STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002646	A. BUILDING: _____ B. WING _____	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF MOLINE	430 SOUTH 30TH AVENUE EAST MOLINE, IL 61244

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S 000	Initial Comments Facility Reported Incident of 4/14/2021/IL132850	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.650a) 300.650e) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.650 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements. e) All personnel shall have either training or experience, or both, in the job assigned to them. 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to safely secure one resident (R1) during transport in the facility van of three residents reviewed for accidents in the sample of three. This failure resulted in R1 experiencing a fall from R1's wheelchair while being transported in the facility van, striking R1's face and sustaining facial fractures requiring multiple hospitalizations. Findings include: The facility's Final Investigation Report (undated) documents that on 4/14/21, R1 fell in the transport van and was sent to the ED (Emergency Department) for evaluation and treatment. Report indicates R1 fell forward when the van had to suddenly stop to avoid an	S9999		

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accident.
Report indicates R1 received two cuts above the eyebrow, one small cut on bridge of nose, one above the lip and a fractured nose.

The facility's Summary of the van accident signed by V1, Administrator dated 4/20/21 documents the following: V6, Driver, called the facility on 4/14/21 to report an incident in the van with R1 during transport. V6 stated he had to quickly brake the van to prevent a collision with a semi-truck. that had to do the same. in front of him. In the summary, V6 stated that, due to the force of the brakes being engaged, R1's buckle came loose and R1 fell forward hitting his face. R1 was then taken to the nearest hospital (Out of State Local Hospital 1). This summary indicates V6 reported that R1 had buckled himself in and that V6 checked the seatbelt by "pulling on the seatbelt several times to check that it was locked in place." V6 stated that he had no idea how R1 could have come out of the belt. This summary report also indicates R1 was interviewed and R1 confirmed that he had buckled himself and that V6 had double checked the belt. In the summary, R1 indicates he was looking at his cell phone when the accident occurred.

Nurse Progress Notes indicates:
4/14/21 at 10:20am, Received call from transporter that during transport, an accident on the highway caused him to slam on the breaks and swerve to avoid collision and the seatbelt holding R1 disengaged and R1 fell forward from the wheelchair. striking R1's face on the center console
4/14/21 at 6:15pm, R1 brought back to the facility from (Out of State Local Hospital 1) with staff assistance. Multiple new lacerations to face - four stitches above left eyebrow, three stitches above

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right eyebrow, three stitches to bridge of nose, three stitches upper lip, bruising to both eyes and swelling present throughout. No breaks present "CT (Computerized Tomography) clear."
4/15/21 at 3:55am, R1 sent to (Local Hospital 1) Emergency Department for excessive nose bleed. CT scan done and found fractured nose.
4/15/21 at 10:07am R1 still in hospital, to be transferred to (Local Hospital 2) for ENT (Ear, Nose, Throat) specialist.
4/15/21 at 11:47am R1 admitted to hospital (Local Hospital 2) with ENT services.
4/16/21 at 1:55pm Assessment of resident at facility (post hospital return)

(Out of State Local Hospital) ED (Emergency Department) record dated 4/14/21 documents that R1 was on Apixaban (anticoagulant) for blood clot prophylaxis presented at the ED for facial lacerations secondary to MVC (Motor Vehicle Collision). (R1) was traveling on highway when transport vehicle came to an abrupt stop due to traffic jam throwing (R1) from chair and hitting face on dashboard. Emergency Department Assessment documents a 2cm (centimeter) laceration above both left and right eyebrow, 2cm laceration along nasal bridge and 1cm laceration upper lip - all with active oozing. This record indicates R1 is alert and fully oriented.

(Local Hospital 1) Hospital Radiology records dated 4/15/21 indicate "Reason for Exam: Car accident with facial contusion earlier today, bleeding from nostril; rule out midface fracture, rule out head bleed; there is nasal packing in right nostril."
Radiological findings: acute highly comminuted fractures of nasal bones and anterior nasal septum bilaterally. Extensive bilateral facial soft

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S9999	Continued From page 4 tissue swelling. (Local Hospital 2) Hospital History and Physical Documentation dated 4/15/21 at 12:21pm indicates R1 presented with nose bleed for 3 - 4 hours due to facial trauma earlier. (R1) stated he was traveling in the facility van to a medical appointment (yesterday) when the driver slammed on the brakes and R1 hit the windshield. R1 was taken to (Out of State Local Hospital), CT scan was negative (for fracture) and R1 was released home. Later that evening, R1 started having copious amount of nosebleed and was taken to (Local Hospital 1) where CT scan showed "highly communicating acute fracture in the bilateral nasal bones and anterior nasal septum." R1's Minimum Data Set Assessment (3/4/21) BIMS (Brief Interview for Mental Status) indicates R1 is cognitively intact. On 4/21/21, R1 stated that he was in his wheelchair in the facility van going to a medical appointment. R1 stated he had the seat belt on, which he fastened and was looking at his phone when "All of a sudden there was all this braking and I flew out of the seat toward the front of the van into the console." R1 stated that V6 began apologizing over and over when he saw his face and that he was bleeding. R1 stated that V6 then helped him get into the passenger seat, seat belted him in and drove to the (Out of State Local Hospital) about 15 minutes away. R1 stated, "I couldn't have accidentally unlatched the seatbelt when (V6) hit the brakes. I tried to brace myself, messing with the seatbelt was the last thing I would've done." R1 stated "In my opinion, both (V5 and V6/Drivers) follow too close to the car ahead of them. V6 was driving too fast and	S9999		

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S9999	Continued From page 5 following too close." R2's Minimum Data Set Assessment/BIMS dated 3/16/21 indicates R2 is cognitively intact. On 4/21/21 at R2 stated he rides in the van two times a week and sometimes he buckles himself and sometimes the driver does. R2 stated that the buckle is off to the side - not in front, not in the lap area. R2 stated, "One time I couldn't get the buckle clicked all the way, told (V5, Driver) who said she already reported it, but it doesn't get fixed. I didn't know it wasn't clicked in all the way until we got back. I just moved and the buckle came apart." On 4/21/21 at 12:40pm V3, Driver/CNA (Certified Nurse Assistant) stated she was trained to fasten the seatbelt for the resident , not the resident to fasten himself. V3 stated that she was also told to be careful when braking , not to break suddenly, something with the brakes wasn't right. V3 stated that V5, Driver, did all the training. On 4/22/21 at 10:00am V5, Transport Driver stated that she worked at the facility for approximately three years and did the driver training. V5 stated that V6, Housekeeper/Driver was not properly trained. V5 stated that V3, CNA (Certified Nursing Assistant)/Driver was the last person she trained. V5 stated that she was trained in 2018/2019 and has been the primary driver since then. V5 stated that because V6 was not properly trained , that is why R1 was allowed to fasten the seatbelt himself. V5 stated that the driver is supposed to fasten the seatbelt, not the resident. V5 stated that she has told V2, DON (Director of Nursing) about the issues with the van and the seatbelt, but nothing was done (to correct the van or seatbelt issue).	S9999		

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S9999	Continued From page 6 On 4/22/21 at 10:10am V6, Housekeeping/Driver stated that he never had formal training. V6 stated, "No in-services or step by step training. Just followed along with V5 on trips sometimes." V6 stated that there was a "paper or sticker" that he found jammed in the buckle of the seatbelt on the day of the accident or the next day. That might have had something to do with the buckle not locking. V6 stated that when the seatbelt is put through the wheelchair, the buckle is not in front of the residents' lap "more off to the side of the resident." V6 stated that he doesn't believe R1 was able to release the buckle of the seatbelt at the time of the accident. V6 stated that he fastened the seatbelt on R1 on the day of the accident "But you barely had to touch it and it would come apart." V6 stated that V5 also had trouble with the seatbelt at times and told management. V6 also stated that the brakes were "spongy" and locked up when he had to slam on the brakes to avoid the collision. On 4/22/21 at 9:45am V4, Auto Shop President stated that the facility brought the van seatbelt on 4/20/21 for inspection. V4 stated that he was the person who physically inspected the seatbelt. V4 stated that the seat belt functioned as it should. V4 stated that the button on the latch has to be fully pushed to disengage the lock. The only other way for the latch to be pulled apart is that it's not fully engaged in the lock to start with. It is possible for the seatbelt to be pushed together, but not fully locked, be tugged on and not fully come out - depending on the angle. On 4/21/21 at 10:15am, the facility's van seatbelt and van were observed. The van seat belt locked and disengaged appropriately. No paper or other debris were noted to be inside of the locking	S9999		

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S9999	Continued From page 7 mechanism. At that time, V1, Administrator stated that they were not using the seatbelt due to questions about it's reliability to remain locked and the facility would be purchasing a new seatbelt. V1 stated she had never been told about any problems with the seatbelt prior to the accident with R1. V1 stated she was unaware the Motor Vehicle Safety Program directs the passenger to fasten the seatbelt. Facility Motor Vehicle Safety Program (undated) documents: Seat belts and shoulder 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 seatbelts. Transportation, Diagnostic services (undated) documents: If a facility is used, the person transporting the resident will ensure that the wheelchair brakes are locked, is properly secured to the floor and that the resident is properly secured in the seat with the seatbelt. (A)	S9999		