but did not remember what happened. It was the one and only time we have ever transported (R375). (V16) did not notify me prior to the accident that	S9999		

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(R375) was refusing to wear her wheelchair band, but I think he thought she was safe and did not anticipate that there would be a problem." "I understand it is our responsibility to keep her safe. If she would have been wearing the motorized wheelchair belt, it may have kept her from falling. She previously refusedto wear her wheelchair belt in the facility but now she wears it all the time."

On 6/22/23 at 11:15 AM, V24, R375's Physician, stated he would expect the facility to follow their policies and procedures, including bus safety. He stated, "If (R375) would have been secured in the vehicle, the risk of injury would have been less."

The Facility's "Driving Safety" Policy, not dated, documents, "It is the policy of (Facility Company) that all Drivers are trained to foster safety in the performance of their duties." "Drivers must be aware of the general and any special needs of passengers; ever prepared to assist them as may be required to provide for their safety and security upon entering, while riding, and upon exiting any vehicle." "Employees and their passengers are required to wear seat belts at all times while they are passengers in any vehicle which is in motion."

The Facility's "Fall Prevention - Steady Steps" Policy revised February 17, 2020, documents, "It is the policy of (Facility Company) to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs."

(A)